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Client-Centered Play Therapy with an Elderly Assisted Living Facility Resident

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To the Graduate Council:

I am submitting herewith a dissertation written by Angela M. Fuss entitled "Client-Centered Play Therapy with an Elderly Assisted Living Facility Resident." I have examined the final electronic copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Counselor Education.

Tricia McClam, Major Professor

We have read this dissertation and recommend its acceptance:

Tricia McClam, Joel Diambra, Vince Anfara, Jeff Cochran

Accepted for the Council:
Dixie L. Thompson

Vice Provost and Dean of the Graduate School

(Original signatures are on file with official student records.)

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Client-Centered Play Therapy with an Elderly Assisted Living Facility Resident

A Dissertation Presented for the
Doctor of Philosophy
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Angela M. Fuss
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Abstract

While play therapy is primarily used with children, recent research has begun to explore the use of this approach with adults and the elderly. The purpose of this study was to explore and describe in detail the process of Client Centered Play Therapy (CCPT) with an elderly assisted living facility resident through use of a qualitative case study. A single elderly resident participated in 12 CCPT sessions over a period of six weeks. Qualitative data were obtained through observational session notes, pre- and post-treatment interviews with the resident and the facility's Licensed Practical Nurse, pre- and post-treatment administrations of the Geriatric Depression Scale, and review of the resident's case file in order to gain insight into the process of CCPT with one elderly assisted living facility resident. Data collected were examined in relation to the play behaviors exhibited by the resident, typical stages of play therapy, potential therapeutic benefits, and the resident's view of the CCPT approach. Results indicate that the play behaviors of one elderly resident were markedly similar to those of children participating in CCPT and that this may be an appropriate and enjoyable method for addressing mental health needs of the elderly. Implications and recommendations for future research are discussed.

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CHAPTER ONE: INTRODUCTION

Background and Context

The population of adults aged 65 and older in the United States is multiplying at a rate that has serious implications for the counseling profession. By the year 2030, projections are that nearly 20 percent of the U.S. population will be over the age of 65 (Cummings, 2002). Current statistics indicate that older adults already have significant rates of untreated mental health issues, with even higher rates demonstrated for those residing in nursing homes and assisted living facilities (Stickle & Onedera, 2006). While early estimates of the prevalence of depression in these settings ranged from 13% to 35% for elderly residents (Chapin, Reed & Dobbs, 2004), more recent estimates suggest that nearly 52% of all assisted living facility residents are depressed (Winningham & Pike, 2007). The majority of residents in these facilities rely solely on primary care physicians for services, who often mistakenly dismiss symptoms of depression and anxiety as inevitable consequences of aging (Hill & Brettle, 2006). As this population continues to grow and assisted living facilities become an increasingly popular alternative to nursing homes, this problem is likely to worsen. Assisted living, however, does seek to provide a variety of services intended to address resident's needs, enabling them to age in place.

The guiding philosophy of assisted living (AL) includes maximizing independence, privacy, autonomy and dignity within a homelike setting, and their popularity continues to grow amongst older adults who require minimal assistance to live on their own and wish to avoid moving into nursing homes (Stone & Reinhard, 2007). As of 2002, approximately 36,400 licensed AL facilities with over 910,000 beds served a large proportion of older adults in the United States (Jang, Bergman, Schonfeld, & Molinari, 2006). This reflects an increase of 48% in

comparison to the number of facilities in existence in 1998 and poignantly demonstrates their growing popularity.

Despite the efforts of AL facilities to maintain the general health and well-being of residents, research demonstrates that residents continue to experience higher rates of depression and mental health problems than those dwelling in the community (Cuijpers & Van Lammeren, 1999; Cummings, 2002; Cummings, Chapin, Dobbs & Hayes, 2004). Jang et al. (2006) conducted a meta-analysis of existing research on the elderly and found that signs of depression were identified in anywhere from 13% to 25% of AL residents included in previous studies. These rates of depression are higher than those found for the elderly dwelling in the community and are nearing rates found for nursing home residents (Cummings, 2002). According to Cummings (2003b), elderly experiencing mental health symptoms are likely to experience decreased functioning and increased mortality. As residents tend to transition to nursing homes when their needs increase, it is much more likely that they will experience symptoms of depression, representing a distinct problem for both residents and facilities hoping to maintain or facilitate independence and the ability to age in place.

Though research demonstrates a significant need for mental health care among AL residents, studies indicate that the majority of AL residents do not receive necessary mental health services (Cummings, 2003a). Recent research by Cummings on the ability of AL facilities to respond to residents' mental health needs identified several factors that contributed to the inadequate provision of mental health services to AL residents. These included an absence of coordination between mental health professionals and other service providers, lack of focus on resident's mental health needs, and minimal expectations for the facilities themselves to provide

or facilitate these services (Cummings, 2003a). Most facilities relied on untrained staff to identify residents' mental health needs, while less than half utilized screening tools such as the Geriatric Depression Scale (GDS) to assess affective, cognitive, and behavioral symptoms of depression prior to admission (Yesavage et al., 1983). The GDS was developed explicitly for use with elderly residential populations in order to assess and screen residents for symptoms of depression without overemphasizing physical ailments. The specificity of this measure, as well as its short length of administration lend to its usefulness with populations who suffer from high levels of fatigue or difficulty concentrating (Sheikh & Yesavage, 1986), and it has become a preferred tool to identify symptoms of depression for settings that serve the elderly.

Identification of mental health issues among residents, however, is only the first step in addressing these needs. Comprehensive therapeutic intervention is necessary to both resolve symptoms and improve overall quality of life. Unfortunately, a large majority of AL facility administrators report making referrals to outside service providers on a very infrequent basis and primarily referring residents to a general practitioner instead of a mental health professional (Cummings, 2003a). These practitioners frequently offer prescriptions as a treatment for depression despite the evidence that medication alone is less effective than other therapeutic interventions (Hill & Brettle, 2006). While a number of approaches have proven effective in treating depression in AL residents such as cognitive behavioral, psychodynamic and narrative therapies (Stickle & Onedera, 2006), there is a growing body of literature supporting the innovative use of play therapy with this population (Landreth, 2002).

Play as a therapeutic modality is traditionally used to facilitate communication with individuals or groups of children for the purpose of enabling children to express their thoughts

and feelings, assimilate reality, achieve mastery, resolve internal conflicts, and cope effectively (Landreth, 2002). Play is also used to promote social interaction, develop communication and motor skills, and release energy and emotion (Guerney, 1983). In relation to play therapy, "play provides opportunities for children to de-intensify, resolve, and integrate stressful experiences by repetitiously reenacting difficult experiences" (Delpo-Guzzi & Frick, 1988, p. 262). This is done through the process that unfolds in play sessions whereby the child brings his/her feelings to the surface by playing them out and consequently facing them (Axline, 1969). The provision of a safe therapeutic environment allows the child to feel free to experiment with different versions of experiences, resulting in feelings of mastery and control over his/her own environment.

Previous research on play therapy provides evidence for the effectiveness of this modality with a variety of populations and myriad issues (Landreth, 2002). Play therapy has been demonstrated as an effective approach with victims of abuse or neglect, children who are mentally or physically challenged, emotionally disturbed, autistic, and those suffering from adjustment issues (Bratton, Ray, Rhine & Jones, 2005). Benefits resulting from the use of play therapy include, but are not limited to decreased aggression, better social and emotional adjustment, reduction in symptoms of depression, improved self-concept, reduction of stress and anxiety, and improved school behaviors (Landreth, 2002). Given the demonstrated effectiveness of this approach with children, researchers have begun to explore the therapeutic role of play in the adult world and the effectiveness and possible benefits of the use of play therapy with the elderly.

Though little research exists on the subject, the handful of studies available serve to inform therapists of key implications and benefits identified through the use of play therapy with

adults. According to Ward-Wimmer (2003), development is an ongoing process and "for adults, play continues as an important vehicle because it fosters numerous adaptive behaviors including creativity, role rehearsal, and mind/body integration" (p. 2). Similar to the role it holds with children, play appears to allow adults to escape reality, to be free from societal constraints and responsibilities, and to find pleasure in the unfolding of spontaneous, freely chosen activities. Much like children, when encompassed by the therapeutic environment and relationship established in play therapy, the adult is free to let the subconscious select issues that still need to be resolved and move towards self-actualization.

According to the literature, play therapy approaches with adults were found to be helpful for randomizing experiences (Bruner, 2000), overcoming obstacles in therapy (Marston & Szeles-Szecsei, 2001; Moffatt, Mohr & Ames, 1995), reviewing and reenacting life experiences (Mangrum & Mangrum, 1995), increasing emotional expression and social interaction (Marston & Szeles-Szecsei; Kendall, 2003), uncovering deep seated issues quickly (Bruner), and resolving play wounds and deficits from earlier in life (Caldwell, 2003). Additional benefits demonstrated through the use of play therapy with adults include improvement of social interactions, increases in cognitive skills, decreased depression, increased self-esteem, and improved openness to therapy (Ledyard, 1999). The demonstrated benefits parallel the areas of impairment that often trigger the relocation of AL residents to nursing homes in order to receive more intensive care (Cummings, 2002). This suggests that play therapy may be an innovative approach for addressing prevalent mental health issues for AL residents while also enabling residents to continue aging in place, thereby fulfilling the overarching mission of AL.

Statement of the Problem

A vast number of AL residents are suffering from untreated mental health issues, leading to higher rates of nursing home placement, decreased functioning and increased mortality. Although researchers have only recently started to explore the potential of using play therapy techniques with adults, success has been evident in studies utilizing this approach with adult and elderly populations in a variety of settings including AL facilities to address mental health issues and life satisfaction (Ward-Wimmer, 2003). As this is a novel approach for working with this population, little is known about the potential impact CCPT may have and few studies have offered researchers an in-depth look at both the process and experience of older adults participating in play therapy. More research is needed to explore the process and benefits of this approach with the elderly. This study seeks to utilize a descriptive case study methodology to explore CCPT with an AL resident, thereby supplying a rich, detailed description of the process of this approach with a single resident, as well as gaining insight into the perception of the individual's experience and potential therapeutic benefits.

Purpose of the Study

The therapeutic use of play with adults is new territory for therapists and more research is needed to understand the benefits of adult therapeutic play and techniques appropriate for this population. The purpose of this study is to explore and describe in detail the play behaviors exhibited, and the process and potential benefits of CCPT with an elderly AL resident through use of a descriptive case study, thereby adding to the limited existing body of research on the topic. CCPT and the stage model developed by Nordling and Guerney (1999) will serve as the theoretical framework through which collected data will be analyzed and interpreted. Qualitative

data will be obtained through observational session notes, interviews with the participating resident and an administrator pre- and post-treatment, GDS administration pre- and post-treatment, and review of the resident's case file post- treatment to gain insight into the resident's history and the process of CCPT with one AL facility resident. The pre- and post-treatment administration of the Geriatric Depression Scale (GDS) assess any changes in depressive symptoms experienced by the resident. Data will be used to describe the process of CCPT with this resident and potential implications for CCPT with other elderly persons may be discussed.

Research Questions

This study explores the following qualitative research questions:

(1) What play behaviors will the resident exhibit in CCPT sessions?

(2) To what extent will play behaviors exhibited by the resident follow the identified stages of CCPT as defined by the theoretical framework of Nordling and Guerney (1999)?

(3) Will there be any observable therapeutic benefits exhibited by the resident as a result of CCPT?

(4) How will the resident describe his/her CCPT experience after termination?

Definition of Terms

In this section, I provide definitions for settings and concepts directly related to the current study.

(1) General terminology:

a. *Assisted living (AL)*: For the purpose of the current study, a definition of AL will be used that highlights essential characteristics, thereby

defining the setting within which the study will take place. Though varying definitions of assisted living are used, typical services provided by AL facilities include 24-hour supervision, housekeeping, meal preparation and assistance with daily activities (Cummings et al., 2004). Additional services may include transportation and a range of group activities intended to provide social interaction. Most AL facilities are for-profit organizations governed by state long-term-care policy goals and licensing laws which provide additional incentives for consumers considering AL as a substitute to nursing home placement or in-home care (Stone & Reinhard, 2007).

b. *Elderly adult*: For the purpose of the current study, the terms elderly or older adult will include those aged 75 and older.

c. *Adult play*: Though a large number of potential definitions exist for play, the current study will utilize Ablon's (2001) definition of adult play. Ablon (2001) defined adult play as "a free ranging voluntary activity that occurs within certain limits of time and place according to accepted rules, accompanied by feelings of tension and joy and the awareness that it is different from ordinary life" (p. 347).

d. *Depression*: According to the DSM-IV-TR (2003), depression is characterized by loss of interest or pleasure in nearly all activities and a combination of the following: irritable or sad mood; changes in appetite, sleep and psychomotor activity; decreased energy; feelings of

worthlessness or guilt; difficulty thinking, concentrating, or making decisions; or recurrent thoughts of death or suicidal ideation. Symptoms of depression in the elderly can be somatic, dysphoric, behavioral, or cognitive, suggesting that individual's symptoms are highly variable and may be disguised by the aging process (Stickle & Onedera, 2006). For the purpose of this study, depression will be measured by the Geriatric Depression Scale before and after the provision of play therapy.

(2) Play therapy terminology:

a. *Play Therapy*: For the purpose of the current study, play therapy will be defined as "a dynamic interpersonal relationship between a child (or person of any age) and a therapist trained in play therapy procedures who provides selected play materials and facilitates the development of a safe relationship for the child (or person of any age) to fully express and explore self (feelings, thoughts, experiences, and behaviors) through play, the child's natural medium of communication, for optimal growth and development" (Landreth, 2002, p. 16).

b. *Child-centered Play Therapy (CCPT)*: For the purpose of the current study, a non-directive approach to play therapy will be utilized and is based on the same premises of play therapy as defined previously.

According to Landreth (2002), "Child-centered play therapy is a complete therapeutic system, not just the application of a few rapport-building techniques, and is based on a belief in the capacity and resiliency of children to be constructively self-directing" (p. 59). When discussion of the use of play therapy with the elderly is reached, Child-centered play therapy will be replaced with client-centered play therapy (CCPT) to emphasize its differential application with adults.

c. *CCPT Stages*: According to Nordling and Guerney (1999), children usually display different behaviors and issues at different times or stages in the therapeutic play process.

    i. *Warm-Up Stage*: This stage is characterized by behaviors that orient the child to the playroom and CCPT procedures, leading to the development of basic trust in the therapeutic relationship.

    ii. *Aggressive Stage*: At this point, the child begins to work on central therapeutic issues underlying the presenting symptoms and usually focuses on emotional self-expression.

    iii. *Regressive Stage*: During this stage, children continue to work on therapeutic issues, this time with a focus on relational issues such as nurturance, attachment, independence, and identity.

    iv. *Mastery Stage*: The final stage of the process involves behaviors that strengthen and consolidate gains as they complete their psychological work. This is often exhibited in

independent play and behaviors representative of difficulties resolved, but may also appear similar to play during the warm-up stage.

Significance of the Study

The current study serves several important purposes that make it a valuable contribution to the literature on play therapy and counseling approaches with the elderly. Perhaps the most important is that this study is one of very few descriptive case studies available on the use of play therapy with the elderly, not to mention its use in the AL setting. Of the handful of studies available on the topic, only one (Ledyard, 1999) sought to specifically describe a CCPT intervention with older adults in a residential setting. A large number of studies on play therapy have utilized case study designs in order to explore the effectiveness of this approach with children (Bratton & Ray, 2000). The limited research on the use of play therapy with adults, however, reveals an even shorter supply of available research utilizing a case study approach.

In regards to play therapy, the choice of a case study methodology offers researchers the opportunity to lend credibility to the effectiveness of an approach which is often seen as mystical and complex (Bratton & Ray, 2000). Though experimental studies are seen as having more credibility, the multiple sources of data utilized in a case study provide researchers with a deeper understanding of the complexities of an experience (Yin, 2003). Given the novelty of utilizing play therapy with the elderly, research providing similarly deep insight into its use with this population, and especially those in AL facilities, could prove to be incredibly informative for both counselors and AL administrators. Another important characteristic of this study, lending to its significance, is the qualitative exploration of the resident's experience with CCPT. While

there is existing research analyzing the subjective motivations for adult play (Ablon, 2001; Goldmintz & Schaefer, 2007; Guitard, Ferland & Dutil, 2005), no research exists that explores the perspective and reaction of the adult CCPT participant.

Limitations and Delimitations

Case study knowledge differs from other research knowledge in that it is more concrete, vivid, and contextual than abstract (Stake, 1995). As case studies are bounded in real-life situations, Merriam (1998) asserted:

> The case study results in a rich and holistic account of a phenomenon. It offers insights and illuminates meanings that expand its readers' experiences. These insights can be construed as tentative hypotheses that help structure future research; hence, case study plays an important role in advancing a field's knowledge base. (p. 41)

Unlike other research approaches, however, case studies are also subject to researcher and reader interpretation and generalization (Stake). This can be a benefit, but also a limitation to case study research. Merriam warned "both readers of case studies and the authors themselves need to be aware of biases that can affect the final product" (1998, p. 42). As case studies may either over simplify or exaggerate the phenomenon under review, readers may potentially draw erroneous conclusions as they attempt to integrate information gleaned from the research.

A major limitation of this study in particular, is the use of a single participant to explore and describe the process of CCPT. Information gathered from a single participant cannot be used to generalize results to a larger population, nor can it be used to make definitive claims about the phenomenon under review (Yin, 2003). Use of a single subject limits the ability of the researcher

to make any claims that similar results may be achieved with a larger population despite similarities with the individual participant. Therefore, results gleaned from a single-subject design are considered exploratory in nature as the design itself does not allow for the demonstration of statistical significance. For the purpose of this study, a single participant was chosen due to an absence of methodological procedures for exploring CCPT with an elderly AL resident. Despite the inherent limitations of single-subject research, this study will serve to provide a rich description of the process of CCPT with the resident, thereby offering readers an in-depth look at the phenomenon. Lack of generalizability, however, is not the only limitation to case study research.

Case studies have also been criticized for their lack of rigor, accumulation of large amounts of data, and for being incredibly time intensive (Yin, 2003). Additionally, as the researcher is the primary instrument of data collection and analysis in a case study design, results may be considered highly subjective, and therefore, potentially unreliable (Merriam, 1998). In relation to rigor, Merriam asserted, "rigor in qualitative research derives from the researcher's presence, the nature of the interaction between researcher and participants, the triangulation of data, the interpretation of perceptions, and rich, thick description" (p. 151). In order to ensure the rigor of the study and the quality of inferences drawn, the direct involvement of the researcher and gathering large amounts of data lends to the overall understanding of the phenomenon under review. For the purpose of this study, attempts have been made to address these potential limitations by incorporating multiple sources of data, couching the data within a specific theoretical lens, as well as identifying potential researcher biases prior to beginning the research.

Organization of the Study

Chapter One presents the current study, the purpose, its rationale, and relevance to the field of counseling. Chapter Two includes detailed reviews of relevant literature on play therapy, adult play, adult play therapy, and depression in the elderly. Chapter Three provides a description of the research design for the current study and methodological considerations including data analysis. The findings of the current study are presented in Chapter Four. Chapter Five includes a discussion of these findings, followed by conclusions drawn from the findings and implications for future research using play therapy with elderly AL residents as presented in Chapter Five.

CHAPTER TWO: REVIEW OF THE LITERATURE

Introduction

The purpose of this chapter is to provide the reader with an overview of the foundations of play therapy, specifically focused on child-centered play therapy and its use with adults. The chapter includes a description of the theoretical basis for child-centered play therapy, characteristics of the approach, and the demonstrated benefits as presented in relevant literature. The chapter continues with a description of adult play and its inherent benefits, followed by discussion of the recent research interest in the application of client-centered play therapy approaches with the elderly. Finally, the chapter reviews relevant information regarding the prevalence of depression in this population, current treatments, and the potential for utilizing client-centered play therapy to address this issue.

Theoretical Framework

Child-Centered Play Therapy (CCPT) was born out of the person-centered approach of Carl Rogers (1951) and adapted by his student, Virginia Axline, to apply parallel theoretical constructs to children. Each approach is centered on the belief that the desire for self-actualization acts as a motivating force within an individual, driving them towards maturity, independence, and self-direction (Axline, 1947). This force acts to propel an individual towards a resolution of problems and mastery over his/her environment. According to Axline, "when an individual reaches a barrier which makes it more difficult for him to achieve the complete realization of the self, there is set up an area of resistance and friction and tension" (p. 13). Behaviors that interfere with one's path to self-actualization lead to maladjustment and, when recognized, often motivate people to seek counseling.

Both Rogers and Axline actively theorized about the powerful impact of the therapeutic relationship as a primary factor in promoting and facilitating growth and adjustment. According to Rogers (1951), there are six conditions necessary for therapeutic personality change. The two persons must be in psychological contact while the client is experiencing a state of incongruence for which they are seeking assistance from the therapist. The therapist provides a safe therapeutic environment by being congruent and involved in the therapeutic relationship, experiencing unconditional positive regard for and empathic understanding of the client, and by communicating this positive regard and empathy to the client (Rogers). These conditions develop a trusting therapeutic relationship between the client and therapist, empowering the client to integrate environmental input, and carefully contemplate and experiment with new areas of self-direction in resolving their issues and becoming more self-actualized.

Both person-centered and CCPT approaches are based on the assumption that "the individual of any age has within him or herself, not only the ability to solve his or her own problems satisfactorily, but also a striving for growth which makes mature behavior more satisfying than immature behavior" (Guerney, 1983, p. 23). This view promotes the tenet that clients are capable of directing their own therapy and identifying areas in need of attention within an appropriate therapeutic structure. Axline (1947) adapted person-centered theoretical constructs to address the developmental differences between adults and children and their ability to self-direct. For adults, verbal expression or "talk-therapy" is the primary means to explore and address areas of maladjustment and the primary method adults use to communicate. Children, however, have yet to develop the same level of verbal functioning or insight necessary for participation in talk therapies. Instead, children communicate through other means, preferring

play to discussion as a way to express themselves. Before further discussion of play therapy can occur, the meaning of play itself must be addressed.

Though a range of definitions exist for play, a set of characteristics have proven common to all play behaviors. Play is intrinsically motivated and performed for the sake of the experience, without a specific underlying goal for the activities (Schaefer, 1993). This enables the pleasurable activities of play to unfold spontaneously at the whim of the child, offering control over the experience. Children at play are also actively involved in their environment and experience positive emotions resulting from the freedom from reality permitted through play (Schaefer, 1993). This allows the ever present motivational drive towards self-actualization to emerge during play, leading to the self-directed exploration of areas of maladjustment (Guerney, 1983). According to Axline (1947):

> Play therapy is based upon the fact that play is the child's natural medium of self expression. It is an opportunity which is given to the child to 'play out' his feelings and problems just as, in certain types of adult therapy, an individual 'talks out' his difficulties. (p. 9)

The incorporation of play, instead of relying solely on verbal communication, marks the major difference between CCPT and Rogerian client-centered therapy. The techniques used in play therapy are designed by knowledgeable adults with expertise in play as a therapeutic modality and child development. Group and individual interventions are planned and purposeful with the following goals in mind:

> (a) promote development of children's psychosocial, cognitive, and behavioral capacities and skills, (b) provide opportunities for children to

> express their ideas, thoughts, feelings, and perceptions, (c) increase children's abilities to effectively assimilate, master, and cope with life experiences and resolve internal conflicts, (d) provide opportunities for corrective learning experiences, and (e) impart information that enables children to learn about themselves and other people, understand their life experiences, and acquire age appropriate self-care behaviors. (Delpo & Frick, 1988, p. 263)

Just as client-centered "talk therapy" offers an adult the opportunity to become more self-actualized, play acts as the means for children to strive for the same goal in CCPT.

Personal growth, however, cannot be accomplished without the presence of a strong therapeutic relationship. Axline (1969) asserted eight basic principles for therapist behaviors that promote growth within the CCPT relationship:

(1) The therapist must develop a warm, friendly relationship with the child, in which good rapport is established as soon as possible.
(2) The therapist accepts the child exactly as he is.
(3) The therapist establishes a feeling of permissiveness in the relationship so that the child feels free to express his feelings completely.
(4) The therapist is alert to recognize the feelings the child is expressing, and reflects those feelings back to him in such a manner that he gains insight into his behavior.

(5) The therapist maintains a deep respect for the child's ability to solve his own problems if given an opportunity to do so. The responsibility to make choices and to institute change is the child's.

(6) The therapist does not attempt to direct the child's actions or conversation in any manner. The child leads the way; the therapist follows.

(7) The therapist does not attempt to hurry the therapy along. It is a gradual process and is recognized as such by the therapist.

(8) The therapist establishes only those limitations that are necessary to anchor the therapy to the world of reality and to make the child aware of his responsibility in the relationship. (p. 73)

Responding empathically to the child's behaviors, feelings and verbalizations is involved in the majority of Axline's eight principles and serves as the therapist's primary method for building rapport with the child and promoting growth. Empathic responses require the therapist to first be sensitive and receptive in order to accurately identify and understand the child's feelings, thoughts and actions. This recognition must be immediately followed by a sincerely worded response that demonstrates understanding and acceptance of the child (Guerney, 1983). Through these behaviors, the therapist stimulates the child to reach greater levels of expressiveness (Guerney). Axline's (1969) principles serve to guide the therapist's behaviors in the process of facilitating the child's growth within a safe therapeutic environment. In addition to providing the necessary therapeutic conditions through empathic responses and acceptance, CCPT must also address the fact that play itself is made up of actions and interactions with

objects, as well as the reality that children are in the process of developing their self-regulatory abilities.

Limit Setting

Axline's (1969) eighth principle addresses the issues of child client's self-regulation in relational and object interaction through setting therapeutic limits and session structuring. Verbal expression is never limited in CCPT and limits that are set tend to be few and are set only when necessary. As the therapist is regularly regarded as a play object and called on to actively participate in the play, the responsibility falls upon the therapist to draw boundaries around certain behaviors in order to maintain the child's safety and to facilitate the child's self-direction, self-exploration, and self-growth (Guerney, 1983). Limits are used to help the child define boundaries for behavior, to enable the therapist to remain accepting and empathic, and to help the child build self-regulation while in a safe environment (Guerney).

The first limit introduced to the child revolves around the structuring of the sessions. The play session begins with an introductory statement by the therapist alerting the child to the freedom available and the potential for limit setting, and the session ends with a countdown for the child alerting them to how much time remains (Landreth, 2002). These boundaries enable the child to differentiate between the play session and the real world, while also understanding that, like the real world, behaviors the play room will have some limitations. Additional limits are set as needed and may be set to maintain therapist's comfort, though they must always be clear, definable and enforceable (Guerney, 1983; Landreth, 2002).

Consistently enforced limits provide a sense of safety and security, furthering a child's self-control while relieving guilt from experimentation with new behaviors (Axline, 1969).

Though limit setting is inherently directive, each limit is purposefully paired with an empathic statement geared towards acknowledging and accepting the underlying desire the child has to break the limits. According to Guerney (1983), "accepting the feeling behind wanting to violate the limitation with the usual tone while controlling the behavior offers great security to the child" (p. 21), suggesting that the experience of limit testing is in itself therapeutic for the child as long as it is addressed empathically. Enforcing limits is approached in a similarly empathic manner offering the child a compassionate reminder and several opportunities to control the limited behavior before a consequence is given. Consequences usually involve ending the session when the limit is broken after a final warning has been given (Guerney).

Stages

Within the boundaries of the therapeutic relationship, children's play appears to follow a distinctive process with four typical stages. These stages are assessed through observation of recognizable patterns of behaviors or themes representative of therapeutic issues being addressed (Nordling & Guerney, 1999). While the number of CCPT sessions is determined by the individual child's demonstrated needs and progress observed across sessions and it is possible for a therapist to spend many months working with a child in CCPT, most children progress through the four stages in 12 or fewer sessions (Guerney, 2001). Though there is great variation in the amount of time an individual child will spend in each stage, the therapeutic relationship strengthens as the child progresses.

During the "warm-up" stage, the child begins to gain familiarity with the playroom and the therapist and moves towards taking a leadership role in exploring the freedom available in the playroom (Nordling & Guerney, 1999). This stage is characterized by limit-testing and

unfocused, briefly segmented play with the toys in the playroom. Examples of play behaviors typical for this stage include quiet and inhibited play, looking tentatively through all of the materials available, and limit testing behaviors such as minor aggression towards the therapist, swearing, or trying to remove things from the play room. During this stage the child is learning his/her role in the playroom and how this differs from other environments, as well as developing the trust needed in the therapist in order to begin therapeutic work (Nordling & Guerney).

After the child begins to feel secure in the playroom and trust has developed in the therapeutic relationship, the child typically feels more at ease to move into the "aggressive" stage where he/she begins to work on underlying therapeutic issues representative of difficulties the individual is experiencing in regards to emotional expression (Nordling & Guerney, 1999). In this stage behaviors can range from expression of anger, rage or desire for control, to developing greater emotional flexibility and assertiveness (Nordling & Guerney). Behaviors characteristic to this stage include dramatically "trashing" the play room (ie. making a mess), violence or passive aggressive acts towards the play materials and the therapist, adopting a directive and authoritarian role, or breaking playroom limits. The results of this stage include "developing increased emotional intelligence, greater confidence in self-expression, increased gains in self-control, and the development of more responsible and adaptive ways of interacting with others" (Nordling & Guerney, 1999, p. 20).

Following the "aggressive" stage is a period in which the child begins to experiment with issues in which the child is much more vulnerable such as attachments, identity and self-image, independence, and interpersonal skills. This is called the "regressive" stage. Behaviors characteristic of this stage include protecting and rescuing behaviors, age regression, and

nurturing (Nordling & Guerney, 1999). Some typical behaviors that often occur in this stage include cooking meals for the therapist, feeding and providing care for dolls or other playroom items, rescuing self or the therapist from danger, or requesting that the therapist provide nurturing through role play scenarios. There may be some blending between the "aggressive" and "regressive" stages, which could be a sign indicating the child is transitioning into the next stage or is addressing a variety of therapeutic issues that may be uncovered through the process of CCPT (Nordling & Guerney).

The final stage of the CCPT process is that of "mastery." In the "mastery" stage, the child works to solidify and strengthen gains made in therapy and demonstrate their newly acquired skills through solitary or cooperative play, as well as repeated play scenarios from previous sessions ending with more positive results (Nordling & Guerney, 1999). For many children, the "mastery" stage is relatively uneventful and may even resemble the play of the "warm-up" stage as these children have completed their psychological work. Behaviors typical for this stage include expressing creativity through art work, actively creating new games to play with the therapist, solitary play without therapist involvement, or construction projects with blocks or other items. When sessions are predominated by "mastery" behaviors a countdown to termination should be initiated.

Setting and Materials

The playroom itself should communicate to children that this is a special place just for them, and creating such a space requires much planning and effort (Landreth, 2002). The room should be comfortable and inviting, while still large enough to promote exuberant expression. It should also provide privacy from view and should be located in an area least likely to distract or

disturb others (Landreth). Just as the playroom is selected and set up carefully, toys selected for inclusion in the room are reviewed with equal scrutiny, keeping in mind that not all toys have therapeutic value. According to Landreth:

> Toys and materials should be selected that facilitate the seven essentials in play therapy: establishment of a positive relationship with the child, expression of a wide range of feelings, exploration of real-life experiences, reality testing of limits, development of a positive self-image, development of self-understanding, and opportunity to develop self-control. (p. 134)

Guerney (1983) recommended the selection of toys which can be used in a variety of ways, toys that encourage the expression of aggression and dependence, and toys that can be used by more than one person. Though it isn't necessary to have a fully stocked playroom, a typical playroom will contain three general types of toys: real life toys, acting-out aggressive-release toys, and toys for creative expression and emotional release (Landreth, 2002). Children often receive mixed messages regarding the expression of certain emotions, such as anger, and learn to avoid punishment by repressing these emotions (Trotter, Eshelman & Landreth, 2003). This makes inclusion of toys that will enable expression of aggression especially important within the therapeutic setting offered by play therapy. Actual items in the playroom might include a dollhouse, dolls, nursing bottle or pacifier, dishes, plastic food, playdough or clay, blocks, masks, crayons or paints, sand or water, bop bag, rubber knife or sword, handcuffs, toy guns, drum or musical horn, toy soldiers, telephone, medical kit, and puppets to name a few (Landreth, 2002).

Benefits

According to Schaefer, "play has the power not only to facilitate normal child development but also to alleviate abnormal behavior" (1993, p. 3). This has been demonstrated with CCPT since its introduction to the therapeutic community in 1947. Since its inception, play therapy approaches have focused on applying the curative powers of play in order to help children overcome their psychological difficulties (Schaefer). Resolution of these difficulties is achieved through a variety of therapeutic factors and clinical benefits characteristic to the play therapy process. Schaefer identified fourteen therapeutic factors and benefits likely to be experienced through play therapy: (1) overcoming resistance leading to a therapeutic working alliance, (2) enhanced communication leading to empathic understanding, (3) mastery over environment leading to increased self-esteem, (4) promotion of creative thinking leading to improved problem solving skills, (5) catharsis leading to emotional release, (6) abreaction leading to improved adjustment, (7) role-playing leading to practice and acquisition of new behaviors, (8) use of fantasy leading to insight and mastery, (9) metaphoric teaching leading to insight and feelings of normality, (10) attachment formation leading to attachment and improved relationships, (11) relationship enhancement leading to self-actualization and improved self-esteem, (12) positive emotions leading to improved well-being, (13) mastering developmental fears leading to overall growth and development, and (14) game play leading to enhanced ego strength and socialization (pp. 5-13). These factors and benefits reliably occur despite variations in treatment provider, setting, treatment duration, presenting problem, and demographic characteristics.

In a meta-analysis of 93 studies examining the effectiveness of play therapy, Bratton, Ray, Rhine, and Jones (2005) analyzed treatment outcomes from the past five decades of research. Initial review of the literature revealed a small number of well-designed studies with empirically valid results, and a wealth of smaller, less empirical studies. This suggests that, despite the large body of research that exists for play therapy, there remains a need for empirically stringent research in order to scientifically prove the effectiveness of this approach. Studies included in the meta-analysis were reviewed from both published and unpublished research and selection was based on the use of a control group along with pre and/or post-measures, and provision of statistical data sufficient to calculate treatment effect (Bratton et al.). Of the studies reviewed, children receiving play therapy performed better than control groups on outcome measures, and those receiving humanistic-nondirective treatments such as CCPT demonstrated a larger effect size than those in more directive treatments (Bratton et al.). The authors found significantly larger treatment effects for children receiving play therapy in a residential setting than in school and clinic settings, where they often receive far fewer sessions. Though short term therapy was also proven effective, longer durations of treatment were found to increase the efficacy and growth achievable in play therapy, with optimal impact occurring at an average of 30-35 sessions (Bratton et al.). The average age of children was seven years, however, no significant treatment differences were found for age or gender. Significant treatment differences were also missing for individual versus group treatment, with both demonstrating similar measures of effectiveness (Bratton et al.). Children were referred to play therapy for problematic internalizing and/or externalizing behaviors, or other targeted concerns such as

adjustment, academic achievement, or relational problems (Bratton et al.). Play therapy was found to be effective regardless of the presenting problem.

Play therapy has been effective in addressing a vast number of children's problems including the following: alleviation of hair pulling; amelioration of selective mutism; decrease in aggressive, acting out behaviors; improved emotional adjustment; reduction of stress and anxiety; improved reading and overall academic performance; decreased maladaptive behaviors; correction of speech problems; decreased emotional and intellectual problems; better social and emotional adjustment; relief of psychosomatic difficulties; reduction in symptoms of depression; improvement of self-concept; and reduction of separation anxiety (Landreth, 2002, pp. 43-45). It has been used effectively with a wide variety of special populations of children including witnesses of domestic violence, victims of abuse or neglect, children of divorced parents, those with mental retardation or learning disabilities, and hospitalized children (Landreth).

Treatment Considerations

Some pre-treatment considerations for CCPT include applicability, contraindications, and demographic characteristics. Due to the fact that the child is in control of determining the content and pace of the therapy, there is little need to identify specific behavioral goals that must be accomplished. According to Axline (1969), "regardless of the type of symptomatic behavior, the individual is met by the therapist where he is . . . and the therapist lets that individual go as far as he is able to go . . . because . . . the client is the source of the living power that directs growth within himself" (p. 25). The only groups for which CCPT is contraindicated are those with severe autism and schizophrenia; those unable to formulate a concept of self within a social environment (Guerney, 1983). Though seemingly applicable with most special populations, there

remains some question regarding age limitations for CCPT. Little information is available on the use of CCPT with children over the age of 12 and many suggest that it begins to lose its effectiveness as a therapeutic modality for children between the ages of nine and 13 (Guerney). No other demographic characteristics, client or therapist, appear to have a differential impact on the effectiveness of this approach.

Another consideration of CCPT surrounds therapist characteristics. According to Landreth (2002), the play therapist is "an adult who intently observes, empathically listens, and encouragingly recognizes not only the child's play but also the child's wants, needs, and feelings" (p. 98). These skills are generally obtained through clinical course work and instruction in CCPT and additional supervised training. However, there is more to CCPT than training and a therapist hoping to use this method must first be open to the approach (Guerney, 1983). As CCPT is child-directed and not symptom oriented, therapists must be willing and able to allow the child to lead the way and determine the direction of therapy. For a therapist, this can be incredibly difficult to do. Guerney (2001) points out that CCPT is more than just a set of techniques or principles, stating that CCPT therapists must be able to follow the system that is CCPT in its totality and must believe in the power of this therapeutic system to promote growth. Landreth (2002) also suggests that therapists should possess certain personal characteristics as well including sense of humor, objectivity, flexibility, non-judgmental nature, open-mindedness, patience and self-awareness.

Though the supply of literature demonstrating the effectiveness and benefits of CCPT as a treatment approach is vast, research exploring the use of CCPT with adults is surprisingly limited. Practitioners seem content to label play therapy as an approach solely for children. Play,

however, is a universal behavior and its curative powers are available to an individual no matter what their age. The following section will explore the role and benefits resulting from adult play in order to better understand its potential for therapeutic application.

Adult Play

There is a moderate body of literature exploring adult play, however, many continue to scoff at the idea that adults actually play, and little consensus exists regarding what specifically constitutes play or playfulness in adults. Ablon (2001) suggested that play doesn't disappear in adulthood but that it merely changes to suit societal norms and the adult world. Mangrum and Mangrum (1995) assert, "adults create their own approaches to play either by contrasting work and other life attitudes with play behavior or by choosing play activities that reinforce their life-styles" (p. 232). Scores of older women join the Red Hat Society, a social group formed to foster play and friendship, specifically for the purpose of embracing silliness and fulfilling a desire to play in an environment that frees them from societal expectations (Yarnal, 2006). Adults seem to seek out opportunities to retell and reenact their life stories and roles through play (Mangrum & Mangrum, 1995). Yet there remains the question of defining play.

In a developmental analysis of the play behaviors of children and adults, Ablon defined play as "a free ranging voluntary activity that occurs within certain limits of time and place according to accepted rules, accompanied by feelings of tension and joy and the awareness that it is different from ordinary life" (2001, p. 347). According to Ablon, play seems to operate in the same manner for both children and adults, serving to "promote development, awareness, organization, and mastery of affects" (p. 358), however, there may be a great range in the play behaviors exhibited.

Whereas children's play tends to focus on object play, adult play evolves to include language, metaphor, nonverbal behaviors and the body (Ablon, 2001). The most common types of adult play include verbal play, role play, construction play, pretend play, sensory motor play, and game play (Goldmintz & Schaefer, 2007). Erikson (1987), as cited in Ablon (2001), described the ever changing nature of play across developmental stages. Beginning with infancy in which play is dependent on the mother, Erikson (1987) outlines the evolution of play behaviors as they begin to incorporate pretend play, self-awareness, imagination, rules, symbolic thinking, and greater cognitive capacity (as cited in Ablon, 2001). Ablon states:

> Play for adults is present in language, verbal symbols, mythic figures, dream scenes, word pictures, drawings humor, and word play such as puns, irony, and sarcasm. Changes in vocalization such as tone, cadence, volume, and timbre, as well as body language and dress (costume) may comprise aspects of play when elements of exploratory, pretend, and for amusement are involved. (p. 351)

Just as play behaviors change over time, so does the time we spend in them. Colarusso (1993) suggested that the frequency of adult play decreases as the need to play out conflicts is mediated by the adult's cognitive capacity and ability to reality test. According to Colarusso, "because the psychic apparatus of the adult is more complex and has a greater repertoire of ego mechanisms available to it, play is not used as commonly by adults; but when they do play, their play is as psychologically determined as the play of children" (p. 231). This suggests that the level of engagement achieved in play may be just as therapeutically effective with adults as it has proven to be with children. Apter and Kerr (1991) further the adult-child play comparison

through their claim that play performs an essential developmental role in the lives of both children and adults:

> It is not just that play encourages learning, or facilitates learning, or makes learning more enjoyable, although it may do all these things. It is that play is necessary for the developing child to become a fully-functioning and psychologically healthy adult, and for adults to tread the difficult path towards self-fulfillment and self-actualization. (p. 171)

This suggests that play is a vital component for healthy aging and may serve as an essential tool for adults in reaching self-actualization, thus reinforcing the need for research exploring the therapeutic use of play with adults and the elderly.

Developmental Needs

According to Colarusso (1993), "play may serve the same functions in adulthood as it does in childhood, promoting the engagement and mastery of phase-specific developmental tasks" (p. 225). In comparison to children, however, adults have very different developmental tasks in life, the practice of which is frequently the unconscious focus of play behaviors. Children play to learn, grow, develop capacities, anticipate change, and recover from upsets (Landreth, 2002). In addition to the continuation of these tasks, adults must also take care of others, work and be productive, cope with loss and aging, find meaning and purpose in life, feel creative, problem-solve, self-reflect, express sexuality, and prepare for death (Caldwell, 2003). Relational and physical changes over time impact the ability of an individual to effectively achieve these tasks and make successful transitions in life.

According to Erikson's (1950) stages of psychosocial development, as older adults, AL residents are poised at the climactic life cycle stage of ego integrity versus despair, in which the resulting virtue involves obtaining the wisdom to accept their lives, however they may have unfolded, and to feel satisfied with their contribution to the world (as cited in Monte, 1999). If able to integrate resolutions from the previous phases of psychosocial development, the resulting wisdom characteristic to this phase serves to confirm the life as it was lived, allowing the individual to transcend feelings of fear towards death and to gain an affinity for what was considered childish in earlier years. This suggests that self-actualized older adults may actually seek out opportunities to play in order to relish in the enjoyment of a life well lived. If, however, the older adult is unable to integrate previous developmental crises and, is therefore rendered unable to consciously accept the inevitability of death, they may suffer desperation for what they feel was an unsatisfying life lived in vain. This represents an important developmental transition for older adults, essentially combining all of life's lessons, and is perhaps the most complicated of all the psychosocial stages.

Benefits of Adult Play

In a recent review of adult play literature, Goldmintz and Schaefer (2007) identified ten psychological benefits specific to adult play most frequently cited in the research. These included the following: relationship enhancement, creativity, mood elevation, optimal arousal, improved learning, skill development, self-actualization, youthful spirit, mental acumen, and positive illusions (Goldmintz & Schaefer). Though the benefits overlap quite a bit with those identified for children presented earlier in this review (Schaefer, 1993), the implications of each benefit in relation to adults is explored. For example, despite the obvious increase in positive emotions

expected of mood elevation among both children and adults, additional implications for adults include physiological benefits and increased participation in social or leisure activities (Goldmintz & Schaefer). The benefit of youthful spirit is more specific to adult play and revolves around the idea that "the youthful qualities that are evident in play – fun-loving, enthusiastic, imaginative, exploratory, and flexible keep us vital and fully functioning individuals" (Goldmintz & Schaefer, p. 20). Mental acumen and positive illusions are also more directly associated with adult play as adults utilize complex play behaviors to keep their mental faculties sharp and to obtain unsatisfied desires (Goldmintz & Schaefer).

Colarusso (1993) suggested that "play is engaged in by both children and adults because it relieves the stress of living in reality and the frustration of basic conscious and unconscious needs; it provides a mechanism for confronting a challenge and overcoming it in a gratifying manner" (p. 226). For adults, play also seems to serve as a protective mechanism; offering a buffer against stress, a support during life transitions, a means of forming bonds and alliances, and a jump start for creativity and problem solving (Caldwell, 2003). Additional functions and benefits indentified as specific to adult play include engagement in social learning without fear of repercussions, continuously refining and extending nonverbal skills, randomizing experiences to help deal with the unexpected, providing social resources, and recovering a natural state of flow (Caldwell, 2003; Guitard, Ferland & Dutil, 2005).

Ablon (2001) asserted, "play in the therapeutic setting augments what in fact is an innate capacity for synthesis and organization of affect and supports developmentally progressive and adaptive forces in children and adults" (p. 351). Based on information regarding the intended goals of play therapy, the developmental tasks addressed through play, and the demonstrated

benefits specific to adult play, play therapy with adults appears to be a promising and underutilized approach appropriate for addressing a great number of issues. The following section will review literature specific to research examining play as a therapeutic intervention with the elderly. Though the available literature is sparse, there is support for its use across settings and methods.

Adult Play Therapy

As cited in Ledyard (1999), the International Association of Play Therapy defined play therapy as "the systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development" (p. 59). Using this definition it is possible to expand play therapy to address not just the needs of children, but those of adults as well. The majority of available research involving the use of play techniques with the elderly utilize directive, group approaches that do not strictly adhere to a particular system such as CCPT. Very few studies could be identified as client-centered, and even fewer followed the precise principles outlined by Axline (1947), Guerney (1983), or Landreth (2002). Despite the variation within the approaches utilized in the available literature, however, play therapy with adults appears to have a wide range of benefits.

In a study by Marston and Szeles-Szecsei (2001), play therapy techniques in the form of game play were used with older adults in nursing homes and other residential settings in order to gain insight into the potential benefits for this population. Case studies presented involved residents who were referred for demanding and agitated behaviors, anxiety, and cognitive impairment. As a result of using therapeutic play techniques, residents were able to overcome

obstacles in therapy and increase their level of emotional expression and social interaction. The play techniques also enabled cognitive assessment of residents as the games required use of hand-eye coordination, recall, focused attention, and judgment, providing insight into the cognitive abilities of the individual.

Kendall (2003) experimented with a structured group play format that also incorporated game play as a therapeutic intervention. The author was a novice counselor with little experience when she was placed in a residential treatment facility for substance abusers and other traumatized adults. Kendall had difficulty in creating any rapport with her clients and many refused to speak during talk therapy sessions. After exploring her client's histories, the author discovered that most of her clients had experienced sexual or physical abuse and neglect as children in addition to their current substance abuse issues and many had never learned to play. The author hypothesized that the women's limited interpersonal skills, social functioning deficits and resistance to treatment could be overcome by group play therapy. Kendall began a pilot group with eight of the female residents and met once a week for 90 minute sessions. Though the women initially scoffed at the idea of a play group, Kendall found that games proved to be the most successful and enjoyable activity for the group and attracted quite a crowd of interested residents. The games also provided opportunities for social interaction, following rules, experiencing winning and losing, learning to negotiate as a team, and cooperating with other players. These benefits served to increase involvement in therapy and to counteract skill deficits from earlier in life, however, the directive approach inherent to game play offers little insight into the self-directed nature of CCPT and its application with adults.

Johnson, Smith and James (2003) developed a method of drama therapy for use in nursing homes and other residential settings that incorporates free play as its central concept in order to address existential issues. The method, *Developmental Transformations*, focuses on the role of the playspace, embodiment, encounter, and transformation in promoting self-actualization. The playspace is characterized by the fundamental conditions of restraint against harm, mutual agreement that behaviors are play, and discrepant communication indicating that both reality and fantasy are present. According to Johnson, Smith and James (2003), the main task of the therapist is to help the client enter and remain present in the playspace in order to facilitate their engagement in the imaginal realm. Within the safety of the established playspace, group members utilize free play to act out their thoughts and feelings through dramatic movement. Embodiment and encounter concepts central to the approach focus on encouraging members to value the body as a source of thought and affect while also attending to the interpersonal encounters and experiences occurring within the group setting, and transformation is facilitated through the expression and resolution of issues. According to Johnson, Smith and James (2003), "Groups do not often leap into free play, so the therapist uses a developmental perspective to help members gradually achieve higher levels of play" (p. 88), this is accomplished through therapist direction in the initial sessions. The flow of play across sessions is maintained by the therapist through purposeful alterations of the level of structure, complexity, and interpersonal demand present in the sessions.

After years of examining play therapy sessions, Caldwell (2003) developed the Moving Cycle to describe the group process of cyclic healing among adults. The four phases of the cycle include awareness, owning, appreciation and action; all of which are similar to the stages

described by Nordling and Guerney (1999) discussed previously. In the awareness phase group members focus their attention on previously unrecognized sensations, feelings and thoughts. Play practices in this phase serve to cultivate attention and awareness of oneself and one another. The owning phase involves members working with the uncovered feelings from the previous phase and using play elements to change patterns of relating with others. The appreciation phase requires acceptance of the changed patterns and welcoming and caring for other group members. The action phase involves members integrating what was learned in the group with our behaviors in the outside world. Though each phase of the Moving cycle occurs in an ordered sequence, each phase is unique to the individual, the group, and the situation. Clinical features involved in the Moving Cycle include working out play wounds from childhood punishment or neglect, recovering from play deficits, practicing play signals, and reviewing a play history (Caldwell).

Bruner (2000) is one of the first researchers to explore the use of non-directive play techniques with adults. She described a group play session with five women and one man in an intensive inpatient unit that seems to combine the client-centered approach with counselor led discussion included for the sake of processing. According to Bruner, "the play happens in a group setting where the individual play and the group interaction provide both the picture of the individual's inner scene and the possibility for change as enacted with others" (p. 334). During the play session, Bruner emptied several boxes of blocks, toys animals, people and furniture in the center of the play space and instructed the group members to sit around the toys and do anything they pleased. All members chose to build structures and the activity was followed by discussion and exploration of each member's structure as they applied personal meaning to the finished products. Through discussion of these play products, several members acknowledged

problematic issues with codependency, hiding behind a façade, feeling weak, and distancing self from others. Bruner worked with the group to reframe ideas and thoughts regarding their structures as well as promoting alternatives to irrational or negative beliefs. She also provides suggestions for working with elderly adults who might not be ready to play and recommends a transitional activity or object, such as alphabet blocks, that provide a bridge from adult to child mode (Bruner).

Demanchick, Cochran and Cochran (2003) explored the adaptation and application of person-centered play therapy for use with adults with developmental disabilities. The authors point out that the social isolation experienced by adults with developmental disabilities can lead to depression, poor interpersonal skills, and negative self-esteem, all of which may be addressed within play therapy. They suggest that person-centered play therapy (PCPT) "may help persons of this population overcome behavioral and emotional difficulties and exceed functional limitations in several major life activities" (2003, pps. 48-49). Through use of a case study approach with two individuals, the authors explored the process and outcomes of this adapted model provided within the individual's day treatment facility. PCPT was provided to each individual for a total of 23 sessions lasting 40 minutes each across a period of 17 weeks. Through observations and interviews regarding qualities of client changes across sessions, as well as quantified observations of client changes and qualities of change outside of the sessions, Demanchick, Cochran and Cochran (2003) were able to identify changes occurring as a result of the PCPT intervention. Despite the lack of certainty regarding a direct link for PCPT and identified changes due to the case study nature of the research, analysis of both quantitative and qualitative data suggest that PCPT played a role in enhancing autonomy, environmental and self-

control, confidence, and self-expression among the individuals (Demanchick, Cochran & Cochran).

Ledyard (1999) provided the most directly relevant study exploring the use of child-centered play therapy with the elderly. In an attempt to identify an innovative way to help nursing home residents adjust to their environment and increase life satisfaction, Ledyard explored the potential benefits for applying CCPT with this population. In addition to facilitating emotional expression, Ledyard suggests that play therapy "can provide an atmosphere and environment in which the elderly feel they are accepted and understood in a time of their life when they are faced with extreme psychological and physiological concerns" (p. 60). She presents the results of three case studies in which CCPT was provided in 45-minute individual sessions once or twice per week for six to 10 sessions. Ledyard utilized a portable play kit with items recommended by Landreth (2002) in order to facilitate emotional expression. As a result of this short-term CCPT intervention, observations of clients suggest decreases in isolation, depression and forgetfulness, as well as increases in social interaction, self-esteem and mental sharpness (Ledyard, 1999). According to Ledyard:

> Clients showed interest in attempting to resolve issues such as loss of loved ones, isolation, lack of control over life situations, loneliness, and fears. These clients were now able to talk about issues they had once thought they had to keep to themselves, thereby finding solutions and discovering other ways of doing things. (p. 72)

These observations serve to support the continued exploration of the use of CCPT with the elderly, and especially those in residential settings such as nursing homes or assisted living

facilities. Given the similarly wide range of benefits for both children and adults in play therapy, CCPT could prove to be essential in addressing the mental health needs of AL residents. Though a large majority of research on therapeutic play with the elderly has involved the use of structured play techniques such as games or other directive approaches to address issues in treatment, there are a few studies that provide support for the use of CCPT with elderly adults in residential settings. As mentioned previously, elderly residents of AL facilities are an underserved population who must face issues related to aging, as well as adapting to a new environment. These variables often compound the risk of depression for this population. The following section will explore the prevalence and treatment of depression among the elderly.

Depression in the Elderly

Many factors associated with aging can contribute to depression including chronic illness, loss of friends and family, medical conditions or impairments, stress, and relational problems (Stickle & Onedera, 2006). In addition to preexisting problems, many of the factors that lead elderly adults to move into AL facilities such as spousal loss, chronic illness, functional disability, and limited social support are also common risk factors for late-life depression (Cummings, 2003b). Even the experience of relocation to an AL facility in itself can have a negative psychological and physical impact on an individual (Rossen & Knafl, 2007). The frequency at which any number of these risk factors occurs in an individual's life often makes it difficult to differentiate between symptoms of depression and normal aging.

Symptoms of depression in the elderly can be somatic, dysphoric, behavioral, or cognitive, suggesting that individual's symptoms are highly variable and may be disguised by the aging process (Stickle & Onedera, 2006). These symptoms may present as a decrease in mental

productivity, hopelessness, irritability, ceasing calls to physicians, or psychomotor retardation in AL residents (Stickle & Onedera). Unfortunately, unrecognized and untreated depressive symptoms can have serious consequences including increased personal and family suffering, apathy and isolation, poor nutrition, neglect of physical health, increased mortality, excess disability, high health care utilization, and longer lengths of hospital stays (Cummings, 2003; Jang et al., 2006; Stickle & Onedera). If depression is left untreated, these consequences serve to increase the amount of assistance needed to live independently and often prompt transitions from AL facilities to nursing homes.

Societal misconceptions of aging have served to compound the risks for older adults in need of mental health services, and led to the biomedicalization of aging in which symptoms are treated primarily with medication (Ponzo, 1992). Whether they are referred or self-directed, the majority of AL residents seek assistance from primary care physicians, who regularly prescribe medications for symptoms of mental illness without recommending any additional treatments (Hill & Brettle, 2006; Voyer & Martin, 2003). Psychotropic medications tend to be prescribed in excess and often for individuals who are not suffering from mental health problems (Voyer & Martin). Despite the over-prescription of medications, research has shown that only 10% to 15% of those elderly actually exhibiting signs of depression take antidepressants (Voyer & Martin). Even when accurately prescribed, ongoing research continues to provide evidence that pharmacological treatment alone for depression is ineffective in improving the quality of life for elderly patients (Kotova, Bondarev & Semyonova, 2004).

Although medication alone does not seem to impact overall quality of life for the elderly, research supports the effectiveness of a wide range of other therapeutic approaches for the

treatment of depression and improvement of well-being. Cognitive behavioral (Hill & Brettle, 2006), remotivation (Cummings, 2003), brief psychodynamic, interpersonal, reminiscence, and life review therapies have all proven effective in reducing symptoms of depression (Stickle & Onedera, 2006). Utilizing these approaches, counselors focus on working with elderly clients to generate more effective styles of coping, clarify emotional states, identify sources of anxiety, improve interpersonal communication, and integrate incongruent life themes (Stickle & Onedera).

Chapter Summary

Though there is an abundance of support for the approaches used to treat mental health issues such as depression in the elderly, as mentioned previously, there is a budding body of research exploring the use of play therapy with the elderly as a method for addressing mental health needs and promoting well-being. According to Terr (1999), though adults tend to devote most of their energy to work and love, play is in fact the third realm of human activity essential for well-being. Marano (1999) holds a similar view and asserts that play "may in fact be the highest expression of our humanity, both imitating and advancing the evolutionary process" (p. 38). She suggests that play in adulthood may serve to maintain and renew neural connections thereby increasing our ability to developmentally adapt and respond to environmental challenges (Marano).

The ability to adapt is a skill that comes in handy for an older adult faced with aging and death, and especially for those also re-establishing life in a brand new setting. Previous studies have explored the use of play as a therapeutic modality with elderly adults in nursing homes, hospitals, and assisted living facilities and have demonstrated the potential benefits of using this

approach with this population. The number of existing studies, however, is sparse and methods used to explore play therapy with this population have varied immensely. With this in mind, the current study seeks to add to the currently limited body of literature on the use of client-centered play therapy (CCPT) with elderly AL residents. The next chapter will describe in detail the methodological framework for the application and analysis of CCPT with elderly AL residents utilized in the current study.

CHAPTER THREE: METHOD

Introduction

The purpose of this study was to describe the process of client-centered play therapy (CCPT) with an elderly male assisted living (AL) resident to gain insight into the play behaviors and process of play therapy with this individual, any therapeutic benefits resulting from this approach, as well as the resident's reaction to the approach itself. This study explored the following qualitative research questions:

(1) What play behaviors will the resident exhibit in CCPT sessions?

(2) To what extent will play behaviors exhibited by the resident follow the identified stages of CCPT as defined by the theoretical framework of Nordling and Guerney (1999)?

(3) Will there be any observable therapeutic benefits exhibited by the resident as a result of CCPT?

(4) How will the resident describe his CCPT experience after termination?

The remainder of this chapter details the methodological procedures used for answering the research questions presented here. Procedures were submitted to the Institutional Review Board at the University of Tennessee for approval prior to data collection.

Research Design

As recommended by Yin (2003), this study followed an inductive, emerging case study design appropriate for phenomena for which little research exists. Yin defined a case study as "an empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between the phenomenon and context are not clearly evident" (p.

13). Boundaries prove to be an essential characteristic of case studies, defining the case itself as a bounded system within which observation occurs. According to Merriam (1998):

> One technique for assessing the boundedness of the topic is to ask how finite the data collection would be, that is, whether there is a limit to the number of people involved who could be interviewed or a finite amount of time for observation. (p. 27)

This study was bounded by time and number of participants, as well as the setting in which the study occurred and the parameters of the CCPT and stage model theories upon which analysis was based. In regards to play therapy, each session was limited to 45 minutes as this was determined to be an appropriate length for an individual to settle into the playroom and begin working (Landreth, 2002). Though observations were ongoing throughout the process of CCPT, observations of the individual occurred only within that particular play space and time, leading to a finite amount of data collected.

Yin (2003) proposed the use of a single-case design as appropriate in instances where the investigator has the opportunity to study a phenomenon over time, thereby offering a progressive and detailed description of the phenomenon. This study offered the opportunity to observe one AL resident over time as he experienced individual sessions of CCPT, thereby enabling the ongoing exploration of changes across six weeks of observation of his behaviors within the play therapy setting and strengthening the validity of the findings. Merriam (1998) also suggested that a case study is often the best choice when the researcher has little control over events, if variables are impossible to identify prior to the study due to their deep embedment in the situation, or if the researcher is particularly interested in process. For researchers exploring the

application of CCPT with various populations, process by which individuals make progress in treatment is frequently central to the study.

This study applied the theoretical framework of CCPT and the stage model of Nordling and Guerney (1999) to assess the process of CCPT with the resident and any therapeutic advancement and benefits experienced. Due to the lack of systematically defined interventions in CCPT and the non-directive role of the therapist, comprehensively identifying variables is a difficult task and case study analysis of process is often favored as the method used to examine the therapeutic impact of the approach (Bratton et al., 2005). Additionally, as CCPT has been effective with a wide variety of issues no matter what the presenting problem, it is hard to predict exactly which variables to measure when gathering data. As is often the case, individuals may begin play therapy with a specific presenting problem, while numerous underlying issues may also be uncovered and addressed during the CCPT process. Given the limited body of research on the use of CCPT with the elderly, let alone AL residents, predicting the potential impact of this approach and identifying measures to demonstrate this is further complicated. This suggests the case study design chosen is an appropriate methodology for use in CCPT research and this study in particular as the design serves to offer a rich, detailed look into the phenomenon as a whole with a single individual.

Though case studies may be particularistic, descriptive, or heuristic; descriptive case studies are especially useful for providing a rich "thick" description of the particular phenomenon researched (Merriam, 1998). Through the provision of such rich descriptions, case studies enable the reader to build upon personal experiences by learning vicariously from the research. This is especially useful in relation to the study of CCPT with an AL resident as very

little research exists on the subject and findings could add greatly to our limited understanding of the phenomenon, as well as the theory as it applied to this particular resident. This study was the first to explore the systematic application of the CCPT approach with an elderly individual residing in an AL facility. Given the lack of research available, it was imperative that this study offer readers the opportunity to gain deeper insight into the use of CCPT with an elderly adult, along with potential implications for future research and treatment.

Sample

Prior to selecting the participant, the researcher utilized knowledgeable administrative staff members from the assisted living facility who interacted regularly with residents to compile a list of residents whom they felt would both benefit from CCPT and be willing to participate in the study. Given the wide application of play therapy with children and its efficacy with a variety of issues, inclusion and exclusion criteria were kept to a minimum. Exclusion criteria included length of residence less than one month, and severe physical or cognitive impairment that may impede participation in play. Selection criteria included residents over the age of 80, who could speak English, and those who the staff felt would benefit from therapeutic intervention as demonstrated by withdrawal, depression, and/or functional impairment. In accordance with IRB guidelines for the treatment of human subjects, each referred resident received an information sheet describing the nature of the study and requesting their participation prior to any data collection. Potential participants also received an informed consent form describing video and audio-taping procedures, potential risks and benefits for the participant or others, and informing participants of their right to withdraw from the study at any time. This consent form was provided in large print to address any visual impairment and was also

explained verbally by this researcher during the initial contact to ensure the residents comprehension of the purpose and risks associated with participation, while also offering the opportunity to have any questions answered regarding CCPT and the study. Thirty potential participants (26 Female, 4 Male) received the information sheet and the informed consent form which were delivered in person by this researcher to each individual's room.

After provision of the information sheet and informed consent form, the researcher made initial contact with each referred resident to review the information provided, answer questions regarding the study and screen for willingness to participate. This researcher made contact with 15 of the potential participants during the first return visit to screen for willingness. Fourteen of the potential participants declined involvement in the study, and one female gave tentative consent but requested to be contacted again at a later date. Prior to a second return visit to the facility to screen the remaining individuals, this researcher was contacted by the daughter of one of the residents who had received a consent form. She stated that her father was interested in participating in the study and that she felt he would be a very good candidate as she saw him as a playful individual. This researcher returned to the facility the next day and met with five additional potential participants who declined participation, followed by a visit to the resident whose daughter had made contact. This resident gave consent and appeared very willing to participate. Therefore, a single participant was purposefully chosen based on selection criteria including need for services, willingness to participate, and convenience (Merriam, 1998). Screening was imperative to the study as the majority of referred residents expressed disinterest during the initial contact in response to the focus on play, thereby decreasing the number of

potential participants drastically. It is unknown if any of the remaining five referred residents would have expressed interest in participating.

In addition to selection of a single participant, a single administrator was selected based on her frequency of interaction with the participant and her ability to provide relevant information regarding the participant's history, current behaviors, and observations of behavioral changes over time. The Licensed Practical Nurse (LPN), who had been employed at the facility for the past 10 years, was provided with both the study information sheet and the informed consent form prior to initial contact. The researcher made initial contact with the LPN to describe the CCPT approach and expectations of the participant, the goals of the pre- and post-interviews that would be conducted with her, and to answer any questions she might have regarding the study.

The CCPT Intervention

For the purpose of this study, 12 sessions of individual CCPT were provided to a single AL resident and video-taped for later analysis. While the majority of studies that have involved play therapy with adults have averaged six to eight sessions (Bruner, 2000; Caldwell, 2003; Johnson, Smith & James, 2003; Ledyard, 1999), research on play therapy indicates that 12 or more sessions may be necessary to advance through the warm-up, aggressive, regressive, and mastery stages of CCPT (Guerney, 2001). The sessions provided in this study were 45 minutes in length and offered twice per week for six weeks, following guidelines recommended by experienced play therapists (Guerney, 2001; Landreth, 2002). Sessions occurred in the resident's apartment in the AL facility, thereby continuing to offer privacy and enhancing the resident's

comfort level during sessions (Ledyard, 1999), and each session was scheduled at a time that was convenient for the resident.

For each session, the same play materials were brought to the resident's apartment by the researcher and placed within the resident's reach on a work table in the apartment. Play materials included the following: Play Doh, drawing materials, plastic animals, water guns, building blocks, plastic food, toy cars, handcuffs, baby doll, army men, toy medical kit, baby bottles and accessories, toy money, cooking equipment, sword, tool box, magic wand, plastic jewelry, and dishes. These materials were selected based on guidelines provided for travel play kits and the range of emotional expression made possible through use of the materials (Landreth, 2002). As is typical of CCPT, each play session began with an introductory statement outlining the guidelines of the session: "This is a very special time for us and in here you can say anything you want and you can do just about anything you would like. If we come to something you can't do, I will let you know." This statement served to introduce the resident to the amount of freedom available in the session and the potential for limits to be set. After the introductory statement was made, the resident was free to choose any activity he liked for the remainder of the session. Any behaviors during the session were responded to with empathy and comments from the researcher were not directive in any way, as is commensurate with the CCPT approach.

Data Collection

Unlike other forms of research, the case study design does not identify any particular methods for data collection or data analysis (Merriam, 1998). Thus, the use of any of a wide range of methods may be utilized when conducting a study of CCPT with an AL resident. This study utilized observational session notes, pre- and post-treatment interviews, pre- and post-

depression scale scores and documents as sources of data to explore the process of CCPT with an individual AL resident and identify therapeutic benefits resulting from the application of this approach.

Observational session notes (see Appendix A for session note format) served as a primary source of data to explore the process of CCPT with an AL resident. As a research tool, observations serve a specific research purpose, are planned, deliberate, and are systematically recorded (Merriam, 1998). In this case, the researcher served as participant observer in each of the 12 sessions and recorded detailed observations of the individual's behavior and verbalizations after reviewing each session. These session notes served to record any changes exhibited by the resident throughout the CCPT process. Sessions were also video-taped and reviewed by three observers selected for their expertise and experience with play therapy. One observer was specifically trained in CCPT and has had over 10 years of experience as a licensed counselor providing this service to children. The second observer had attended numerous training courses on the CCPT approach and had 15 years of experience as a school counselor utilizing directive play therapy techniques with children. The third observer, also a licensed professional counselor, was also trained in the CCPT method and has had over 20 years of experience in applying this approach in a wide range of settings and with innumerable children, and has contributed greatly to the related body of literature through research articles and textbooks. Neither the observers nor this researcher had had any experience in applying play therapy approaches with adults. In preparation for assisting with the study, observers met with the researcher to receive the recorded sessions, address any questions regarding the study, discuss the purpose of the observational notes, and to review CCPT stage-related information

including typical behaviors and indicators of progress. Observers were provided with blank copies of the session note formatted for use in the study as well as copies of relevant literature to provide a source of information in case the observers felt they needed to review CCPT or the related stage theory while recording their observations. The multiple perspectives offered by the researcher and experienced observers served to triangulate results and add to the validity of the findings by mediating researcher bias.

In addition to session note data from multiple sources, interviews (see Appendices B and C for interview protocols) were also conducted to provide insight into the resident's history, and the therapeutic benefits and reaction of the AL resident to CCPT. According to Kvale (1996), the purpose of the research interview is "to elicit spontaneous descriptions from the subjects rather than to get their own, more or less speculative explanations of why something took place" (p. 131). The current study utilized semi-structured interviews to elicit relevant information from the resident and the LPN regarding history, current behaviors, changes in behaviors, and reactions to CCPT. In a semi-structured interview, questions included are either flexibly worded or may involve a mixture of structured and unstructured questions. The majority of the semi-structured interview, however, is "guided by a list of questions or issues to be explored, and neither the exact wording nor the order of the questions is determined ahead of time" (Merriam, 1998, p. 74). This format enables the researcher to respond in the moment and explore new ideas related to the emerging perspective of the interviewee, and is further facilitated by the use of follow-up questions and probes to prompt the gathering of more information (Kvale).

This study included interviews of both the LPN, and the AL resident undergoing CCPT for the purpose of gathering relevant information (see Appendix B for LPN interview protocol).

As CCPT therapists must accept the client with unconditional positive regard, having too much information about the individual prior to beginning therapy could bias interpretations made (Landreth, 2002). Therefore, a minimal number of questions were asked of the LPN in order to gather only pertinent information regarding the resident's current needs and the reason for referral. The interview was scheduled at the convenience of the LPN and was audio recorded and transcribed for the purpose of later analysis by the researcher.

In order to further avoid biasing interpretations, similar guidelines for asking a minimal number of questions were followed during the interview of the resident prior to beginning CCPT (see Appendix C for resident interview protocol). After consent was obtained from the resident to participate in CCPT, a semi-structured interview was conducted with the resident in order to explore his history and perceptions of his current mental health needs. This interview served to develop a context for the resident's behaviors and offered insight into his specific needs at that time. The interview was scheduled at the convenience of the resident and was audio-taped and transcribed for later analysis by the researcher.

In addition to interviewing the LPN and resident prior to beginning CCPT, the researcher also conducted post treatment interviews with both individuals at the completion of the 12 sessions for the purpose of eliciting the reaction of the resident to the experience of CCPT (see Appendices B and C for interview protocols), as well as identifying any changes in the resident as observed by the LPN. These interviews were also semi-structured and utilized follow-up questions and probes to enable deeper exploration of the LPN and resident's responses (Kvale, 1996). These interviews were also scheduled at the convenience of the LPN and the resident and were audio recorded and transcribed for later analysis by the researcher.

For the purpose of the current study, relevant documents were also utilized as a source of data. Merriam (1998) stated, "documents are, in fact, a ready-made source of data easily accessible to the imaginative and resourceful investigator" (p. 112). Their authenticity and accuracy, however, must be assessed in order to realistically interpret data obtained from documents. With this in mind, the researcher obtained consent from the resident and LPN to review case file documentation maintained at the facility including the resident's current medical records. Review of these records provided information regarding the resident's medical history, previous Geriatric Depression Scale (GDS) scores, current medications and demographics, as well as the events occurring throughout his AL residency. This information provided additional context within which to consider his behaviors and any observed therapeutic change and deepened the researcher's understanding of the resident.

The final form of data collected in the study was a standardized measure for depression given to the resident before and after the CCPT intervention. As AL residents often suffer from untreated depression, it is important to assess any pre-existing depressive symptoms experienced by the resident, as well as any changes that might have occurred as a result of CCPT. Symptoms of depression were measured in this study using a shortened version of the Geriatric Depression Scale (GDS), which was designed explicitly for use with elderly in a wide variety of settings including the community, nursing homes, hospitals, and assisted living facilities (Yesavage et al., 1983). The GDS was developed in response to limitations of existing measurements when applied to the elderly population. Yesavage asserted that, though there are many self-rated depression scales in existence, many are not specifically designed for use with the elderly, focus too heavily on physical complaints, and are often complicated and not easily understood. He

further suggests that in selecting a measure to be used with AL residents, the researcher must be purposeful in choosing a measure that is not overly taxing or stressful for the resident, thereby improving the odds of completion (Yesavage et al.)

The GDS requires up to 10 minutes to verbally administer and consists of 30 items measuring affective, cognitive, and behavioral symptoms of depression. Questions assess mood quality, levels of energy and motivation, hopelessness, social initiative, and subjective evaluation of functioning (Peach, Koob & Kraus, 2001). Responses are given in a simple, yes/no format and a total score ranging from 0-30 is calculated with higher scores indicating greater severity of depressive symptoms. The GDS demonstrated reliability of internal consistency and stability with a chronbach alpha of .94, split half reliability of .94 and a one-week test-retest correlation of .85 (Peach, Koob & Kraus). Studies utilizing a cut-off score of 11 on the GDS to indicate depression yielded an 84% sensitivity and 95% specificity rate (Yesavage et al., 1983). These rates were confirmed, in addition to the construct validity of the GDS, in relation to two other depression measures; the Hamilton Rating Scale for Depression and the Zung Self-Rating Scale for Depression with sensitivity ratings of 90%, 82%, and 86% respectively, and specificity remaining constant across scales at 80% (Yesavage et al.).

Sheikh and Yesavage (1986) developed a shortened version of the GDS that included 15-items derived from the larger GDS (see Appendix D for shortened version). This measure has also been demonstrated as a reliable and valid measure for depression and may be preferred for residential populations due to its minimal administration time of 5-7 minutes (Jongenelis et al., 2005). This study utilized the 15-item GDS to measure depressive symptoms in the resident before and after the 12 sessions of CCPT to assess the therapeutic impact of the approach with

the resident. For the shortened version of the GDS, scores range from 0-15, with higher total scores indicating greater severity of depressive symptoms. A cut-off score of five was used in this study to differentiate between levels of severity in relation to symptoms of depression, as is suggested for the shortened version of the GDS, with total scores equal to or greater than five indicating moderate to severe depression (Sheikh & Yesavage). In addition to established reliability and validity measures, the 15-item version has also demonstrated the ability to measure changes in depressive symptoms over time (Vinkers et al., 2004), and may be used as a continuous indicator of depression in addition to its use as a discrete screening measure (Mitchell, Mathews, & Yesavage, 1993). This is another benefit relevant to this study as the shortened GDS remains sensitive to changes that may or may not have been due to the CCPT intervention.

Data Analysis

In case study research, data collection and analysis are conducted simultaneously and at multiple levels of description and interpretation (Merriam, 1998; Stake, 1995; Yin, 2003). This study utilized the constant comparative method of data analysis within and between multiple data sources in order to identify emergent categories and findings developed from analysis of session notes, interviews, and documents. Total scores for the resident on the pre- and post-administrations of the GDS were also calculated in order to assess any changes in symptoms of depression.

Observational session notes produced by the researcher and three experienced observers viewing video-taped sessions were analyzed to identify themes appearing in the resident's play sessions, as well as any adherence to the stage process of CCPT as defined by Nordling and

Guerney (1999). Each set of session notes was read by the researcher who then produced an initial list of behavioral, verbal, and stage-related themes based on notably recurring behaviors/verbalizations as reported by the researcher and the observers. Session notes were then re-read by the researcher to adapt and verify the initial list of themes. The modified list was then reviewed by the researcher and each observer in separate meetings, two in person and one over the telephone, to discuss and determine accuracy of thematic labels, reach agreement on the behavioral themes and proposed stages, and to allow for triangulation of the data obtained via member checking.

Pre- and post-interviews with the LPN and resident were transcribed and analyzed by the researcher in order to identify information relevant to provide a context for the resident's behaviors, therapeutic benefits resulting from CCPT, and the resident's reaction to the CCPT experience. The interviews were transcribed and reviewed for relevant themes and information that arose. Thematic topics and relevant information was initially identified along with particular quotes exemplifying each topic, followed by a second review to verify the appropriateness of themes. Data regarding the resident's depressive symptoms as measured by the 15-item GDS was collected before and after the completion of the CCPT intervention. Total scores were calculated at both points in time, representing the resident's level of depressive symptoms before and after treatment. Given the single-subject nature of this study, any changes in the resident's scores were analyzed in relation to three previously calculated total scores from staff administrations of the GDS occurring at several points during his residency at the facility.

Data Validity

Yin (2003) suggested that issues of construct validity, external validity and reliability should be addressed prior to conducting the study in order to strengthen the resulting findings. In the current study, construct validity and researcher bias was addressed through use of multiple data sources and triangulation. Stake (1995) defined triangulation as the use of "multiple perceptions to clarify meaning, verifying the repeatability of an observation or interpretation" (p. 454). This was achieved by enlisting three experienced observers to review video-taped sessions and record their own observations regarding the resident's play behaviors and progress in CCPT. External validity was addressed through the application of the theoretical frameworks of CCPT and the stage model (Nordling & Guerney, 1999) characteristic of the play therapy process, which provided a lens through which to view play behaviors and progress. In this study, CCPT offered a viewpoint from which to analyze the resident's play behaviors, advancement through stages, and therapeutic changes experienced by the resident over time. As suggested by Yin (2003), analysis of data in single-case research can serve to reify the specific theory as it applies to the case. Therefore, a single case study involving one AL resident as he undergoes CCPT is expected to offer insight into the application of this theory with this particular resident, as well as the future application of this approach with similar individuals.

Chapter Summary

Merriam (1998) asserted, "the uniqueness of a case study lies not so much in the methods employed (although these are important) as in the questions asked and their relationship to the end product" (p. 31). In this study, the use of multiple sources of data such as observations, interviews, depression measurements and documents served to establish a chain of evidence

directly related to the theory used, while also strengthening the construct validity of the findings, and adding to the ability of the case study design to provide a full and rich description of the case (Yin, 2003). These benefits are especially pertinent for the study of CCPT with an AL resident. The use of a case study methodology provides deeper insight into the process and impact of CCPT than might be available through quantitative study. Though generalizability is limited by the single-subject design, the current method greatly adds to the body of knowledge related to the use of play therapy with the elderly and offers readers the opportunity to learn from and replicate the process in future research.

CHAPTER FOUR: RESULTS

Introduction

In preparation for the presentation of findings in this chapter, an initial review of the purpose, research questions, and methods involved in the study are provided. The purpose of this study was to describe the process of Client-Centered Play Therapy (CCPT) with an elderly assisted living (AL) facility resident. In accordance with this purpose, one resident participated in 12 individual CCPT sessions that were video taped. Each session was 45 minutes in length, during which the resident was offered the opportunity to interact with a large variety of toys brought to his room in the facility. The researcher was interested in obtaining data regarding the following research questions:

1. What play behaviors will the resident exhibit in CCPT sessions?
2. To what extent will play behaviors exhibited by the resident follow the identified stages of CCPT as defined by the theoretical framework of Nordling and Guerney (1999)?
3. Will there be any observable therapeutic benefits exhibited by the resident as a result of CCPT?
4. How will the resident describe his CCPT experience after termination?

Multiple sources of data were utilized in order to obtain information regarding each research question. Data sources included the following: observational session notes for each individual CCPT session as recorded by the researcher and three experienced observers, pre- and post-interviews with the participant and a facility administrator, pre- and post-administrations of the Geriatric Depression Scale (GDS), and a review of the participant's case file at the facility at

the conclusion of the study. As described in Chapter Three, for the process of organizing and analyzing the data collected, the researcher utilized a constant comparative method to organize and analyze data and to identify themes that emerged from CCPT session notes. Pre- and post-interviews were transcribed and thematically analyzed for relevant information regarding the resident's history, current needs, changes in behaviors, as well as the resident's reaction to the CCPT process. The resident's standardized scores obtained from the completion of the GDS before and at the conclusion of the CCPT sessions were calculated to measure depressive symptoms. Finally, the resident's case file was reviewed in order to identify relevant information regarding demographics, medical history, and current medications for the purpose of providing a context for the study. The remainder of this chapter includes a detailed description of the resident, followed by the results obtained from data sources as related to each research question.

The Resident

For the purpose of maintaining the resident's confidentiality, he will be referred to as Coby. Much of the information used to conceptualize and describe Coby was obtained from the case file maintained by the assisted living facility. The case file consisted of documentation of his medical history including current medications and any critical incidents occurring during his residency, as well as demographic information. The case file was reviewed in its entirety at the completion of the study, and the researcher identified information relevant to formulate a detailed description of the resident.

Coby is a 96 year old white male who has been a resident of the AL facility for the past six years. Though his cognitive functioning is intact, he suffers from a variety of medical issues including oxygen dependent Chronic Obstructive Pulmonary Disease (COPD), coronary artery

disease, a pituitary tumor, spinal stenosis, impaired mobility, cataracts, and hearing impairment. Coby has been prescribed a number of medications including two antidepressants (trazodone and citalopram), and multiple breathing and heart functioning medications. His case file indicates that he takes up to 13 medications per day along with vitamins and other medications taken on an as-needed basis. There is no record of Coby having ever received mental health services outside of the two antidepressant medications prescribed to him by his primary care physician. While residing at the facility, Coby is provided with daily assistance in medication administration, meal preparation, and cleaning services, as well as reminders for bathing and participation in activities as requested at the time of his admission. In addition to these basic services, Coby is also visited weekly by a physical therapist and the Licensed Practical Nurse (LPN) on staff for participation in structured exercise regimens and health evaluations.

Additional personal details were gleaned from the pre-interviews conducted with Coby and the LPN. Each pre-interview was semi-structured and included only questions that would lead to information regarding Coby's life history and current needs. While only a minimal number of questions were pre-planned, the open ended nature of the questions and prompts utilized throughout the interviews encouraged interviewees to share additional and voluntary information. The interviews were transcribed and reviewed for relevant themes and information that arose from the conversations. Thematic topics and relevant information was initially identified along with particular quotes exemplifying each topic, and then reviewed to verify themes and appropriateness of quotes as adding to the information obtained from the case file. The majority of the details shared in the pre-interviews revolved around work history, aging, hobbies and relationships. When asked about his past, Coby explained:

> "Well, I started out farming a little and it wasn't no good, then I moved to Knoxville when I was 40 years old. Went to work for the mechanic. Anything with an engine or wheels on it and I could make it run. Cars, trucks, tractors, lawn mowers, big ole diesel engines. I did a lot of it and enjoyed it. I worked until I was 81 years old!"

Work was a major theme throughout the pre-interview and Coby had difficulty identifying any other activities that he enjoyed in the past such as hobbies, sports, or spending time with friends. Both Coby and the LPN mentioned that he does not currently, nor did he have many friends in the past. According to the LPN, Coby has always been a "take charge type of person" who has had a very difficult time giving up his independence after moving to the facility. She describes him as stern and directive with the staff and other residents, while also having a strong desire to help others and feel needed and in control.

Coby's statements throughout his pre-interview were also heavily weighted towards the desire to be useful and active. When asked how he felt about his life now, he mentioned feeling like he sits around and does nothing, stating "well, I'm just here waiting for the good Lord to come for me." According to the LPN, Coby does attend church at the facility every once in a while, but tends to abstain from activities due to respiratory and mobility impairment. Though he does not participate in many activities organized by the facility, Coby does have a current hobby in which he chooses to spend the majority of his time: making baby blankets and scarves. According to the LPN, Coby is very talented and his knitting and crocheting, which he does in his room, occupy a lot of his time. When asked what he likes to do, Coby stated:

> "Well, I walk around every once in a while, trying to get my exercise and things like that. But I don't do any work around here outside of this room. I work on about four or five of these things (baby blankets) and I live here and eat way over there to get my exercise. Gotta do that walking, it's good for you!"

Coby has limited social interaction while residing at the facility and staying busy with his hobby and exercising seemed to be his primary activities. According to the LPN, Coby and his wife, who have been married for 75 years, have minimal contact outside of daily phone calls. Coby shared that he and his wife have a home in town, but that he wasn't able to remain there or visit as often as he would like due to health concerns and impairment. Coby also has three children, including one son who resides in the same facility due to mild mental retardation. When not working on baby blankets, he spends the majority of his free time visiting and eating with his son whom he sees on a daily basis. According to the LPN, Coby has very few visitors outside of one daughter who visits two to three times each week.

When asked about Coby's current needs, the LPN primarily cited health problems as the root of his unhappiness. He suffers from severe respiratory and swallowing issues that impede his mobility and food intake. While she explains that Coby is "mentally intact and his cognition is very good," she feels that his other health problems keep him from interacting with others and participating in activities. She also shared that Coby responds very well to affection and being made to feel important or needed and, as a side note, mentioned that she hopes that he will "smile more" at the conclusion of the sessions.

Coby was identified as an appropriate candidate for this study for a number of reasons. First, though Coby is not diagnosed as suffering from depression and his memory and cognitive

functioning are intact, he is currently dealing with a large number of health problems that may be emotionally taxing. Secondly, Coby was seen as very withdrawn and does not spend much time outside of his room, nor does he receive many visitors. Thirdly, he has been noticeably stern and directive with staff and other residents, trying to control where and when they do things. Finally, Coby spends the majority of his time with creative tasks such as knitting and crocheting, suggesting that he would be open minded towards CCPT. Each of these characteristics made Coby an appropriate participant as they indicated a variety of issues that might be addressed through CCPT, as well as a willingness to participate in play. The following section will discuss the findings from the study as revealed through Coby's play behaviors and verbalizations.

Findings

Research Question #1: What play behaviors will the resident exhibit in CCPT sessions?

In order to address this particular research question, detailed observational session notes were produced for each individual CCPT session independently by the researcher and three experienced observers. Each session was videotaped and reviewed at the completion of the study by the researcher and observers, who recorded detailed notes on the play behaviors observed, verbalizations that occurred in the sessions, potential themes that were observed, and identifiable play stages. Observers were instructed to record initial behaviors and verbalizations, any notable changes that occurred across the sessions, and the play stage that Coby's behaviors seemed to represent. Each set of session notes was read by the researcher who then produced an initial list of behavioral, verbal, and stage-related themes based on notably recurring behaviors/verbalizations as reported by the researcher and the three observers. Session notes were then re-read by the researcher to adapt and verify the initial list of themes. The modified

list was then reviewed by the researcher and observers in separate meetings to determine accuracy of thematic labels, reach agreement on the behavioral themes and proposed stages, and to allow for triangulation of the data obtained.

Each 45-minute session took place in Coby's private room at the facility due to mobility constraints and the need for privacy during sessions. During each session Coby was presented with a variety of toys with which he could choose to play. Materials included the following: drawing supplies, plastic animals, Play Doh, water guns, building blocks, plastic food, toy cars, handcuffs, doll, doll accessories, army men, squeeze ball, toy medical kit, cooking accessories, toy money, sword, tool box, magic wand, plastic jewelry, and dishes. These toys were presented on a table directly in front of Coby with smaller toys grouped together in large, see through plastic bags.

Coby quickly developed a general routine for each session consisting of handling each item, followed by returning to several specific items with which he spent more time. Despite the large number of toys provided, Coby chose to spend the majority of his time with a handful of self-selected items. The materials he used most frequently during the play sessions included the doll, building blocks, magic wand, band aids, tool box, baby blanket, squeeze ball, and items Coby himself introduced to the sessions. Personal items that Coby chose to bring into the sessions included a decorative origami globe, materials he used to make baby blankets and scarves, and the Bible. These items served as triggers for conversation and will be discussed in relation to verbalizations during sessions after Coby's behavioral themes are addressed. As both action and discussion take place during CCPT, the findings for this particular research question will differentiate between behavioral and verbal themes.

Behavioral Themes

Behavioral themes arose from the analysis of session notes and repetitive behaviors displayed by Coby across each of the 12 CCPT sessions. As mentioned previously, these themes were identified based on the ongoing recurrence of particular behaviors in the play sessions and were agreed upon by the researcher and observers via peer review in which themes that were labeled by this researcher were reviewed by the observers and play behaviors and accuracy of themes were discussed. Identified themes that emerged from the data include the following: naming and memory rehearsal, nurturing, building, sharing hobbies, and organization and control. Though the observers and the researcher readily agreed on the majority of the themes and their labels, there was disagreement from one observer regarding the nurturing theme. This will be discussed in relation to the identified behaviors relevant to the nurturing theme.

Naming and Memory Rehearsal. Perhaps the most noticeable of the recurring themes demonstrated through Coby's play was that of naming and memory rehearsal. Observers noted that in each of the 12 sessions, Coby spent a large amount of time identifying/labeling every item included in the play kit and often repeated this behavior more than once during a single session. He would diligently name each item as he took it out of the bag, stating "this is a pear, a snake, plate" etc., and would often name each item again as he put it back into the bag in addition to returning to items later in the session. Coby would remain focused during this task and would hold and examine items carefully before deciding what they were. If he was unsure of the name of an item, he would either request the help of the researcher in identifying the item by saying "what is this supposed to be" or he would apply a label he was satisfied with. This was evident with several items including a bunch of grapes which he would often label "a pinecone," or a

cow with horns which he would often label "a moose." Observers suggested that this behavior may indicate that Coby was attempting to test his memory by working to recognize each item and engaging in cognitive exercise, a method for relating to the therapist, or a transitional activity allowing him time to decide what to do next.

Nurturing. Another major theme reported by observers that emerged from the sessions was that of nurturing and being nurtured. This was demonstrated primarily through Coby's interaction with the doll in the play kit. Coby would regularly pick up and hold the doll frequently during each session. Observers noted that he would often speak to the doll, saying "we got us a pretty doll here" and admiring her tiny features by saying "she has pretty little toes, little fingers, pretty blue eyes," or saying "she doesn't need this" when referring to her pacifier. He would often put the baby down on a blanket on the table and say "she needs a nap now" and pat her stomach after he put her down, thereby providing care for the doll. Coby was also observed speaking for the doll at times, repeating his verbalizations in a sing-song tone, as opposed to the serious tone he took at other times when speaking to the doll. These behaviors were accompanied by smiles and chuckles and occurred throughout each session, often during and between other tasks, or when Coby was taking a break from tasks and trying to catch his breath. Two observers noted that Coby seemed to utilize his interactions with the doll as a self-soothing activity during which Coby could nurture himself when feeling vulnerable.

There was some disagreement about this theme, however, and one observer suggested that Coby may have interacted with the doll more frequently than other objects due to its proximity and availability. The observer suggested that these interactions may have been more indicative of helping behavior towards the researcher in that Coby may have been interacting

with the doll to pass time during the session in order to please the researcher. She further pointed out that she never observed Coby actually cradle the doll or attempt to feed it, as one might expect to see in the exhibition of nurturing. The doll was in fact located immediately to Coby's right and was within easy reach at all times, however, the repetition of this behavior as well as his non-verbal behaviors seemed to suggest he was genuinely interacting with the doll and providing subtle nurturing that may not have been readily recognized by the observer. The thematic label of nurturing was maintained due to agreement between the researcher and two other observers who both noted that Coby would move the doll to its position directly to his right if it was not placed there immediately by the researcher.

Building. Building and working with his hands was another theme that arose from Coby's play behaviors. This theme was demonstrated through a variety of behaviors during the sessions including interactions with legos, objects in the tool kit, and the squeeze ball. Coby spent a large proportion of his time in sessions using the building blocks to build a structure by assembling and disassembling chunks of blocks until each would fit where he had determined it should go. Observers noted that he utilized every block available to build what resembled a wall, creating a foundation and then stacking each block in such a way as to keep the "wall" even. After stacking had been completed, his attention seemed to turn to modifying the top of the "wall" in order to make it look a certain way though no discernable pattern was noticeable. This often required changing the position of some blocks in order to achieve the structural appearance he had in mind. Coby remained silent throughout the majority of the building process and made little eye contact until he had put each block in place, at which point he would look directly at the

researcher, smile and chuckle. Coby would also carefully take apart his structure while putting the blocks back into the bag.

Another example of this theme existed in his interaction with the tool box in the play kit. Observers reported that Coby would name the items he took out of the box, including "screws, nuts, and washers," as well as spending time putting together and taking apart the nuts and bolts included in the box. This required a level of focus for Coby as his gross motor skills were affected by health problems and general aging. He would often take several minutes to put one nut and bolt pair together, slowly moving the nut the entire length of the bolt. The same amount of focus and concentration were needed to take these pairs apart and both behaviors, putting together and taking apart, were not always performed in the same session. Other repetitive behaviors supporting this theme included utilizing the squeeze ball with each hand for a period of time, and pretending to conduct an orchestra with the magic wand in the play kit. Each of these behaviors was accompanied by smiles and chuckles from Coby, indicating his enjoyment of the activities. For Coby, block play occurred the most frequently, followed by using the squeeze ball, conducting with the wand, and putting together the nuts and bolts.

Hobbies. Sharing his hobbies was another theme that arose across the play sessions. One of the items included in the play kit as a doll accessory was a small handmade blanket. This would spark Coby's interest as he spent time admiring and folding the baby blanket and other small clothing items included for the doll. He would express his curiousity and interest in the blanket by asking "did you make this" or saying "this is a pretty blanket." Interacting with the blanket from the play kit also triggered Coby to introduce his own materials used for making baby blankets and scarves as he would often make the connection between the two by saying "I

make these." He regularly showed the researcher any works in progress he had at the time, yarn that he was planning to use, and even demonstrated his techniques several times during sessions. Sharing this hobby was rather easy for Coby to do as the table upon which the play materials were placed also served his work table and his blanket materials were organized directly to his right and within reaching distance at all times. He would explain to the researcher as he showed her his materials that "this is what I'm working on next," or "what do you think of these colors" in relation to the yarn he was using in projects. Observers suggested that by sharing a hobby that was important to him and one in which he spent the majority of his free time, Coby seemed to be further developing a connection and relationship with the researcher by sharing his interests and skills.

Organization and Control. Yet another theme that arose from Coby's play behaviors pointed to his desire to maintain organization and control over the session and materials. This was observed through his focused determination to return each item to the bag from which he had removed it, and the directiveness he exhibited later in the sessions. In relation to Coby's ongoing focus on maintaining order, observers reported that he would diligently return each item to its bag as soon as he had finished naming all of the items that had been removed from the bag. If Coby noticed that an item had been left out of one of the bags, he immediately halted his play saying "oops, left that out of something" to locate the appropriate bag and return the item to it. This particular theme was present from the beginning of treatment, but became more pronounced in session six when Coby began to narrate this behavior, saying "Putting that back in" and "got to get them all back in there" as he returned items to the bags. This focused and often triumphant

narration continued throughout the remainder of the sessions and will be discussed next in terms of verbal themes that emerged from Coby's play.

Directively exerting control over the placement of items during the session and the timing of the end of each session were observed as additional examples of the "control" theme that emerged later in the CCPT sessions. As Coby adopted a play routine consisting of naming items and then focusing on the few items he was more drawn to, he also began to exert more control over when he felt the session should end. Depending on how quickly he finished each task he had self-identified, he would often revisit his favorite items before deciding that he was finished playing for that day. At that point, Coby would say "I'm done, might as well pack up for the day," indicating that he had completed all the behaviors he had intended for the session. During the last few sessions, Coby decided to end the sessions anywhere from 5-15 minutes early and would direct the researcher to pack up the play kit. This type of behavior is considered typical in CCPT and is commonly recognized as an attempt at feeling or exerting control (Landreth, 2002). Observers noted that Coby would also direct the therapist to move certain objects out of the way, actively deciding which items he needed within reach for later use.

Verbal Themes

In addition to behavioral themes, several verbal themes arose from conversations occurring during the sessions. The primary source of these data was the observational session notes analyzed by both the researcher and three experienced observers. Verbal themes were initially identified by the researcher from recurring topics observed across sessions. Themes were then modified and adapted via member checking until consensus could be reached among the observers and the researcher on thematic labels. Given the limited verbalizations across the

intervention, there was no disagreement among the observers and researcher regarding these themes. Of the occurring verbalizations, observers noted that conversations were initiated by Coby and took place during play, as well as during breaks from play in the sessions. Identified themes included verbalizations regarding the following: process related comments, death and aging, health problems, hobbies, life history, family members, and the weather.

Process related comments occurred regularly throughout the sessions. These comments were directed towards specific toys, difficulties during play, and items that Coby himself introduced to the play sessions. Organization was a major behavioral theme for Coby and he would often couple the task of putting items back into the appropriate bags with narration of what he was doing. Observers noted that this became a regular occurrence with Coby later in the play sessions and he would triumphantly comment that he "got them all back in" each time he closed a bag full of toys. In relation to specific toys, Coby would often remark that he "likes the pretty doll" and, as mentioned in relation to behavioral themes, would speak to and for the doll frequently throughout the sessions. He also began to exhibit feelings of ownership later in the sessions, referring to the doll as "my doll," or joining with the therapist and stating that "we have ourselves a pretty doll", or "we've got us a big snake." The building blocks were also used regularly and, beginning in session seven, Coby would often narrate the process of building a structure and how he wanted it to turn out, labeling "smokestacks" or "chimneys" on the finished products. Coby also spent time gazing at a box of Curious George band aids included in the medical kit. Each time he looked at the box observers noted that he would laugh and smile, commenting on how he remembered seeing the "silly" monkey on television and enjoyed thinking about him. Another item that Coby would regularly play with was the squeeze ball

included in the kit. He would repeatedly inform the researcher that using the squeeze ball was "good for you" and was "good exercise." These comments were directly related to his play behaviors and were often used to narrate or explain what he was doing.

For Coby, death and aging also served as regular topics during the play sessions and were addressed in nearly every session. At 96 years of age, Coby voiced that he felt he had been here long enough and didn't think that he would make it much longer, saying "I'm just waiting for the good Lord to take me." He would regularly comment that he felt "worn out" and "about gone," often reviewing what he could and couldn't do in his current physical state. Coby would voice his frustration with health problems as new issues arose and previous issues worsened. Initially, Coby's primary concern was his hearing impairment, until he started suffering from watering eyes that blurred his vision and made it difficult to see what he was working on for several weeks. This was followed by a general increase in breathing difficulties and feelings of weakness. He reflected, "I'm getting weak, can't even go to the bathroom without getting out of breath." During session five, Coby spent a great deal of time discussing his health problems and medications. He explained that he couldn't afford all of his medications and didn't like taking them. He continued to discuss how he felt that taking all of his medications was pointless, stating "I don't know why they make me take all them pills" and that he would like to die in his sleep, just like his brother did.

Feelings of weakness and being out of breath continued throughout the last half of the CCPT sessions and required Coby to take multiple breaks from play during each session. These breaks normally lasted no more than 3-5 minutes and consisted of Coby taking deep breaths and closing his eyes, while also conducting short conversations with the researcher in which he

would voice his frustrations saying “my eyes just won’t stop watering” or “I can’t hardly breathe.” During these episodes, observers noted that Coby would often reach for the doll in the play kit and interacted with it by saying things such as “she feels better now” or “she needs a nap.”

In addition to general conversations about aging and health problems, Coby often related his developing impairments to the impact they had on his work; namely, making baby blankets and scarves. In reference to this topic, Coby would say “I can’t hardly work anymore.” This hobby was something that Coby was very proud of as evidenced by telling the researcher that he has “blankets all over the world” and regularly discussing works in progress, finished projects, people who were in possession of things he had made and where they lived, as well as materials he used and ideas he had for future projects. He once reflected, “at least I’m making baby blankets. Staying busy keeps me from going crazy.” It was very frustrating for him when blurry eyes or feeling weak and out of breath interfered with his work and play behaviors.

There were three sessions in which Coby offered a more detailed description of his life history that shed some light on the importance of work to Coby. In sessions three through five Coby told the researcher pieces of his life story beginning with the fact that he had lost his parents at age 16 and was responsible for his siblings from that point on. He revealed that he had wanted to get a better education, saying “I wanted to go to school, but had to work,” and therefore couldn’t get a “good job” and had to work very hard all of his life. He was, however, very quick to point out that he could fix any type of engine put in front of him, saying “if it had an engine, I could make it run.” Coby informed the researcher that, when he was younger, he didn’t have any toys like those in the play kit and always had to work instead of play. In session

five, Coby added more detail to his life story, sharing how difficult it was for him to take care of his siblings and how he had tried everything to make enough money to support them. He stated, "I tried so hard to keep up, but I just couldn't." Somberly, Coby also shared that he had had to sell the family farm that his father had built because he couldn't keep up with all the responsibilities. He stated that he was bitter about the uncle who had been appointed the children's guardian because the uncle "didn't help at all. He just drank." Coby also informed the researcher that he thinks about this experience every night as he reads the Bible. According to observers, Coby seemed to utilize these conversations to build a relationship with the researcher and to express his feelings regarding parts of his life that may have been unresolved or goals that he had been unable to achieve in life.

In addition to the toys included in the play kit, Coby also introduced a few items of his own to the sessions. These included blanket making materials, the origami reflective globe, and his personal Bible. As mentioned previously in relation to behavioral themes, observers also noted that Coby regularly brought his own materials into the play session and would inform the researcher of new projects he was starting, techniques he was using, and any new materials he had acquired for future projects. In relation to talking about his hobby, Coby would present materials and say "this is what I'm making next." Verbalizations in relation to the globe consisted of admiring the work and describing the process and time that went into making the item, as well as where he got it and that his wife had a matching globe at home. He would ask the researcher "how long do you think it took to make this" and explain that "it took this little Chinese girl five hours to make it, look at all them folds! Do you think you could do it?" When showing the researcher his Bible, Coby would often explain that he would read parts of it every

night before going to sleep and would proudly say "I've read it through two times already." He spoke of this item as giving him comfort and things to think about such as his experiences with the alcoholic uncle or not being able to go to school as he would have liked.

Family members were a somewhat rare topic across the 12 CCPT sessions with Coby. Of the family members that did come up, he spoke infrequently about his son, wife, daughter and brother. Often, talk of family members would occur in relation to the items he was working with that reminded him of each person. He spoke of his son and how much he would like the toys in the play kit and would want to keep most of them, saying "better not let R see any of these, he'd keep them." His wife most often came up when interacting with his origami reflective globe as he had given her a matching globe which she kept in their home, saying "she's got one at home, don't know where she keep it though." Other family members came up on rare occasions during sessions. Coby would mention his daughter visiting once or twice, or where she was if she went out of town and couldn't visit him explaining "she went to Colorado for a few weeks, not sure when she's coming back." Coby's brother was mentioned during a single session when Coby was reflecting on how he might like to die, as his brother had passed away in his sleep several years previously.

Finally, Coby also made comments that seemed to be information related or made simply to pass the time. He would often glance out of his window and inquire about the weather, asking "is it cold out there" or "are we getting any rain yet?" This would be followed by comments regarding whether or not he might venture outside that day, saying "better stay inside, don't want to get sick." Coby would also talk about daily occurrences such as haircuts or tasks that he needed to complete such as going to the doctor, though he did this seldomly as most of his tasks

revolved around making blankets in his room. Outside of the daily weather inquiries, this type of conversation occurred infrequently in comparison to the other themes that emerged from the sessions.

Behavioral and verbal themes consistently arose from Coby's play sessions and were identified through analysis of the observational session notes. Behavioral themes included naming and memory rehearsal, nurturing, building, control/staying organized, and sharing his hobbies. Verbal themes included discussions of death and aging, health problems, life history, process comments, hobbies, family members, and the weather. Each of these themes provides unique insights into the CCPT process for Coby and will be expounded upon in relation to stages in the following section.

Research Question #2: To what extent will play behaviors exhibited by the resident follow the identified stages of CCPT as defined by the theoretical framework of Nordling and Guerney (1999)?

In relation to this particular research question, data were obtained from observational session notes analyzed by the researcher and three experienced observers. Session notes were reviewed by the researcher with a focus on changes in behaviors and verbalizations across sessions and progress made in relation to the play therapy stages as defined by Nordling and Guerney (1999). Initial stage-related behaviors were identified by the researcher and then reviewed, modified and agreed upon by the observers and the researcher. The stage model was used to provide a framework for understanding Coby's behaviors as it was primarily developed to help therapists understand and gain insight into the play therapy process, thereby assisting in tracking progress and making termination decisions. Based on the session note data from each of

the 12 CCPT sessions with Coby, the warm-up and working stages will be discussed in relation to demonstrated behavioral and verbal changes observed across the sessions.

Warm-Up Stage

Based on Nordling and Guerney's (1999) definition, the warm-up stage generally consists of behaviors offering the participant the chance to orient himself to the playroom and play materials, develop trust and comfort with the therapist, and to adopt a leadership role in the sessions. Play behaviors in this stage are often exploratory and less focused than play in later stages, allowing the participant to develop flexibility in modes of self-expression utilizing the materials provided. While time spent in this stage varies from person to person, Coby's behaviors in sessions one through four closely resembled those expected for the warm-up stage.

In session one, Coby was very hesitant to begin exploring the items in the play kit, tentatively touching the bags of toys without opening them. After several minutes he began pulling out and naming each item after carefully examining it, identifying each item stating "that's an orange, an apple," etc. He spent time looking at and holding the "pretty" doll, as well as building a wall-like structure with the building blocks in large chunks. During this session, Coby made eye contact consistently and regularly smiled and laughed while playing and verbally interacting with the researcher commenting that "I can't hear too good" and "got a lot of stuff here." He was also hesitant to stop playing at the end of the session. Observers noted that these behaviors were typical of initial CCPT sessions with children in that the focus of play was exploration of the materials provided and becoming acquainted with the researcher.

Coby initiated the start of session two without waiting for the researcher to sit down, immediately grabbing and admiring the doll, calling her a "pretty doll." He again went through

every item in the play kit, naming each one carefully as "a snake, a bug, some kind of gun," while smiling and laughing throughout the session. In this session, however, observers recognized several behavioral changes that occurred in addition to the immediate initiation of play. Not only did the frequency of Coby's conversations increase, observer's also noticed that in his interactions with the doll, he began speaking to and for the doll remarking how much he liked her and what she liked to do by saying "she likes to lay on her blanket" or "she needs to take a nap." In his work with the building blocks, Coby spent time dismantling the chunks of blocks prior to building a structure. When he realized that he still had time left in the session, he returned to naming items that he had already interacted with earlier in the session. Observers also pointed out that this session marked the first time that Coby started using "we" when playing, and actually thanked the researcher at the end of the session, indicating that he had developed a relationship with the researcher and was genuinely enjoying the sessions. One observer noted that the "self-nurturing" behavior Coby exhibited with the doll could indicate regression and progress towards the working stage.

According to the observers, sessions three and four began to reveal a general routine for Coby consisting of starting to play immediately, beginning with interacting with the doll, followed by naming each object in the play kit. He continued to spend time carefully examining each item while naming them and putting them back into the bags and would interact with the doll throughout the session as he began to describe her "pretty little ears, pretty little toes, pretty little fingers, and pretty blue eyes" and informing the doll that she was "too pretty for that (pacifier)" and that she didn't need it. When building with the blocks, he began to purposefully break up the chunks of blocks before beginning to build a structure and would carefully decide

where each block belonged in the structure by changing the placement of the blocks several times until satisfied. In these sessions, Coby also began to experiment with new behaviors such as putting together the nuts and bolts in the tool kit and introducing items of his own to the session such as the origami globe and his blanket making materials. Observers agreed that Coby was also very verbal in these two sessions, sharing information about his life and play history commenting that "96 isn't very young" and he "had to work hard all of my life" by "making a job for myself." Greater detail on this conversation was presented in relation to the verbal themes identified for research question one. During session four, Coby also shared how much he enjoyed the sessions and expressed his curiosity about others who the researcher might be playing with, asking "do you do this with any other folks in here?" This type of question is also typical of children who have participated in CCPT as they work to understand why they have been chosen to participate in such a unique treatment (Landreth, 2002). One observer noted that when the researcher answered Coby's question by indicating that he was the only person participating, Coby seemed very pleased as evidenced by a large smile. The observer commented that this is much like play with children in that there is a strong desire to feel special in the eyes of the therapist.

Observers reflected on the behaviors Coby exhibited in session five as possibly marking a transition from the warm-up to the working stage. In this session they noted that there was an obvious change in the amount of time he spent playing with certain items. Though he again started playing immediately by checking in with the doll followed by naming each item in the play kit, he spent much less time carefully examining each item and completed the naming task quickly. Also, despite touching the bag containing the building blocks several times, observers

pointed out that he actively decided when he was ready to use them and waited until he had finished naming all the rest of the items before creating his structure. He was again very talkative during this session, sharing a much more detailed version of his past and would interact with the doll when discussing details that upset him such as health problems or thwarted desires for a better life. This was evident when he spoke of his inability to keep up the family farm or go to school as he reflected "thinking about this stuff keeps me up at night, I have a hard time sleeping because of it," and would reach for the doll when the topic became too emotional. During these interactions with the doll observers described his behaviors as more nurturing than in previous sessions as he would hold her and give her the pacifier, saying "she feels better now" after putting it in the dolls mouth. One observer suggested that this may indicate that Coby was projecting his own feelings onto the doll as the conversation during this session appeared cathartic and self-soothing.

Across the first five sessions, observers suggested that Coby exhibited a range of behaviors indicative of the warm-up stage. Coby was tentative to begin playing in the first session and spent time getting acquainted with the materials in the play kit and both his own role and that of the researcher in the sessions. The next few sessions showed a marked increase in experimental play behaviors, sharing personal information with the researcher, developing a routine for the sessions, and adopting a leadership role. The tentativeness of the initial session disappeared and Coby would often begin playing before all of the materials had been set up. Coby also began to express his enjoyment in relation to the CCPT sessions and would thank the researcher for bringing the toys to him. Observers suggest the remaining sessions continued to

indicate progress Coby was making and any changes in behaviors and verbalizations will be discussed as they relate to the working stage.

Working Stage

As described by Nordling and Guerney (1999), the working stage is made up of both aggressive and regressive behaviors which focus on emotional self-expression. Generally, behaviors occurring in this stage revolve around issues of control, nurturing, independence, self-image and relationships. As with the warm-up stage, time spent in the working stage varies depending on the individual and the number of issues that arise. For Coby, behaviors exhibited in sessions six through 12 (the final session) resembled those of the working stage. Observational session note data indicate that while Coby's play routine stabilized in terms of the general flow of each session, behavioral changes were observed indicating a new level of focus for certain tasks and continued progress across the stages.

In session six, Coby moved very quickly through the toys when naming them and began to interact with the doll in between naming the items in each bag. Observers noted that his frequency of interacting with the doll increased considerably, especially when he felt out of breath or needed a break from playing. The interactions with the doll continued to be coupled with comments related to the pacifier and Coby would state that "she's doesn't need that anymore." Coby continued to actively decide when to play with the blocks, and the amount of time he spent with the building blocks greatly increased during this session as well. He was very careful to take apart every block before building a structure and spent a great deal of time deciding where each piece should go. Observers also pointed out that this session marked the first instance of Coby directing the researcher to remove toys from the table as soon as he had

finished naming them, as well as a significant decrease in verbal interaction with the researcher. Outside of comments such as "I'm out of breath" or "my eyes won't stop watering," Coby seemed to immerse himself in play rather than conversation. Two observers felt that the behavioral and verbal changes that occurred during this session may have marked transition to the mastery stage of the model as Coby had experienced cathartic self-disclosure in the previous two sessions.

In session seven, Coby's verbal interaction remained limited and he continued his routine of interacting with the doll first, naming each item in the play kit quickly, followed by building a structure. If he discovered that any item had been left out of the appropriate bag, he would immediately stop playing and find its rightful spot before continuing what he had been doing. He repeated his interactions with the doll frequently throughout the session, especially when mentioning health problems, and again spent a great deal of time with the building blocks making sure to get each piece exactly where he wanted it to go. In this session observers commented that Coby was very deliberate in his building behaviors and actively chose which colored blocks needed to go where, saying "not the red ones" or "that's a smoke stack." He also began to express frustration with the Curious George band aids when he could not keep the box closed despite multiple attempts. It was noted that Coby completed his play routine with approximately 15 minutes left in the session and decided to go back through only his favorite toys with the time remaining.

Session eight marked the first countdown session towards termination. Coby again repeated his play routine consisting of interacting with the doll, naming every item, followed by building a structure. In this session, Coby spent additional time examining his block structure

and making changes until he was satisfied with the results. He again expressed frustration towards the band-aid box when it refused to remain closed. He also chose to ignore the time limit warning marking the end of the session as he had not finished putting some items away. Observers noted his mood during this session was serious and somber, unlike previous sessions in which he smiled and laughed throughout, and while he continued to interact with the doll frequently, there did not appear to be a connection between talking about health problems and the interaction as in previous sessions. While the conversations held during the sessions have become shorter and less frequent, observers commented that Coby's play behaviors remained focused, suggesting that his play required more of his attention.

Session nine did not differ greatly from the previous few sessions in that Coby continued to follow his regular play routine, however, the somber and serious attitude that was present in session eight was discontinued and observers noted that he had returned to smiling and laughing throughout the session. He continued to express frustration with the band aids stating "I just want it to stay closed," and he again requested that the toys be moved out of his way after he had gone through them, saying "put that over there" and indicating a chair that was beside the researcher. During the building process, however, Coby was observed as he narrated the careful placement of each block exactly where he wanted it and experimented with new positions until he was satisfied, saying "nope, not there, there." He again brought out his blanket making materials to show the researcher his current project and noticed that the frame he was using to make a scarf had broken. Observers acknowledged that Coby chose to spend the remainder of the session repairing the broken frame instead of playing with the provided materials,suggesting that his hobby may also represent a form of play.

In session ten, a few major changes were observed in Coby's play behaviors. Though he continued to follow his routine, his building behaviors were markedly different. In this session, Coby chose to dump out the entire bag of building blocks instead of removing them one at a time as he had done in all the previous sessions. He again built a structure very thoughtfully and spent time admiring his finished product; however, in this session he also took each and every piece of the structure apart before putting them away. Observers pointed out that this greatly increased the amount of time he spent with the building blocks. Coby also chose to return to the blocks when he realized he had time left in the session and built a second structure with the same attention to detail as the first. One observer suggested that Coby may prefer this activity over interacting with other items as he spent a great deal of the session in this task. He continued to interact with the doll frequently, especially when feeling out of breath or in need of a break. Additionally, Coby chose to show the researcher several personal items that were important to him including a card and photograph that he kept in his Bible. Observers noted that this behaviors suggests that Coby had developed a relationship with the researcher and was willing to share personal items of importance.

According to observers, session 11 was also markedly different from previous sessions with Coby. Unlike other sessions in which Coby started playing before the researcher had even sat down, he chose to continue working on a blanket for several minutes before allowing the researcher to set up the play kit. He resumed his routine after moving the blanket materials out of the way, playing first with the doll and then naming items. He put the items away very quickly and requested that they be moved when he had finished naming them. Observers noted that his energy level seemed quite low, and during the session Coby explained to the researcher

that he had been in the hospital the previous week and felt "very weak" and didn't "have much time left." After discussing his experience at the hospital and how he was currently feeling, he returned to playing with renewed energy. He again emptied the entire bag of building blocks onto the table, but did not narrate as he built his structure. His focus then moved to repairing the bent sword in the kit and voicing his frustration with the band aid box as he wanted "to keep it closed." After realizing he had time left in the session, observers noted that he contemplated working with the blocks again, but instead just broke them up into individual pieces while leaving them in the bag. With five minutes left in the session, Coby requested that the researcher pack up the toys and end the session early so that he could get ready for lunch.

The final session, session 12, marked a return to the routine Coby had developed. He began playing immediately and visited with the doll first, followed by the very quick completion of naming every item and finally, building a structure. Observers noted that he spent the majority of his time during the session carefully building with the blocks and interacting with the doll. Much like the last session, he contemplated returning to the blocks, but again chose to break up the individual pieces while leaving them in the bag. Also, after having expressed his frustration with the band-aid box that would not remain closed across the last several sessions, Coby chose to remedy the problem by bringing out his own tape and sealing the box shut. This was followed by his request for the researcher to put away the toys and end the session early. Coby chose to end this final session with approximately 12 minutes left. Two observers pointed out that by ending the session early, Coby's behaviors continued to mirror those of children in CCPT when experiencing closure.

Observational session note data indicate that sessions six through 12 were noticeably different from the first five sessions in relation to Coby's behaviors and verbalizations. After session five, Coby was observed as becoming less talkative and more focused on completing the routine that he had developed for the play sessions. Though he continued to practice naming each item in the play kit, he did so quickly, and reserved other tasks for after this had been completed. The amount of time he spent interacting with the doll and building structures greatly increased, as did his focus during these tasks. Observers also pointed out that Coby became more directive in these sessions, requesting that the researcher remove toys that he had already used and actively deciding when the sessions should end. His interaction with the researcher decreased outside of Coby's directive requests for assistance. Observable changes in Coby's behaviors and verbalizations indicate progress was being made across the 12 CCPT sessions. The theoretical implications for these changes and progress made will be discussed in greater detail in Chapter Five.

Research Question #3: Will there be any observable therapeutic benefits exhibited by the resident as a result of CCPT?

The primary sources of data utilized to address this particular research question included the Administrator Post-Interview, review of Coby's case file, and comparison of Coby's pre- and post-Geriatric Depression Scale (GDS) scores. As with the pre-interviews, the administrator post-interview was semi-structured and included only questions that would lead to information regarding any observable changes in Coby's behavior since the beginning of treatment. The interview was transcribed and reviewed for relevant themes and information that arose from the conversation. Thematic topics and relevant information was initially identified along with

particular quotes exemplifying each topic, and then reviewed to verify themes and appropriateness of quotes as adding to the information obtained from the case file.

The same LPN who had participated in the pre-interview completed the post-interview which focused on any changes she had noticed in Coby since the completion of the CCPT sessions. The main positive change she had noticed related to his controlling behaviors towards other residents in the facility. These behaviors had decreased in frequency. The LPN did not notice any other positive changes in Coby and cited his worsening health issues as a mitigating variable. She mentioned that he had become quieter and more withdrawn over the past few weeks and had been having additional respiratory and swallowing problems leading to a recent hospitalization. Coby's case file revealed that he has been hospitalized more in the past year than any other time during his six year residency at the facility. It is the LPN's opinion that Coby knows death is near and is tiring of fighting to stay alive while the treatments he is currently on are becoming less effective. She stated: "I feel sorry for him. And I think he knows, and may be depressed about it. I can't imagine knowing that the end is so close and knowing that it could be just any day! How you would feel? You just want to give up." She did mention that she feels being able to interact with and take care of his son may be what is keeping Coby alive. According to the LPN, other than the decrease in controlling behaviors and rapidly deteriorating health, Coby had not demonstrated any additional observable positive or negative change across the six weeks of the study.

Prior to the undertaking of this study, Coby completed several screenings over time at the facility utilizing the Geriatric Depression Scale (GDS) and documentation of these scores was included in his case file. Though the facility purports to screen residents at intake and every six

months following, Coby's case file included only three instances in which the screening scores were recorded despite his six year residency. Both this study and the screening process at the facility utilized the short form of the GDS with scores equal to or greater than five indicating severe depressive symptoms and serving as a clinical cut-off point. Coby's scores on the GDS prior to the study were as follows: two in September of 2006, two in August of 2008, and one in March of 2009. Indicators of depression in the screenings prior to the study included dissatisfaction with life and low energy levels.

For the purpose of this study, Coby was administered the GDS before the start of the study and at the completion of the CCPT sessions by the researcher. A total scale score was calculated for each administration, utilizing the clinical cut-off score of five to assess severity of depressive symptoms (Yesavage, 1983). His total scale score on the GDS before beginning CCPT in May of 2009 was two, indicating minimal symptoms of depression. His total scale score following the CCPT sessions remained stable at two in June of 2009. Indicators of depression cited in these two administrations included fear of something bad happening to him, and preferring to stay at home rather than going out and doing new things. Participation in the CCPT sessions did not have a significant impact on Coby's GDS scores.

Few changes were observed at the completion of the 12 CCPT sessions that would indicate concrete therapeutic benefits. Though Coby's LPN noted a decrease in directive behaviors towards staff and other residents, she had not observed any additional positive changes. With his health issues worsening, the LPN had in fact noticed that Coby had become quieter and more withdrawn. These health problems triggered an increased frequency in hospitalizations and, according to the LPN, were mitigating variables that interfered with the

potential positive changes promoted by the CCPT sessions. Despite ongoing health issues, stable scores on the GDS indicated that Coby was not suffering from increasing depressive symptoms. The following section will explore Coby's personal reaction to participating in CCPT and his view of the process as a whole.

Research Question #4: How will the resident describe his CCPT experience after termination?

While adult play therapy is beginning to grow in popularity among practitioners, little is known about the participant's perspectives regarding the play therapy process. This research question was addressed primarily through the post-interview with Coby in which he was asked what the CCPT experience was like for him. This post-interview was also semi-structured and included only questions that would lead to information regarding Coby's perspective regarding the CCPT approach and his participation. The interview was transcribed and reviewed for relevant themes and information that arose from the conversation. Information relevant to understanding Coby's perspective regarding his experience was identified by the researcher, who then reviewed the transcription to determine which of Coby's verbalizations best represented his view of CCPT. In the post-interview regarding his experience with play therapy, Coby's statements revolved mainly around being able to "stay busy" and "work" during the sessions. He had very positive things to say regarding the experience including the following: "I had fun;" "I liked it;" "It was really good exercise, keeps your arms a moving;" and "It kept me from going crazy." He also mentioned how much he enjoyed playing with the doll in particular and would be open to continuing the play sessions. Coby may have other plans however that might get him out of his room. He stated "Once I get these baby blankets done, I might try something else. I might do something else. Might go outside into the hot air."

Though Coby was generally not very talkative during interviews or play sessions, he was able to voice his perspective on the CCPT sessions during the post interview. Coby had come to identify the play sessions as "work," something that kept him busy, gave him an opportunity to "exercise," and was enjoyable. Though he spent time with all of the items in the play kit, he specifically mentioned playing with the doll as something that he looked forward to during each session. Coby also commented that he would be open to continuing with CCPT, but that he might also spend his time branching out and trying new things. The following chapter will present a summary of the study, review of each research question and relevant findings in terms of the theoretical underpinnings of CCPT and the stage model, implications for counseling, and recommendations for future research.

CHAPTER FIVE: DISCUSSION

Introduction

In this study, client-centered play therapy and stage model theoretical frameworks were applied to organize and analyze data collected in order to understand the process of play therapy with an elderly assisted living facility resident. Client-centered Play Therapy (CCPT) is founded on the Rogerian belief that there exists a powerful motivating force within individuals that leads them to continuously strive for self-actualization (Guerney, 1983). According to Rogerian theory, an individual has the ability to solve his or her problems and will continually strive for growth, no matter what his or her age or developmental level. Self-actualization, however, is a complex process complete with a multitude of challenges. In essence, individuals must be granted complete freedom to be themselves with the assurance of unconditional acceptance from self and others in order to achieve self-actualization (Axline, 1947). These conditions are met through the systematic application of CCPT techniques.

The CCPT approach is founded upon Axline's eight basic therapeutic principles that help to guide therapist behaviors and the process of CCPT. The eight principles include developing a warm and friendly relationship, accepting the child as he/she is, establishing a feeling of permissiveness, recognizing and reflecting feelings to prompt insight, maintaining a deep respect for the child's ability to self-direct therapeutically, avoiding attempts to direct the sessions or hurry progress, and establishing only necessary limits on behavior (Axline, 1969). In accordance with these principles, the play therapist responds in ways intended to facilitate self-direction, self-exploration, and growth. It is through the development of an unconditionally accepting, safe and permissive environment in which an individual's strivings for self-actualization may be

expressed that therapeutic change can and does occur. The therapeutic intervention presented in this study adhered explicitly to these principles, thereby facilitating the opportunity for Coby to address any obstacles he faced in relation to self-actualization.

Harnessing an individual's self-directive potential within a therapeutic environment has proven efficacious for both children and adults suffering from a large variety of problems (Guerney, 2001). Recently, a handful of researchers have explored the potential of using CCPT as an innovative method for addressing mental health issues with elderly populations in attempts to improve adjustment and life satisfaction. The design of this study was based upon the theoretical foundations and practices of CCPT with the purpose of exploring the process of CCPT with a single elderly assisted living (AL) facility resident. A descriptive case study design was used to address several research questions including an exploration of play behaviors and themes, stage progression, therapeutic benefits, and the resident's perception of the approach. Observational session notes, pre- and post-interviews with the resident and facility LPN, pre- and post-administrations of the Geriatric Depression Scale (GDS), and review of the resident's case file were used to obtain data relevant to the intended purpose of the study.

This chapter presents a discussion of the study findings as viewed through the theoretical framework of CCPT and the stage model proposed by Nordling and Guerney (1999). Coby's verbal and behavioral themes, stage progression, and potential therapeutic benefits will be discussed. This will be followed by discussion of the implications for AL facilities and residents and counseling professionals, as well as recommendations for future research using this approach.

Verbal and Behavioral Themes

Before discussing the findings in relation to the research questions at hand, it is important to consider general characteristics of the developmental context within which the play sessions and Coby's behaviors and verbalizations occurred. The elderly are faced with a multitude of developmental issues including the following: coping with death and loss, declines in independence, depression, anxiety, lack of relatedness, changes in cognitive functioning, memory deficits, and other limitations to communication and understanding (Ledyard, 1999). In order to facilitate ongoing healthy development, it is recommended that psychotherapy with the elderly should focus on developmental consolidation through which an individual may experience mastery of the past and adaptation to the present (Yesavage & Karasu, 1982). This is facilitated by allowing the individual to revitalize experiences, reduce routines of daily living, confront conflicts and anxiety regarding death, and discuss physical and personal losses experienced. The goals of psychotherapy with the elderly do not differ from the goals and demonstrated benefits of CCPT when used with children or adults. At the age of 96, though still functioning reasonably well, Coby is not immune to any of the issues that often characterize this stage of life and many were addressed verbally and behaviorally during his play sessions.

The verbal themes that emerged from observations of Coby's play sessions included conversations about death and aging, health problems and impairments, his life and work history, hobbies, and family members. These are often difficult topics to discuss however, within the therapeutic relationship and the safe and supportive environment provided through CCPT, Coby felt at ease to discuss his frustrations with worsening health problems and the inevitability of his death. He also took the opportunity during the CCPT sessions to review his life story and

aspects of it that he was unhappy with or regretted, thereby offering the chance to express positive and negative feelings regarding his past and adapt his present view of these experiences. Conversations were not just limited to somber topics, however, and it was obvious that Coby relished in talking about his baby blanket making hobby and family members. These were topics that enabled him to experience feelings of competence and mastery and to acknowledge his role as a productive member of society. Through verbal interactions, Coby was able to explore both positive and negative variables in his life, offering him the chance to alter his perception of his present situation and revitalize past experiences, both of which are important steps towards self-actualization and improved well-being.

In addition to his verbalizations, Coby's play behaviors were observed in each of his 12 CCPT sessions, allowing the researcher to watch these behaviors across the six week intervention and identify recurring themes. These ongoing observations offered insight into the process of CCPT with this individual, as well as the functional role that play served in this process. Coby was able to use play as a vehicle for expressing himself and addressing unresolved or difficult issues in his life. Colarusso (1993) asserted that play serves the same functions in adulthood as it does in childhood, offering the player the chance to engage in and master phase-specific developmental tasks and the internal conflicts that arise. Gordon and Esbjorn-Hargens (2008) expanded upon this, suggesting that "players are often attracted to the play forms that engage the particular vulnerabilities that limit or inhibit their playfulness and address the emotional tensions that match those they face in everyday life" (p. 217). This parallels the theoretical assumptions of CCPT in that individuals are therapeutically self-directed in the selection of play behaviors and the issues that are addressed in sessions, which may include

developmental tasks. During his CCPT sessions, Coby exhibited a variety of behavioral themes that directly connect to the developmental tasks a 96 year old man is likely to face, as well as the emotional turmoil that is just as likely to accompany them. The CCPT approach and materials, though novel to this individual, offered him the opportunity for further growth and development. Through the therapeutic relationship and atmosphere of safety established in the CCPT sessions, Coby was able to find behavioral methods for expressing his desires to maintain his cognitive functioning, to be nurtured and provide nurturing to others, to regain control over his outside environment, to experience positive emotions, and to maintain some semblance of physical activity. This was observed through Coby's interactions with several items in particular including the doll and building blocks, as well as resulting from the overall process of CCPT. Coby was strongly motivated to keep both his mind and body active and he resented the impairments he suffered from for interfering with his activities. He utilized the play sessions as a method to stimulate his cognitive functioning by naming each item in the play kit, a task that took less and less time to complete as the sessions progressed. The variety of items included in the kit offered Coby the opportunity to both identify a wide range of objects and to act out the function of the items. Coby viewed the naming task, as well as his other interactions with the materials, as "exercise" and seemed to find the physical activity involved to be both stimulating and enjoyable. The simple act of interacting with the toys was greatly significant to Coby, allowing him to experience positive emotions and mastery, and to guard against additional physical and mental losses. Without the opportunity to develop a therapeutic relationship and experiment with new methods of self-expression as facilitated by CCPT, Coby may not have had additional chances to experience feelings of mastery. Ward-Wimmer (2003) purported that adults

have a continuing need to experience mastery beyond childhood in order to nurture one's ego. Coby sought out behaviors in his play sessions that would allow him to experience an absence of failure, in addition to expressing his needs to feel useful and to regain control over his outside environment. An unexpected behavioral theme that occurred regularly throughout the CCPT sessions was that of sharing his hobbies through display of materials, demonstration of tasks, or presentation of finished products. Given Coby's limited play history, it is important to recognize that the hobby with which he spends most of his time is a form of play, as well as a source of mental and physical stimulation. Viewed through the lens of CCPT, this suggests that Coby was attempting to introduce his own familiar play materials to the play sessions in addition to sharing a skill that he had mastered and that made him feel useful and productive. Through this behavior he had the opportunity to explore esteem building activities that he seemed to feel gave him purpose in life.

According to the LPN, Coby also attempted to make himself useful around the facility by telling other residents where to go or to sit. By directing other residents, Coby may be attempting to control his environment, as well as feel that he is being a useful member of the community. Menec and Chipperfield (1997) pointed out that perceived control is a very important psychological variable that contributes to healthy aging. According to Bruner (2000), block play inherently provides ultimate control on the part of the builder, who can choose to build, change or completely destroy his creations. Coby exhibited focused behaviors while building, often taking each piece apart in preparation for building and carefully analyzing where each piece should go in the structure before placing it. This was a very serious task for Coby and he would often relish in the satisfaction of gazing upon the final product before slowly tearing it

down. This is commensurate with the theoretical underpinnings of CCPT as well, and it is not surprising that building structures became one of the activities in which Coby spent a great deal of time and changes in this behavior demonstrated progress across the sessions. Coby also expressed this need to have power over his environment by maintaining organization among the play materials and directly controlling where each item went, as well as the length of the sessions. Through the lens of CCPT, this is seen as aggressive behavior through which issues of control may be addressed. For Coby, no item could be left out of its place without an almost immediate reaction from Coby who would halt what he was doing and determine exactly where the item belonged. He also began to relegate items that he was finished with to an area outside of his play range, thereby actively deciding that he no longer needed them in the area and allowing him to focus on activities with the objects he preferred. In his last session, Coby attempted to leave his mark on the play materials and control his environment by repairing the band-aid box that had frustrated him in previous sessions. Additionally, in deciding to end his last few sessions early, Coby exerted direct control over the sessions themselves, triggering the immediate removal of play materials from his room. This behavior is easily identified through the theoretical framework as an effort to control his environment.

In direct contrast to Coby's desire for control, his behaviors also seemed to express a need to nurture, and to be nurtured and vulnerable. The majority of these behaviors were exhibited through his interactions with the doll. This type of behavior is often identified as regression in CCPT, offering the individual an opportunity to examine views of self and relationships with others. For Coby, the doll symbolized a beautiful, helpless infant. She was sweet and innocent and needed to be cared for by Coby, who would often hold her, talk to her

and put her down for a nap. Coby would often adopt a childlike tone to his voice when speaking for the doll, suggesting that he was acting as if he was the doll - vulnerable and in need of nurturing. His interactions with the doll occurred on a frequent basis, and were especially prevalent when Coby wasn't feeling well. Bruner (2000) suggested that play sessions open individuals to expressions that are outside of their awareness, allowing the unconscious to find expression in the play that occurs. She stated that structures or scenes created in play "are images of a person's present situation and sense of self in relationship to others" (Bruner, 2000, p. 336). Both CCPT theory and Bruner's perspective suggest that the doll represented the helpless and vulnerable side of Coby, a side that he may find difficult to accept and try to hide from the outside world. Through his interactions during and across the CCPT sessions Coby was able to address his own vulnerabilities in a non-threatening way while held in a safe and accepting environment.

Stages

The stage model developed by Nordling and Guerney (1999) provides a framework for therapists to gain insight into and understanding of the CCPT process with an individual. Application of this stage model helps therapists to track movement and progress across sessions and make termination decisions, and appears to be useful in examining the play behaviors of both children and adults. Children exhibit different behaviors and focus on various issues during certain stages in the CCPT process (Nordling & Guerney, 1999). "Stages are recognized by the pattern of behaviors or themes that occur frequently or even dominate during that period of sessions" (Guerney, 2001, pg. 22). Though this theory and approach were primarily developed for use with children, Coby exhibited distinct behavioral themes across the play sessions, the

meanings of which are more clearly understood through CCPT theory and the application of the stage model.

The amount of time each individual spends in each stage of the process varies (Nordling & Guerney, 1999). This is true for both children and adults. While myriad issues may surface and demand attention and time in any stage, the general process of the stage model views behaviors as characterized by warm-up, aggressive, regressive, and mastery play. The occurrence of each stage represents therapeutic progress, with prolonged mastery play indicating the need for termination. For Coby, the majority of his play fit the descriptions of warm-up and aggressive/regressive, or working stage play.

According to the stage model, during the warm up stage, one would expect to see behaviors that help the individual orient themselves to the playroom and materials, and begin to build trust and comfort with the therapist (Nordling & Guerney, 1999). These behaviors tend to be unfocused and tangential. Sessions one through five seemed to encompass Coby's warm-up stage as they were characterized by initial behaviors that indicated limited and unfocused interaction with the toys, which then transitioned to more focused and self-directed play. During these sessions, Coby was initially timid about exploring the toys, followed by such eagerness that he would begin playing before the researcher could even sit down. He examined each item carefully in the first few sessions, trying to put his finger on exactly what the name of each item was. This was followed by moving increasingly faster through the naming, seeming to indicate that finding exactly the right term wasn't as important as other things he wanted to do during the session. Any structures built in these first few sessions were built in large chunks of blocks with little attention to how the final product was supposed to look. Initial interactions with the doll

were frequent, but short, until Coby begins to express ownership of the doll, after which he begins to hold short conversations with her. These changes, when viewed through CCPT and the stage model suggest that Coby had gained familiarity with the items and the researcher, after which point he was able to therapeutically self-direct the sessions by spending more time on activities that allowed him to be self-expressive.

Changes in Coby's behaviors seem to indicate the warm-up stage as they demonstrated his efforts to familiarize himself with the play materials and how he wished to interact with them. Additional indications of the warm-up stage included the self-directed play routine that Coby adopted, and verbalizations made across the sessions. In session two, Coby began to speak about the materials using the term "we," indicating that he and the researcher were together in these sessions. Coby also worked to establish a relationship with the researcher during his sessions by sharing his life story, including details that upset him, possibly in an attempt to build trust with the researcher or indicating that his comfort level with the researcher was increasing. Though the self-disclosure that occurred in sessions three, four and five seem to indicate warm-up behaviors, it could also represent a transition into the working stage, suggesting that trust and comfort had already developed through his interactions with the researcher and the play materials.

According to the stage model, during the aggressive and regressive stages, or the "working stage" as they are often referred to together, behaviors focus more on self-expression of emotions and issues of control, self-image and relationships with others (Nordling & Guerney, 1999). This can occur through verbalizations, aggressive or passive aggressive acts with toys or the therapist, or nurturing behaviors towards self, toys, or the therapist. The term "working

stage" is adopted here as both aggressive and regressive behaviors can occur in the same session, and this proved to be the case for Coby. If sessions three through five are viewed as a transition period before entering the working stage, then Coby's self-disclosures perhaps represent a step that he knew he needed to take before work could begin. These same verbalizations, however, could also represent the direct method of self-expression of emotions expected of the working stage, when the individual is addressing particular issues that are either conscious or unconscious.

Issues of control, self-image and relationships were expressed more through Coby's behavioral themes in the last half of the treatment, as verbalizations dropped dramatically and play became much more focused in session six. The stage model provides the framework necessary for understanding these changes and how they might represent progress in CCPT (Nordling & Guerney, 1999). Across sessions 7-12, Coby's behavior changed quite a bit from that exhibited in the first few sessions and his routine seemed to become second nature. Though he continued to go through the motions of naming each item, the time he spent doing this greatly decreased and he seemed to view it as a task that needed to be completed before he could move on to what he really needed to do. He began to interact with the doll much more frequently and for longer periods of time, especially when he wasn't feeling well. His interactions with the doll were nurturing, yet he too seemed to receive nurturing from the interactions as he would also play the part of the doll. Turning to the doll when he was feeling most vulnerable became a regular occurrence, suggesting that he often felt helpless, feared being viewed by others in that manner, and desperately needed to express those feelings. Through the lens of CCPT these behaviors are representative of regressive play, and through the application of the stage model

we can see that addressing vulnerabilities and sense of self was an important therapeutic task for Coby.

CCPT and the stage model identify aggressive play as being characterized by efforts to exert control during the sessions and many of Coby's behaviors during sessions 7-12 can be interpreted as his own attempts to feel in control. Though Coby focused on imposing organization on the materials, determining which should remain in reach, and when the sessions should end, one of the more notable behaviors he chose to spend his time in was that of block play. Through this medium, Coby had the power to create whatever he wished and to destroy it at any time. This assembling and disassembling process seemed to tap into additional energy Coby had within him as his attitude was serious and his focus unwavering during this task. The structure that Coby built repeatedly resembled a large wall that he would sometimes add "smokestacks" or "chimneys" to. This behavior allowed him to exert control over the materials, and to experience mastery since it was impossible to build the structure incorrectly. The changes in the amount of time Coby spent on this task and the amount of concentration involved indicate progress across sessions when viewed through the stage model.

Though the majority of Coby's behaviors in the last half of treatment fit quite well into the warm-up and working stages of the model, his progress across the sessions also appears to have neared the final stage of the model. The mastery stage is characterized by behaviors that assist the individual in consolidating therapeutic gains achieved across sessions. According to CCPT and the stage model, this may be expressed through solitary or cooperative play that focuses on demonstrating competence and mastery of particular tasks. Behavior in this stage may also resemble that of the warm up stage in that psychological work has been completed and

play becomes less focused (Nordling & Guerney, 1999). For Coby, hypothetical mastery stage behaviors might include interactively building a structure with the researcher, halting all naming behavior, or working with his own materials during the play sessions. It seems, however, that Coby has more work to do before progressing into mastery. Lack of progress into the mastery stage should remain under consideration while examining potential therapeutic benefits as Coby's psychological work may not have been completed during the 12 allotted CCPT sessions.

Therapeutic Benefits

This study sought to explore changes in Coby's depressive symptoms and observable changes in his behaviors as reported by the LPN who frequently interacted with him, thereby enabling tentative identification of the therapeutic benefits that may have occurred as a result of CCPT. Ledyard (1999) suggested that in using play therapy with the elderly, a variety of outcome results may occur including decreased depression, increased self-esteem, less isolation, increased cognitive responses, and an overall increase in life satisfaction. In her own experiences with the elderly, she found that play therapy also offered the opportunity for individuals to warm up to the helping process, overcome resistance, relive enjoyable memories, and reminisce about life. Many of these opportunities were facilitated by the CCPT approach as utilized with Coby. He was tentative to begin therapy, possibly due to the nature of CCPT and the toys provided, but also possibly due to the instigation of a therapeutic relationship. Despite this, he was able to become comfortable with the process as evidenced by focused play during the sessions and openly sharing information about his past and memories that he was fond of. Furthermore, according to Schaefer (1993), play has a number of identifiable therapeutic benefits including overcoming resistance, enhancing communication, experiencing competence and

mastery, attachment formation, relationship enhancement, positive emotions, and addressing developmental fears to name just a few. While this study was unable to demonstrate measurable change in Coby's depressive symptoms, as evidenced by stable total scores on his pre- and post-GDS administrations and the information gleaned from the LPN post interview, the potential therapeutic benefits just mentioned are directly relevant to the CCPT process that unfolded with Coby as they are inherent to the therapeutic relationship and the CCPT approach.

Although depressive symptoms did not measurably change and observations from the LPN indicate very few changes in Coby's behaviors outside of becoming less directive and more withdrawn, the potential impact of variables inherent to CCPT should not be ignored. Many of the potential therapeutic benefits mentioned by Schaefer (1993) and Ledyard (1999) were not specifically measured in this study however, the CCPT approach itself is known to have a wide range of benefits. CCPT theory supports the idea that within the safety of each play session, Coby was able to build a trusting relationship with the researcher and experiment with new methods of self-expression. Through these new forms of expression, he was able to warm up to the helping process, experience positive emotions and mastery, and to address the developmental fears he encountered. He also recognized the play sessions as an opportunity to share himself with the researcher through the telling of his life story, and discussion of hobbies and treasured memories. Though these behaviors did not result in measurable or observed change in this particular study, there is an undeniable benefit to the individual who took part and to counselors who seek to utilize this approach. Additionally, it is important to note that Coby's health problems increased significantly over the six week intervention. Depressive symptoms would be

expected to worsen given these circumstances however, Coby's GDS scores remained stable, suggesting that CCPT may have provided a means for coping with ongoing changes in health.

Resident's View of CCPT

Play therapy participants, young and old, are rarely asked to share their perspective on the play therapy process. The use of CCPT with the elderly, however, is brand new territory for counselors, and there are very few studies heralding the impressive results of studies exploring the approach. Therefore, it was important for this study to actually ask Coby to share his view of the play sessions and the process as a whole. Despite the fact that introducing Coby to a suitcase filled with toys undeniably took him out of his comfort zone, he found the play sessions and materials to be enjoyable and stated that he would be open to continuing his sessions after the study was complete. He chose to label the process with words that he was comfortable with such as "work" and "exercise," suggesting that he viewed the play as being a serious, yet fun time during which he could participate in activities that were beneficial for him and made him feel useful. His comments on CCPT suggest that age and limited play history are not barriers to the application of these techniques or the experience of potential therapeutic benefits of CCPT. This further supports the use of CCPT as an appropriate therapeutic intervention for Coby and similar individuals.

Implications

Through use of a descriptive case study focusing on one elderly assisted living (AL) facility resident's experience of CCPT, intriguing observations were made that have implications for a wide range of audiences including the elderly and counseling professionals who serve this population. Not only was this study the first to apply this approach with a 96 year old man, it

marked the first attempt to qualitatively explore the behaviors, stage progression, and personal perspectives of an adult undergoing the systematic application of CCPT over 12 play sessions. Given the novelty of using this approach with the elderly, this study served to provide qualitative descriptions of the behaviors one might expect to see in play sessions with an elderly adult, examples of how progress may be demonstrated in CCPT, and insight into the potential therapeutic benefits of the approach. This information, as well as the resident's perspective of CCPT, addresses a large gap that has existed in the literature. Not only does the information gleaned from this study have the direct implication of adding to the literature, findings also offer important insights for assisted living facilities and staff, elderly adults, and counseling professionals.

Contributions to Counseling

In spite of its popularity with practitioners, play therapy approaches have historically been used solely with children and little attention has been given to the potential of using the CCPT approach with adults. In fact, play and its importance in adulthood have been additionally thwarted by our puritanical history, leading to poor understanding and undervaluing of the behavior as a whole (Goldmintz & Schaefer, 2007). As Caldwell (2003) suggested, "One of the reasons adult play therapy has not been as well developed may be because of a cultural taboo against it, seeing it as childish, frivolous, and contrary to the productive work required of us" (p. 301). Along a similar vein, it is a common assumption that developmental and maturational drives are exclusive to childhood and adolescence, suggesting that adults may have little left to learn and don't need to play (Neubauer, 1993). It is important however, for counselors to remember that play in adulthood is not an abnormal behavior and should be viewed as a healthy

and normal expression of self (Apter & Kerr, 1991). Given the inherent benefits of adult play, the CCPT approach offers counselors the opportunity to harness the power of these behaviors within a therapeutic environment, thereby facilitating ongoing self-actualization in adults.

Much like with children, counselors can use CCPT in a variety of settings and for a multitude of purposes with adults as seen when conducted with Coby. "Play therapy with adults can be used to diagnose, break through the defense of clients, help clients who find it difficult to verbalize their concerns, relieve tension, and transcend communication barriers" (Ledyard, 1999, p. 60). It has the capacity to overcome resistance and facilitate relationship building, as well as address a wide variety of presenting problems. For Coby in particular, CCPT sessions offered the opportunity to warm up to the helping process, build a therapeutic relationship with the researcher, and express emotions both verbally and through his play behaviors. No adaptations to the approach were necessary to achieve these experiences and observers frequently noted parallels between the play behaviors observed in Coby's sessions and those of children involved in CCPT.

According to Ledyard, "play therapy can provide an atmosphere and environment in which the elderly feel they are accepted and understood in a time of their life when they are faced with extreme psychological and physiological concerns" (1999, p. 60). The CCPT approach offers individuals the opportunity to feel in control, accepted, and valued while held in the safety of the therapist's genuineness and unconditional positive regard (Demanchick, Cochran & Cochran, 2003). Through the development of a safe and supportive atmosphere, an individual may practice new behaviors and skills without fear of repercussions and may also gain a general sense of competence and confidence through this rehearsal. Additionally, experiencing

feelings of control over environment can lead to improved moods, increased participation in activities, as well as improved health and life satisfaction (Menec & Chipperfield, 1997). This can be especially important for elderly clients who have succumbed to ageist social attitudes that label them as being useless and helpless. According to Apter and Kerr (1991), "play is necessary for the developing child to become a fully functioning and psychologically healthy adult, and for adults to tread the difficult path towards self-fulfillment and self-actualization" (p. 171). Coby was able to address many difficult issues through play including accepting physical limitations, expressing feelings of vulnerability and lack of control, as well as forming a meaningful relationship based on mutual respect and positive regard. This offered Coby the chance to integrate new perspectives and reframe his outlook on both the past and present. Therefore, counseling professionals need to recognize and utilize the role and power of play in helping the elderly to resolve any obstacles to self-actualization in order to promote continued healthy development through the end of life. Without the opportunity to address vulnerabilities, express emotions and practice mastery through play, self-actualization is likely to be stifled.

Implications for Counselor Educators

The population of elderly adults in the nation is growing rapidly and the practices of counselor educators must reflect this by introducing innovative approaches that are effective with these individuals such as CCPT. This approach is not as readily accepted by elderly adults as it is with children and future counselors should be prepared to address considerations specific to the practice of CCPT with the elderly. As was found in this study, enrolling a willing participant could be a difficult initial task. With this age group, play is often viewed negatively and individuals are not always willing to try something new or unfamiliar. Bruner (2000) found that

initiating a play therapy group may serve to quickly dispel any reservations individuals may have regarding participating in a play focused treatment and may even impact the perspectives of entire facilities via word of mouth. While Coby himself may have had initial reservations about participating in CCPT, he quickly grew comfortable with the approach and openly communicated his enjoyment during the second session. Educating future counselors on appropriate methods for presenting CCPT and how to address expectations or reservations elderly adults may hold regarding the approach could serve to make CCPT program development or individual services easier to implement.

Other considerations important for counselor educators to address include the types of play materials used, the length of time it may take for individuals to warm up to the approach, and the range of verbalizations and behaviors that may be exhibited. While the toys selected for use in the current intervention were effective, it may be possible that toys that looked more like the real objects they represented would have furthered Coby's level of self-expression. Counselor educators should remind students to be purposeful when selecting items in order to keep materials as age appropriate as possible. This may further impact the amount of time it takes for individuals to warm up to the CCPT approach, however, research (Ledyard, 1999) has demonstrated that despite differences in individual characteristics and levels of reluctance, most adults cannot resist the urge to play and will do so in their own time. Ledyard found that some individuals took several sessions to begin playing and chose to spend the first 2-4 sessions talking with the therapist. This was not the case for the current study however, as Coby immediately began playing with the materials and chose to interject conversations into later sessions. Therefore, counselor educators should prepare students to anticipate the potential for

several talk therapy sessions prior to the emergence of play behaviors, as well as during the play itself. Finally, future counselors should also be alerted to the potential range of behaviors that may be exhibited during CCPT sessions. The play of elderly individuals may be difficult for inexperienced counselors to identify as it may be more reserved than behaviors seen in children. By encouraging future counselors to explore their own play behaviors and those they see in other adults, the process of identifying play in the elderly may be demystified.

Conclusions

Aging is a complex developmental process offering challenges at every turn and rewards or consequences for every choice we make, with our quality of life hanging in the balance. AL residents with unmet health needs are likely to experience physical and mental declines. According to Chapin, Reed and Dobbs (2004), "these declines could likely result in an increased need for assistance, which if beyond the care capacity of the assisted living setting, would lead to discharge to a setting that provides a higher level of care at more cost, such as a nursing facility" (p. 362). Accordingly, facilitating the process of healthy aging for AL residents is much more complex than simply decreasing symptoms of depression or overcoming anxiety, and requires an approach that impacts more than just a handful of identified symptoms in addition to those expected of normal aging.

Play may serve as a powerful tool for addressing mental health issues and improving life satisfaction for adults and the elderly. According to Johnson, Smith and James (2003), many older people express a quiet playfulness through activities that lie somewhere between work and play such as gardening or knitting. Caldwell (2003) expanded upon this notion, suggesting that "many behaviors we do as adults frequently are not seen as play behavior when they really are

play at its best" (p. 304). If an innovative approach such as adult play therapy can be demonstrated as effective with the elderly population, it should not be discounted simply because little research or limited evidence exists that supports the fact that adult play can be therapeutic. In addition to the therapeutic benefits connected to the application of CCPT, provision of mental health services such as CCPT on site, or promotion of awareness and access to services could serve to prevent early discharge of residents to nursing homes. Through proper identification of symptoms and active treatment of mental health issues in the elderly population, counselors can assist in improving an individual's quality of life and helping them move closer to self-actualization, no matter what their age. Counselor educators should be made aware of the potential therapeutic benefits of CCPT with populations other than children and should educate future counselors on the possibility of using this approach effectively with the elderly.

Recommendations for Future Research

Studies exploring the use of play therapy approaches as a whole have been criticized for small sample sizes, lack of sound empirical evidence, and inability to generalize results (Bratton et al., 2005). The current study is also vulnerable to these criticisms. Though the use of a descriptive single subject case study provided insight into the behaviors, process and perspective of the individual participating in CCPT, due to the nature of the design, results cannot be generalized to a larger population. Furthermore, the self-report measure used to assess changes in depressive symptoms, the GDS, did not reveal therapeutic change in relation to this particular outcome measure. Additional research with larger sample sizes is needed to identify therapeutic benefits of CCPT, compare CCPT interventions with other approaches, explore immediate and

long term effects, identify the optimal number of sessions and length of treatment, and to explore the most efficient methods of service delivery (Bratton & Ray, 2000).

Though play therapy in general and CCPT specifically have proven useful with the elderly, a major issue that must be addressed is choosing an approach that is most appropriate for the individual. Given Coby's very limited play history, a directive approach may have been more effective. Directed play therapy is characterized by the active role of the therapist who predetermines the content and theme of the play sessions based on knowledge of the individual's concerns and presenting problems with the specific goal of addressing these issues (Delpo & Frick, 1988). It is through the identification of the purpose and goals of treatment that either directed or non-directed play is deemed appropriate. While humanistic, or non-directive approaches to play therapy have demonstrated greater effectiveness than their directive counterparts, especially when offered in residential settings, decisions should be made based on the presenting problems of the individual (Bratton et al., 2005).

Given that the length of Coby's treatment demonstrated progress across the stage model to the working stage, it is possible that additional sessions could have increased the potential effectiveness of CCPT with this individual, leading to further therapeutic change which may have been identified through outcome measures. In a meta-analytic review of existing play therapy literature, Bratton et al. (2005) found that the benefits of play therapy with children continue to increase up to a treatment length of 35 sessions, after which point benefits appeared to stabilize and decline. As Coby was only provided with 12 sessions of CCPT, it is feasible that a longer length of treatment could have been beneficial. Directive or non-directive, 12 sessions or 35 sessions, these are matters that should be addressed by future studies, however, they do not

change the fact that the process of CCPT with Coby had inherent therapeutic benefit. This alone should stimulate researchers to further explore this approach with elderly AL residents who are often underserved by our profession and left to suffer as a consequence of ageist social attitudes.

AL facilities have a wide range of resources at hand that could be utilized to improve service provision and detection of mental health problems in residents. These facilities are often large enough to have unused spaces that may be transformed into private and permanent therapy rooms, offering the opportunity for the provision of services on site. The residents also interact with a large number of staff each day, however, the majority of staff members are not equipped or educated to recognize symptoms of mental health problems. Therefore, continuing education for both the family of residents and the staff of AL facilities should be provided to improve treatment rates for the elderly. In order to counteract the prevalence of untreated mental health issues among AL residents, it is imperative that the counseling profession focus its efforts on acquiring new skills, practices, and knowledge to meet the needs of this underserved population. This includes the continued exploration into the effectiveness of proven techniques that have yet to be thoroughly empirically validated specifically for use with the elderly such as play therapy. Considering Coby's positive view of CCPT and with the help of facility staff and resources, this approach could prove to be extremely effective with the AL population. Play can be a powerful tool in helping the elderly to express themselves and experience mastery, thereby reengaging their drive towards self-actualization, and its potential to impact life satisfaction should not be ignored.

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Appendices

Appendix A: CCPT Session Note

Date: Session #:

1. Summary of Play Behaviors:

Themes:

Stage:

2. Summary of Verbalizations:

3. Evaluation:

4. Comments:

Appendix B: Administrator Interview Protocol

Pre-Interview

1. What have you noticed about this resident since his move here?
2. What prompted your referral of this resident?
3. What changes would you like to see occur?

Post-Interview

1. What have you noticed about the resident's behavior since the intervention?
2. Have you noticed any other positive or negative changes?

Appendix C: Case Study Participant Interview Protocol

Pre-Interview:

1. How would you describe your life right now?

2. Could you tell me a little about yourself?

Post-Interview:

1. What stood out to you the most about the experience?

2. Is there anything else you would like to add?

Appendix D: Geriatric Depression Scale Short Form

Choose the best answer for how you have felt over the past week:

1. Are you basically satisfied with your life? YES / **NO**

2. Have you dropped many of your activities and interests? **YES** / NO

3. Do you feel that your life is empty? **YES** / NO

4. Do you often get bored? **YES** / NO

5. Are you in good spirits most of the time? YES / **NO**

6. Are you afraid that something bad is going to happen to you? **YES** / NO

7. Do you feel happy most of the time? YES / **NO**

8. Do you often feel helpless? **YES** / NO

9. Do you prefer to stay at home, rather than going out and doing new things? **YES** / NO

10. Do you feel you have more problems with memory than most? **YES** / NO

11. Do you think it is wonderful to be alive now? YES / **NO**

12. Do you feel pretty worthless the way you are now? **YES** / NO

13. Do you feel full of energy? YES / **NO**

14. Do you feel that your situation is hopeless? **YES** / NO

15. Do you think that most people are better off than you are? **YES** / NO

Answers in **bold** indicate depression. Although differing sensitivities and specificities have been obtained across studies, for clinical purposes a score > 5 points is suggestive of depression and should warrant a follow-up interview. Scores > 10 are almost always depression.

Vita

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