Case Study in Play Therapy:

Analyzing Play Behavior According to Marijane Fall

by

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ABSTRACT

There is an innate challenge for educators in understanding the world of a child. Children express their needs and stories differently than do adults. Children do not yet have the vocabulary to express themselves as adults do. Play therapy allows for the gap in understanding to be bridged. There are differences between how different play therapists analyze behavior: some choose to analyze according to stages and others choose to analyze according to categories. Fall has established categories of play that children move fluidly between during the play therapy process: connecting play, safe play, unsafe play, resolution play.

This case study attempts to discuss the process by which one child traveled between Marijane Fall's categories of play behavior in order to further support or refute Fall's theory. Throughout a process of fifteen thirty-minute play therapy sessions that were analyzed, support was granted to Fall's theory. This study supports the idea that

children travel through categories fluidly rather than through stages systematically. This client moved between many of the different categories throughout the sessions.

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TABLE OF CONTENTS

Chapter I

Historically, children have been considered "miniature adults" (Landreth, 2002). Children were expected to take on tasks as adults, and were expected to be able to communicate as adults. A child's act of play was even once considered "child's work" in attempt to legitimize a value that adults place on what a child does (Landreth, 2002). Play is much different from adult work; there is no goal with play, it is complete wherever it ends. Fortunately, with new understandings and research in the field of child development, we as a society are now aware of differences between adults and children and have learned to put appropriate expectations on children.

There has been much emphasis placed on children's ability to express and comprehend language (Moustakas, 1997). Researchers, as early as Piaget, have emphasized how young children live in very concrete world and how sophisticated language to describe thoughts, opinions, and emotion is not within a child's repertoire. Piaget said it was in fact *play* which children learn about the abstract world. Children learn by interacting with their environment and conceptualize their surroundings based on their experience through play (Landreth, 2002).

More contemporary authors and researchers, such as Landreth, have acknowledged that children's verbal skills are not developed strongly enough to allow them to express their emotions in ways that adults can comprehend them (Landreth, 2002). This has a significant effect on how children participate in therapy and counseling when faced with crisis, trauma, or instability in their lives. When an adult has emotional difficulties, he will visit a psychotherapist or counselor in order to verbalize and make sense out of these challenging emotions. Children younger than 11 years old

do not have the verbal ability, nor the patience to express feelings and emotions through words, but they are still able to express them. Children are better able to express emotions through objects and through symbolic play; this idea is the basis of play therapy.

Play therapy is most often used with children between the ages of 3 and 10, although it can be useful with some older children as well (Kottman, 2004). One of the main reasons why play therapy works with children is because it feels natural to them; play is not something they need to learn how to do. It is unrealistic for adults to expect children to verbalize thoughts and emotions, because children do not have the abstract reasoning skills that allow them to do so. Children are able to understand concepts that they receive from others, but are not yet capable of verbalizing this information (Kottman, 2004).

There are many reasons why children need play therapy. Children suffer from a variety of issues including, but not limited to the following: depression, fears and phobias, conduct disorder, selective mutism, parental divorce, sibling rivalry, and children with attention deficit disorder (Kaduson, Cangelosi, & Schaefer, 2004). Play therapy is a technique that can be used to guide these children toward beneficial outcomes that lead to healthy developmental progress.

Through play therapy, children who are dealing with chaos, neglect, or any sort of confusion in their lives can sort through emotions in a safe and systematic way while being guided by a professional (Kottman, 2004). In play therapy, children will place their life stories into their fantasy play. Children will develop themes that can be interpreted by the play therapist and often these themes will carry throughout the duration of the sessions; often these play themes come through the play media. The goal of play therapy

is for children to find resolution in their daily lives through play (Fall, 1997). Children need to make sense of the chaos of their lives in order to continue healthy developmental growth along many different spectrums.

There have been several authors, researchers, and play therapists who have attempted to describe, analyze, and categorize the types of play behaviors children exhibit when participating in play therapy (Moustakas, 1997, Fall 1999, Norton and Norton 1997, and Rogers). Yet, these authors have not come to consensus on the experience of the child during play therapy. Understanding what a child exhibits and experiences during play therapy is extremely important to the practicing therapist for various reasons.

The therapist needs to be able to connect a child's actions to the appropriate destination, which in most cases, the child knows but is unable to communicate verbally. A skilled therapist is able to make connections between the play actions and metaphors that a child uses to the child's life or world. Play therapists must be aware and educated about the different theories of play therapy. Each child is different and is not to be interpreted the same as another child. A skilled therapist will be able to successfully monitor a child's behavior while connecting what is known about the home life of that child. A therapist needs to have a firm knowledge base so he/she can accurately interpretation of the child's story. A therapist that is able to track behaviors effectively while paying close attention to the emotions and sometimes statements behind these behaviors has a better chance of recognizing problems in the child's life.

Case studies are often used to examine the effects of play therapy. Large-scale studies are very difficult due to the intensive relationship between the child and therapist. Therefore, by using case studies, we not only can examine the effectiveness of play

therapy on a child's behavior outside the play room, we also can examine the child's experience in the play therapy room by coding and categorizing different behaviors the child exhibits. The detail of this analysis can be accomplished through a qualitative, case study design.

Statement of the Problem and Purpose of the Study

It is important to understand child's play behavior. Play behaviors give a window of opportunity for adults to analyze and understand how a child views the world Children tell their stories through play (Landreth, 2002). Qualatative case studies allow researchers to closely analyze and describe play behavior. Given that authors, play therapists, and researchers cannot come to conssensus on the experience and play behaviors of children during play therapy, a need exists to continue analyzing children participating in play therapy, particularly cases of children who are signaling developmentally inappropriate behaviors. The more research that goes into the field of play therapy analyzing different cases, the better the chance that we will come to an understanding about the experiences in play therapy.

In effort to expand upon the knowledge of play behavior, the following case study will be conducted in order to analzye the behaviors of a five-year-old child according to the categories established by Marijane Fall (1999). The objective will be to assess Fall's categories of play therapy by analyzing fifteen video-recorded play therapy sessions held at the UW-Stout Vocational Rehabitation Building in the play therapy room. The purpose of the research will be to determine whether Fall's categories of children's play therapy behaviors are valid to this case.

Definition of Terms

The following definitions have been established in order to assure complete comprehension of the proceedings of this case study.

Connective play: During this stage of play, the child connects to the therapist by asking questions and describing his world to the therapist. The child looks and glances quickly at the therapist and is in close proximity to the therapist. The child touches the toys and explores the playroom.

Person-centered play therapy: This type of therapy allows for the client to lead the way through the therapy process. This is able to occur when the therapist values and respects the child and believes that the child is capable of leading the way.

Reflecting Feelings: A skilled response that allows for the therapist to teach a child how to identify/name emotions exhibited by the child.

Resolution play: During resolution play, a solution appears in unsafe situations. Children exhibit a new sense of control over thoughts, feelings, and actions.

Restating: A skill in which a therapist restates the meaning of what a child states.

Returning responsibility: A skilled response to a child that allows for a child to try to achieve an obtainable goal without help from the therapist; this helps a child to become more self-confident.

Safe play: During safe play, children have control over the therapist and over the toys. There is also a varying continuum of emotion utilized throughout play which can be described as a child requesting the therapist to do something (low emotion) or a child demanding the therapist to do something (high emotion). This is also exhibited in toys by

sorting or categorizing toys (low emotion) or by confusing right and wrong or using illogical sequences (high emotion).

Tracking: Stating what a child is doing or what a child is doing with a toy; used to let child know that the therapist is paying attention to everything he or she is doing.

Unsafe play: During unsafe play, children exhibit feelings of victimization or a loss of control. Some patterns frequently exhibited in unsafe play include confusion over right or wrong. In unsafe play, there is not a solution to a problem situation.

Limitations of the Study

This study has limitations that stem from limits of play therapy in general. Play therapy includes much interpretation and whenever there is interpretation, there is the chance for errors and misjudgment. If the therapist incorrectly interprets a situation, there is a chance that the play therapy process will be hindered. Another limitation of this study is that the client's participation depends upon his parents' approval and support of the play therapy process. The play therapy process also could be hindered due to the gap between sessions number nine and ten due to logistical issues.

Chapter II

This chapter will include the historical background of play, Virginia Axline's eight principles of play therapy, the foundations of child-centered play therapy, clientele of play therapists, thematic play, and Marijane Fall's constructs of play therapy.

History

Play has been recognized as a significant part of children's lives since as early as 1762 (cited in Landreth, 2002). At that time, Jean Jacques Rousseau recognized that children should be treated differently than adults. A second example of the importance of play was illustrated by Sigmund Freud in a 1909 case study that used play with a five-year-old child who had a phobia (cited in Landreth, 2002). Freud gave suggestions to the parents in order to assist them in parenting their child. In doing so, play was to be monitored by the parents in order to further understand the child.

Person-centered play therapy is the most popular type of play therapy conducted. The premise of person-centered play therapy was derived from non-directive therapy developed by Carl Rogers (cited in Landreth, 2002). This premise theorized that behavior occurs in order to obtain self-realization. The child client is free to play with whatever he wishes or even remain silent if that is what he wishes. Two objectives of child-centered play therapy include self-awareness and self-direction (Landreth, 2002). Self-awareness allows for children to become aware of their abilities and empowers them to achieve goals, while self-direction allows children to make choices with confidence.

Axline's Eight Principles

Another important theorist in play therapy is Virginia Axline. Born in 1911, Axline was a pioneer of play therapy (Brenner, 2007). In her book, Play Therapy, 1981, Axline outlines eight principles of play therapy:

1. The therapist should develop a warm and friendly relationship in order to build a positive rapport with the child.
2. The therapist must accept the child exactly as he is.
3. The therapist must be permissive in order for the child to feel free to express feelings openly.
4. The therapist reflects feelings back to the child appropriately and accurately.
5. The therapist believes that the child is able to solve his own problems if he is given the opportunity to do so.
6. The child must always lead the way; the therapist should not lead the way at any time.
7. Therapy is a gradual process and should not be hurried.
8. The therapist must only present limits as necessary to anchor play therapy to the real world (Axline, 1947).

These eight principles provided a foundation for many current person-centered play therapists today. These basic principles help play therapists to successfully adhere to a therapeutic child-centered environment.

Axline's book, *Dibs: In Search of Self*, (1964) is a personal account of the play therapy process with a young boy who has been emotionally neglected throughout his

young life. Throughout the book, Axline illustrates the sessions for the reader displaying the eight principles she developed in 1947 that are essential to person-centered play therapy.

Theoretical Foundation of Child-Centered Play Therapy

Child-centered play therapy is more about a way of viewing children than it is about technique (Landreth, 2002). The belief that children are resilient creatures is essential to child-centered play therapy. Because child-centered play therapists believe that all children are capable of solving their own problems, the belief in resiliency is necessary. Two of the most important values that a play therapist must hold include trust and patience (Axline, 1947). Therapists must also be nonjudgmental of children, exhibit warmth, and utilize empathic responses. These values allow for therapists to successfully wait for children to grow with the process in order to achieve healing within themselves (Axline, 1947).

According to Landreth, 2002, a child's behavior depends more upon how a child feels about himself or herself than intellectual knowledge. In order for a child's functioning to change, there must be a change within the child. Child-centered personality theory discusses three central constructs developed by Carl Rogers in 1951: the person, the phenomenal field, and the self (Rogers, 1951).

The construct of person includes the thoughts, behaviors, feelings, and physical being of a child (Landreth, 2002). As the child experiences life, he or she organizes these interpersonal experiences by his or her personal reaction. When a change occurs in one part of a child's life, there will undoubtedly be a change in another part of him or herself which ideally would strive toward a more positive self image (Landreth, 2002). When the

experiences a child has caused negative reactions or feelings, including rejection from family, neglect, or abuse, a child will view him self as negative or unworthy (Axline, 1964; Landreth, 2002).

The second construct is the phenomenal field. This construct encompasses everything that the child experiences, including conscious and unconscious experiences (Landreth, 2002). The perceptions of what is happening to the child are exactly how the child will remember any experience; it cannot be wiped away or changed within the child's memory. In child-centered play therapy, it is vital for the therapist to understand the child's perceptions in an effort to completely support the child in everything he or she does (Landreth, 2002). Virginia Axline was a great example of supporting her client in *Dibs: In Search of Self* (1964). The client, Dibs, was a child who had been emotionally abandoned by his family. He exhibited few social skills in school and rarely if ever spoke to anyone. Axline used child-centered approaches with Dibs, along with basic skills essential to play therapy such as tracking, restating, reflecting feeling, and returning responsibility in order to help Dibs grow into a more functioning child. These skills help children to understand that they are in an environment where they are understood and accepted, freeing them of fear and inhibition (Axline, 1947).

Self is the final construct of child-centered play therapy (Landreth, 2002). When children are capable of differentiating between themselves and others, the self has been constructed. Although these three constructs are vague, they hold together the pieces that aid understanding of child-centered play therapy. When the self is successfully constructed, children will identify their own need for positive regard from others. In turn,

children will learn that giving positive regard to others will fulfill their own needs (Landreth, 2002).

Clientele of Play Therapists

Often children who are referred for play therapy are suggested because of aggressive, shy, or otherwise maladaptive behaviors (Landreth, 2002). Maladaptive behaviors can be understood using the constructs defined in the previous section. When children are unable to come to a self-realization, they are unable to understand that they have the opportunity for freedom and independence (Landreth, 2002). These children become victims of their circumstance.

Play therapy often brings about success because children are able to visualize and act out play themes through toy characters; these characters help children to confront and solve problems that occur in their personal lives (Fall, 1997). Children are able to learn about success through the toys and are eventually able to carry that lesson to their own lives (Fall et al., 1999).

The first category of clientele is children with low self-efficacy. In a 1999 study, (Fall et al., 1999) children with low self-efficacy were referred for six sessions of play therapy. During the sessions, children showed an improvement in their own self-efficacy. Changes were illustrated by how the children manipulated situations in order to solve or confront a problem (Fall et al., 1999). The children who once gave up easily and used to show low effort grew from the sessions into children that made choices more easily and were persistent (Fall, et al., 1999). Some interventions that Fall suggested in her 2001 study suggested that professionals can help to increase self-efficacy by positively influencing any of the following areas: performance experiences, performance of peer

role models, verbal acknowledgment of their abilities, and understanding physiological changes or vulnerabilities (Fall, 2001).

Children with depression present another group of clientele who could benefit from play therapy (Kaduson et al., 2004). Twelve-thousand children per year are hospitalized due to suicide attempts or ideations that can be traced back to childhood depression (Kaduson et al., 2004). Play therapy is helpful with depressed children because it allows them to express feelings and emotions in a way that they can understand. Most depressed children have difficulty establishing a sense of mastery and control in their lives (Kaduson et al., 2004). The symptoms of depression, especially the dispirited mood and social withdraw, quickly inhibit children of learning that they are competent beings and rather they begin to believe that they are helpless (Kaduson, et al., 2004). Types of play that are helpful to a depressed client include role playing that allows for children to practice being strong and confident and also allows them to act out their emotions. Play therapy can be vital to a depressed child whom has forgotten how to play (Kaduson et al., 2004).

Children who have experienced sexual abuse are in a position where they need to express their experience with an adult, but do not have the verbal skills to do so; this is why play therapy is helpful to these particular clients (Kaduson et al., 2004). Often with sexual abuse victims, secrecy plays a major role. This secrecy blocks normal developmental growth which is detrimental to children. Play therapy is especially helpful for these children because they are able to express their feelings about the abuse while the therapist assists them in examining the destructive messages that have been sent to the child through the abusive experiences (Kaduson et al., 2004). Because sexual abuse

violates trust, play therapy is useful for children to re-learn to trust adults (Griffith, 1997). Play therapy's purpose for children is to allow for relief of stress and emotional pain. Sexual abuse victims include a very special population of children who can greatly benefit from the goals of play therapy (Griffith, 1997). One technique that can be used with sexually abused children is the game called "The Starting Over Wedding Gown Ceremony" (Kaduson & Schaefer, 1997). Many sexually abused children feel dirty or unclean and often these children feel the need to avoid "messy" play or are meticulously clean. The purpose of using this game with children is to help to alleviate the shame that is involved with sexual abuse by helping the child to learn that he or she can start from a clean slate and that they are not contaminated (Kaduson & Schaefer, 1997). When working with children of sexual abuse, it is important to remember that many of these children suffer from Post Traumatic Stress Disorder. These children will often appear to struggle with identify issues, anxiety issues, nightmares, distractibility, and often display overly sexual behaviors. One of the best ways that practitioners can address these issues includes working toward the healing process individually using a variety of play media. These children respond best to non-directive approaches (Schaefer, 2006).

Currently, one third of all children will experience a change in family status including divorce or separation before the age of eighteen (Kaduson, Canelasi, & Schaefer, 2004). Children express their feelings about the divorce differently. An example of one child's coping mechanism for the divorce was an incessant video-game playing addiction (Kottman, 2004). This child was referred for play therapy because his addiction was interfering with school and his relationships with his family members. For a total of twelve play therapy sessions with this client, the therapist was able to highlight

the presenting problem by using a more guided type of play therapy, James Mann's Time Limited Play Therapy (Kottman, 2004). In this type of play therapy, the therapist structured the play therapy sessions enough that the therapist can ensure that the presenting problem was addressed, while also utilizing Axline's eight principles of play therapy (Kottman, 2004). Some other techniques to use with children coping with divorce include small group counseling which can include dramatic play, role play, and puppetry (Schaefer, 2006). Children can reenact what they have seen in the home through play media. This is less threatening for children than talking is and is a more developmentally appropriate way for children to successfully report their feelings (Kaduson & Schaefer, 1997).

Conducting play therapy in a school setting allows many different kinds of children to participate in play therapy, some that would not have gotten this type of therapy from the private sector. Play therapy is an important tool for elementary school counselors as children do not have fully developed verbal communication skills. It was not until the 1960's that play therapy was brought into the schools. Prior to this, play therapy was only available through private practitioners. Several different practitioners, including Landreth, Muro, and Myrick began writing literature about their experiences in play therapy which assisted the movement of play therapy into the schools as well as private practice (Landreth, 2002).

There are large amounts of students that come from a minority background in schools today-even rural schools. Students of minority background have different needs and circumstances than students of the majority population (Kueng Ho, 2007). Some of the needs for these students include: counselor knowledge of cultural values, knowledge

of family structure and rituals, and understanding of differences in parenting (Hueng Ho, 2007). A culturally competent counselor is a necessity for students of diverse backgrounds, especially those children who are in need of play therapy.

Thematic Play

Play therapists need to be skilled in examining the child's play behavior for themes. For children participating in play therapy, themes arise throughout. Children utilize metaphors in their play and therapists must be hyper-aware of what children do in the playroom in order to identify themes correctly. For example, children coming from chaotic families will often demonstrate a theme of disorder or messiness throughout play (Boyd Webb, 1991).

All children deal with daily occurrences of problems and are able to illustrate their feelings about these problems through play. Some of these occurrences or dilemmas children encounter include parental conflict, conflict between parental and peer or self desires, reunions (especially for children of divorced parents), forbidden items, or jealousy to name a few (Woolgar, 2001). Often, children will reenact events from their daily lives through dramatic play. This can be events ranging from work related play (cashiering, banking, teaching, etc.) to dramatic play involving fights or events happening at home through a dollhouse or puppetry (Christie, 1990).

Children suffering from separation anxiety will often express themes of separation. In a study by Mary Ellen Milos and Steven Reiss, it was found that these children benefit from having theme related toys available to them along with a nondirective, nonjudgmental adult (Milos, 1982). It is also important that the adult be present with the child while he experiences the working stage of play therapy.

Marijane Fall

Marijane Fall is currently a professor in Counselor Education at the University of Southern Maine. She has teaches a variety of courses with special interest in play therapy. Some of the courses include counseling children, school counseling, play therapy, as well as clinical supervision. Fall is the author of Clinical Supervision: A Handbook for Practitioners as well as 25 journal articles. Fall also spends time delivering conference presentations nationally. She is a member of the American Counselor Association, the Association for Counselor Education and Supervision, The Association for Play Therapy, as well as the Maine School Counselor Association.

Fall identifies four categories in play therapy: connecting, safe play, unsafe play, and resolution play. Many play therapists choose to view play behavior as a progression of stages, but Fall has moved from stages to categories. She has chosen to do this as categories reflect the clinical reality of play behavior more accurately than stages (Fall, 1997). Through her case study, she analyzed 31 children aged 5 through 9 with classroom behavior problems. In this study, five judges were assigned positions including investigator, research assistant, and play therapists. Throughout this process, the research assistants transcribed the 186 sessions into coded behaviors. The steps that these judges took included independent viewing and coding of data, personal notes on content, and communication between researcher and judges regarding perceptions of each session. Two of the judges analyzed data and the other judges assisted in contrasting any discrepancies between the first two judges. Following this, the categories were refined. The points of contention were studied and discussed along with pictorials of the categories representing the interrelationship between categories (Fall,1997). Boundaries

were clearly defined and categories were given names. Lastly, the researchers reviewed the categories for finalization.

Category one is the connecting stage. Children explore the playroom and connect with the therapist. Some ways that children will connect with the therapist is by telling the therapist about their outside world; children strive to find a way to bond with the therapist. Children connect with the play space by exploring, entering, and moving around the room in order to learn the room. In this study, all of the children displayed play behavior that fell into this category (Fall, 1997).

Category two is entitled Safe Play. This category of play was the most frequently documented play behavior. Safe play has been defined as controlled play. Children control the room, toys, or therapist in safe play. Children are able to protect themselves by controlling the reactions of others or of toys items. It is during this stage where children learn whether or not they should express strong negative emotions (Fall, 1997).

Unsafe play was decided as category three. This category is categorized by out of control behaviors. Play characters were portrayed in hopeless situations, or sometimes engaged in harmful or negative actions. In this study, children that displayed unsafe play generally also had established feeling safe in the playroom. In unsafe play, a continuum exists in which few (play characters) are in dangerous situations to many are in dangerous situations (Fall, 1997).

The final category Fall identified is resolution. During this category, a solution appears in situations where they had not yet appeared. The children learned how to cope with challenging situations and exhibited their coping skill through resolution play (Fall, 1997). Through play therapy, children are able to problem solve and practice coping with

real life situations. Resolution play is the category in which therapists learn that a child has developed healthy coping skills.

Following this study, Fall's categories produced supporting evidence for the four categories of play. Fall believes that the categories are separate from one another, but do have connections between the categories. Every child in this study had a different experience; some of the children stayed within the same stage the duration of the play therapy, while other children went between categories (Fall, 1997). Stages of play therapy are similar to that of categories, but the categories allow for children to move more freely between them.

Chapter III: Methodology

This chapter will include information about the subject selection and description, the instrumentation, data collection procedures, data analysis, and limitations. This case study was conducted in order to further support or reject Marijane Fall's categories of play therapy (Fall,1997). The purpose of this study is to find support for Fall's four categories of play behavior and through this methodology, support will either be granted or denied.

Subject Selection and Description

The client selected for this case study was a volunteer for the play therapy course SCOUN-706 in the Spring of 2006. This client's parents signed up as volunteers at Safe Kids Day in 2005. Upon being contacted by the researcher in January, 2006, the parents gave consent for their son to participate in nine play therapy sessions held at the Vocational Rehabilitation Building playroom at the University of Wisconsin-Stout campus in Menomonie, Wisconsin. Following the completion of nine sessions, permission was requested of the parents to allow their child to participate in six more sessions held at the same location with this researcher.

The client, a five-year-old child will be referred to as "Brian". Brian is a kindergarten student at a local elementary school. His family presents itself as stable and safe. Brian has one younger brother and a teenage foster sister. He presents himself as an active, intelligent young boy.

Data Collection, Instrumentation, and Analysis

Data collection began in the Spring of 2006. The sessions conducted with Brian were video-recorded and saved for analysis. Data collection continued for this case study

from June 2006 through August of 2006 producing a total of 15 sessions. All necessary written parental permission has been granted for this type of collection prior to collection.

These video-taped sessions were transferred to DVD format so the play behaviors the child exhibited through all sessions could be coded and categorized into Marijane Fall's four categories of play. Upon completion of the sessions, the data was analyzed according to the following categories: connecting with room, connecting with therapist, safe play, animal violence, human violence, resolution play, safe play to unsafe play, nonhuman to human play, unsafe play to safe play, and unsafe to resolution play (See Appendix A for further detail about the definitions used to code). Each session was viewed and analyzed to count each behavior occurring in each category.

After all sessions were coded, the data was graphed. The different categories of play were examined across time to see if different types of play are more prevalent at different points in therapy. Furthermore, data will be compared by the number of times Brian switches between unsafe to safe play, the number of times he exhibits resolution play, as well as the changes in violent play behavior over time. The percentage of times that Brian changed from unsafe to safe play is calculated by the number of codes for unsafe to safe play divided by the number of codes for unsafe play. This formula will produce the percentage of times that he moved from safe to unsafe compared with the times that he did not move to safe play.

Limitations

One of the major limitations of this methodology within this case study was the fact that there was two months in between the first nine sessions and the post-course sessions. Having such a large gap of time hindered the play therapy process and forced

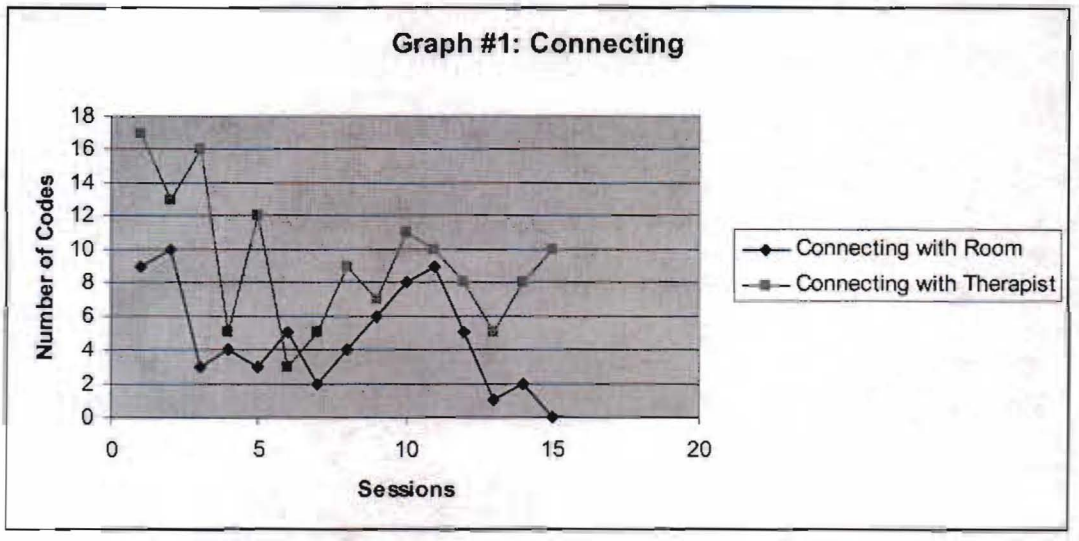
the therapist and client to take steps backwards in order to regain rapport. Another limitation of this case study occurred due to the fact that analyzing this data was a meticulous process. Since the sessions were only analyzed by one examiner, the inter-rater reliability was not able to be established. The coding is based on just one examiner's perceptions of play behavior. Case studies such as this are necessary and appropriate in order to gain further real-life knowledge that will improve upon what we already know about play therapy.

Chapter IV: Results

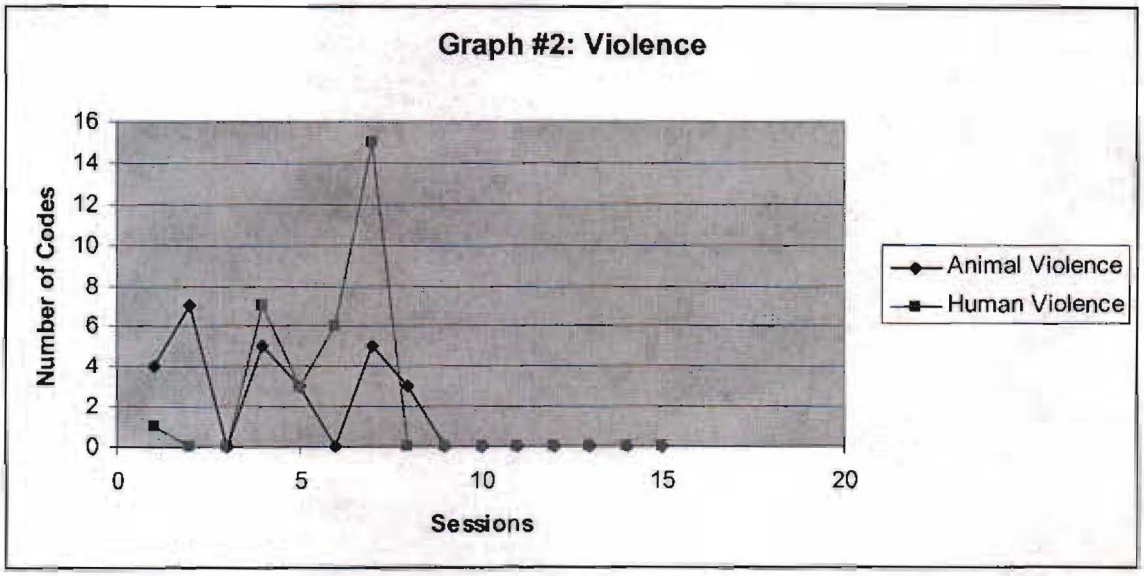
This chapter includes the results for each category: connecting with room, connecting with therapist, safe play, animal violence, human violence, resolution play, safe to unsafe play, nonhuman to human, unsafe to safe, and unsafe to resolution typed play. These are Marijane Fall's categories of play and have been analyzed through this case study. There are four graphs depicted below that are used to analyze the codes to discover if support can be granted.

Graphed Data

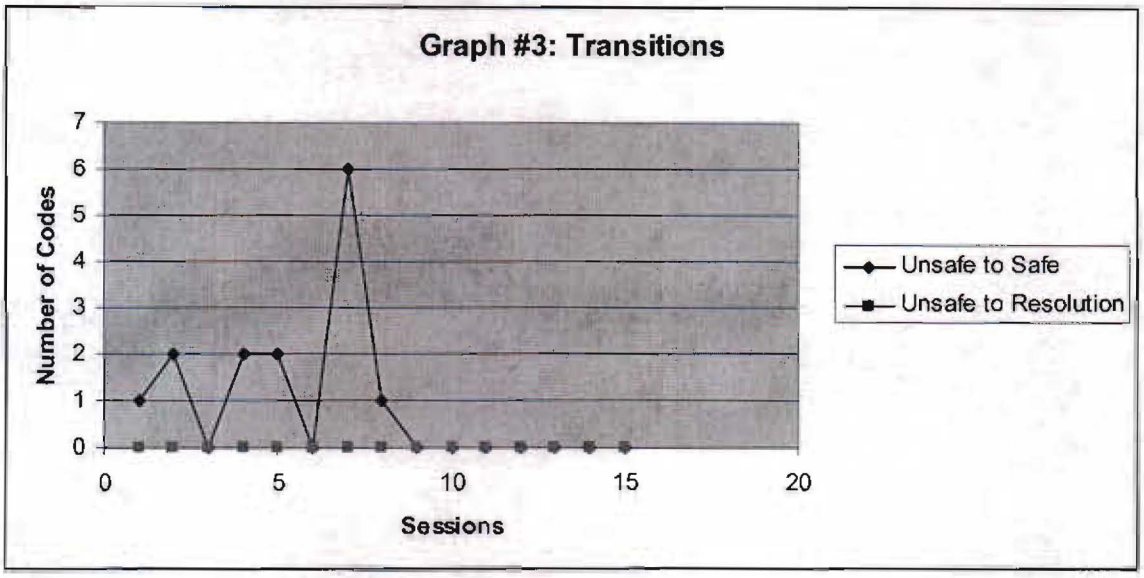
In the first graph represents the number of codes of connecting play over time. Brian displayed peaks in the first three sessions. Throughout the sessions, the graph depicts that connecting with the therapist remains stronger than connecting with the room and at the last session, connecting with the room has completely been eliminated. Interestingly, the last six sessions show a rise within both categories as there was a two month period when Brian did not meet for play therapy. He began to fall back into the earlier categories of play to reestablish the connection between himself and therapist.



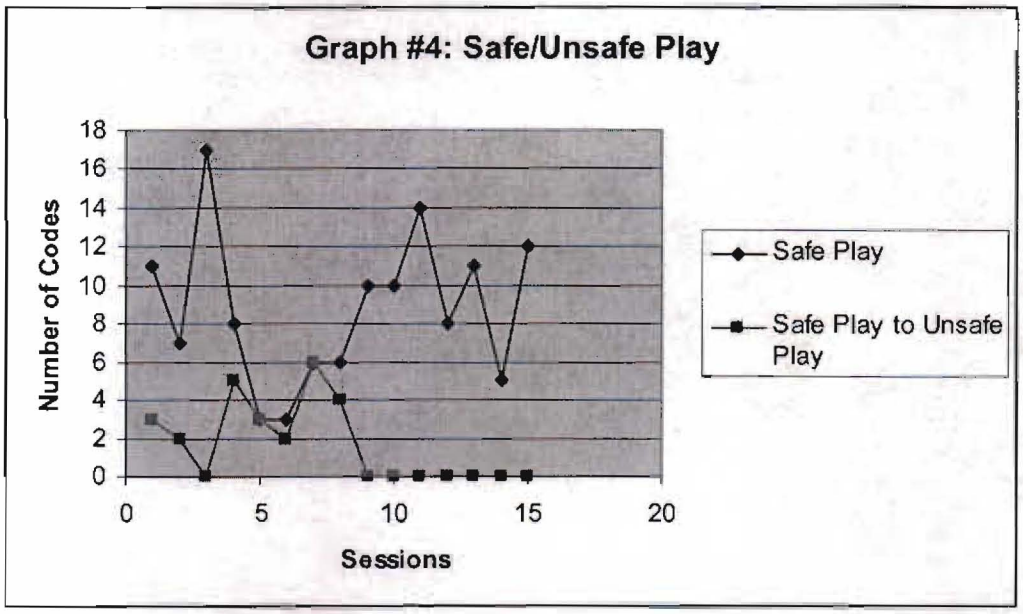
The second graph displays the range of violence found in Brian's play over time. In the beginning of sessions, there are few acts of human violence. In sessions six through nine, incidents of human violence are greater and escalate to higher levels than what animal violence did. It is apparent when the sessions began once again as levels of violence were completely nonexistent.



The third graph represents transitions in which Brian switched from safe to unsafe play in comparison with how frequently Brian exhibited resolution typed play. Sessions four through seven present the greatest amount of safe to unsafe play. Because of the lapse of time in between session nine and ten, support is further granted in favor of Fall's categories as Brian completely stopped producing unsafe play behaviors after connection of client and therapist were diminished.



The fourth graph represents the number of times that safe play is exhibited in contrast to the number of times Brian moves from safe play to unsafe play. This graph represents the problems that were encountered upon beginning this case study. Brian did not achieve the category of resolution in the beginning nine sessions; after all 15 sessions were analyzed and coded, it is apparent that Brian never achieved the stage of resolution.



Patterns

Throughout this case study, Brian demonstrated several different patterns. One pattern that Brian had was going from safe play to unsafe play. An example of Brian moving from safe play to unsafe play is when Brian was playing checkers. He made up his own rules and controlled the game and the therapist. Brian moved quickly from a controlled environment of checkers to a violent puppet show that involves hitting, and calling the police. Similar situations occurred on several occasions as Brian frequently moved from checkers or another board game to an uncontrollable game. In session eight, an entire suit of armor was built and he proceeded to ask the therapist to be the "good guy" and Brian portrayed the bad guy. During this play scene, Brian controlled the environment by giving directives to the therapist, but then quickly moved back to uncontrollable acts. Brian stated during this session, "I wish I had this at home." Brian was exhibiting characteristics of the connecting stage. He expressed his desire to have protection to keep him safe outside of the playroom. This phrase illustrates how a child can be in several different categories within the same play act. This session supports Fall's idea that some children move quickly between categories.

Percentage of Times Brian moved from Unsafe to Safe Play (Unsafe to safe divided by unsafe)				*Percentage of Times Brian moved From Unsafe to Resolution (Resolution divided by unsafe)*		
1	1/5	.20=20%		1	0/5	0%
2	2/7	.285=28.5%		2	0/7	0%
3	0/0	0%		3	0/0	0%
4	2/12	.166=16.6%		4	0/12	0%
5	2/6	.333=33%		5	0/6	0%
6	0/6	0%		6	0/6	0%
7	6/20	.30=30%		7	0/20	0%
8	1/3	.33=33%		8	0/3	0%
9	0/0	0%		9	0/0	0%
10	0/0	0%		10	0/0	0%
11	0/0	0%		11	0/0	0%
12	0/0	0%		12	0/0	0%
13	0/0	0%		13	0/0	0%
14	0/0	0%		14	0/0	0%
15	0/0	0%		15	0/0	0%
Average: 23%				Average: 0%		

The above chart displays the percentage of time during each session that Brian moved from unsafe to safe play and from unsafe play to resolution play. It is apparent that Brian did not achieve the resolution stage at any point within the play therapy process. He did, however, average at 23% of the time, moving from unsafe to safe play.

Some behaviors exhibiting this category include demanding his therapist to play hide and seek, checkers, Don't Break the Ice, and other games that allowed for him to control situations following a violent play excerpt. Nearly one quarter of the time during Brian's play, he moved from the category of unsafe play to safe play.

Chapter V: Discussion

The purpose of this study is to either support or refute Marijane Fall's theory that suggests that children move fluidly from category to category during play therapy. Fall's theory states that children move between the following four stages: connecting, safe play, unsafe play, and resolution play. In an effort to either support or refute her theory, this case study has been analyzed and the results from the previous chapter will be discussed. The theory suggests that some children make a strong connection with the therapist before opening up, some move from unsafe play to safe play, and others move from unsafe play to resolution play.

Fluidity

The theory presented contrasts stage theorists who believe children move from one stage to the next in a consecutive order. Fall's theory suggests that children will decide for themselves where they are at in the therapy process and that it is not as structured as stage theories suggest. Children will move between categories and will sometimes revisit or completely skip different categories numerous times throughout the therapy process (Fall, 1997).

Throughout the play therapy process, Brian revisited several of the categories and moved between connecting, safe, and unsafe play many times. Brian never reached the resolution stage of play throughout the play therapy process following unsafe play. This information supports Fall's theory that children move fluidly rather than consecutively through stages and also supports the idea that some children will not reach all categories.

Fall's article highlights the fact that not all children reach the resolution category of play therapy (Fall, 1997). In contrast with stage theories, the categories allow for

differences between clients; some clients will enter into all categories while others will only enter into one or two. Graph number two displays a difference between the first 9 sessions and the last 6 sessions. In the first sessions, Brian displays many unsafe acts of violence throughout his play, whereas in the final six sessions, there are no acts of violence. This is representative of several clients in Fall's study as some clients do not enter into resolution during play therapy and Brian is one of these clients.

Connecting

Fall's theory suggests that children need to bond and connect with a therapist before they will exhibit unsafe behaviors and this usually happens in the early sessions (Fall, 1997). Graph number one has shown that Brian displayed a high number of connecting behaviors throughout the first several sessions. Some of the connecting behaviors that he displayed include glancing at the therapist, exploring the room, and telling the therapist about his world outside of the playroom. This supports Fall's idea that children must feel connected to the therapist before exhibiting unsafe behaviors. The theory implies that it would be unusual for a child to enter a playroom without connecting with the room and the therapist (Fall, 1997). Because Brian displayed such a great number of exploratory behaviors, this part of the theory is supported. Just as the theory states, Brian explored the room in order to discover what the uses of the toys are as well as testing responses of the therapist. These acts support this section of Fall's theory.

Unsafe Play to Safe Play

In unsafe play, children feel a lack of control of the outcome of the play. In safe play, children are in control of the play situation, are free from self-harming play, and are in charge of play. Fall also suggests that before a child will exhibit unsafe behaviors, they

will have established a rapport with the therapist (Fall, 1997). In the results section, it is noted that Brian moved from unsafe to safe play 23% of the time. This means that he switched from using play in an uncontrollable manner (dramatic play) to a much more controlled play in nearly one quarter of the time that he participated in play therapy. Brian exhibited the most violent behaviors in sessions four through seven. Prior to these sessions, Brian has exhibited the highest amount of connecting behaviors in the entire play therapy process. Brian moved into these categories shortly after he had spent time connecting with the room and the therapist, which again, supports Fall's theory in the respect of connecting as well as supporting the descriptions of categories stating that children are more likely to display unsafe behaviors after they believe they can trust the therapist (Fall, 1997).

Summary

This case study was intended to provide data that would either support or refute Marijane Fall's theory that children travel through categories fluidly rather than through stages consecutively. In the cases from above, in all aspects analyzed, the data provided from Brian's experience in play therapy has supported Fall's theory. Brian went in and out of the four categories at his own rate, sometimes going quickly from one stage to the next, and sometimes never even entering into a category.

The evidence provided in this case study has contributed a great deal of information that helps to support Fall's theory. Brian moved from safe to unsafe and back to safe many times throughout the sessions. He also never entered into resolution play following unsafe play. Brian exhibited violent behaviors with animals and humans after he had connected with the therapist. It should also be noted that when there was a lapse of

sessions between session nine and session ten, Brian seemed to start over in the play therapy process as he reverted back to the connecting category rather than continuing in unsafe play. Each of these incidents give support to Fall's theory of fluid categories.

Brian's experience in play therapy was filled with many different behaviors that helped to support Fall's theory. Brian traveled between the categories fluidly and did so in a way that helped contribute supportive evidence. Overall, this case study provided a great deal of support for Fall's theory.

Play therapy is an important tool used to help children express themselves in a way that is appropriate for them. Fall has taken the opportunity to adjust the stages into a more flexible setup—the categories. In the case of Brian, these categories of play were appropriate and helped to explain his play behaviors.

Implications for Further Research

With further research, more support can be gained in order to further solidify the validity of Fall's theory. This one case study contributes to the process of gaining more evidence that Fall's theory is strong and valid. In order to her theory to become more recognized and substantial to the field, therapists must continue to produce case studies analyzing the way that children behave throughout play therapy. As more and more cases are analyzed, therapists will be able to see the patterns that Fall has identified and contrast this category theory with different stage theories. On a larger scale, studies could be done that will watch child behavior in other play settings as well as in the play therapy room. This would help to contrast how children play in therapy versus the way they play in a completely unstructured play setting. The information gained from this could further Fall's ideas and theory by providing more evidence on the way that children play. Further

study on this theory is important because it considers a different angle than what many stage theorists present. The more case studies and large scale comparison studies that are done, the more evidence that will be provided to present either in support or in refute of Fall's theory of categories.

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Appendix A

Coding of Play Categories

Stage #1 Connecting

The stage of connecting can be defined as the child examining the physical playroom, the toys, and the therapist. During this stage the child determines the worthiness of the therapist and the different characteristics and aspect of the toys and play space. During this stage there are tentative verbal interactions between the child and the therapist.

Code CR: Connecting with room/toys

Video segments that include the following characteristics will be coded as CR (Connecting with room)

- Child entering a play area with curiosity and exploration.
- Child looking around the room and scanning toys or materials.
- Child examining objects for function and use.
- Child asking questions about function or use of toys.
- Child telling therapist about the nature of the toys and/or play space.

Code CT: Connecting with therapist

Video segments that include the following characteristics will be coded as CT (Connecting with therapist)

- Child tells the therapist about his outside world.
- Child asks the therapist questions about herself.
- Child glances at therapist to check the therapist's responses to his actions.

- Child engages in eye contact or looking at the therapist to explore the therapist's characteristics and intentions.

Stage #2 Safe Play

During Fall's category of safe play the child attempts to gain the control. The child may be controlling himself, the play activities, the toys, or the therapist. The child feels safe when he is holding control over the therapeutic process. The behaviors with safe play range from low emotion, repetitive play activities to relational control over the therapist. Often times, therapists can feel confused by the child's actions during safe play due to role confusion of play characters because the child attempts to control the play theme.

Code SP: Safe Play

Video segments that include the following characteristics will be coded as SP (Safe Play)

- Child engages in sorting, organizing, planning, categorizing, and/or arranging of the play toys.
- Child exhibits game play where he controls rules and routine board games, card games, etc.
- Child directs, commands, and/or dictates to the therapist to do something.
- Child shows role confusion between play characters (bad is good, good is bad), but with little emotion.

Category #3 Unsafe Play

The category of unsafe play is identified when the child exhibits being out of control. Helplessness, hopeless sequences, smashing objects or body parts, and unstoppable killing occur in the unsafe play stage. Children exhibit violent emotions including rage, hopelessness, and helplessness. Unsafe play escalates from one person or animal being unsafe to many/all being unsafe.

Code AV: Animal rage/violence

Video segments that include the following characteristics will be coded as AV (Animal Violence)

- Child exhibits rage or violence towards animals through burying, harming, fighting, biting, or killing animals.
- Child reenacts violent stories through animals, non-human puppets or other non-human play objects.

Code HV: Human rage/violence

Video segments that include the following characteristics will be coded as HV (Human Violence)

- Child exhibits rage or violence towards humans through burying, harming, fighting, biting, or killing.
- Child reenacts violent stories through human puppets or other human play objects (dolls, figures, or drawings).
- Child includes the therapist in reenacting violent stories by the child and therapist being assigned roles/characters.

Category #4: Resolution Play

During resolution play, there is a problem and a solution. This is the stage when the child finds a new response to an old problem. When the child finds a solution, the child regains control over the situation and the child finds a way out of the bad situation. During this time, the child's anxiety is lowered and confusion is lessened.

Code RP: Resolution Play

Video segments that include the following characteristics will be coded as RP (Resolution Play)

- Child engages in a problem, but then finds a solution.
- Child allows the play characters to escape violence or dangerous situations.
- Child reenacts past play themes, but with a different ending to the story.

Coding of Play Patterns

Times when two consecutive segments which show the following patterns will also be coded.

Safe to Unsafe

Non-Human to Human during Unsafe Play

Unsafe to Safe

Unsafe to Resolution