CHAPTER 6

Evidence-Based Play Therapy

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The U.S. Surgeon General's 2000 report on mental health described the shortage of appropriate services for children as a major health crisis and estimated that less than half of children in need receive any treatment (U.S. Public Health Service, 2000). Mental illness is now the leading cause of disability for all persons 5 years of age and older (U.S. Public Health Service, 2000). Evidence exists that untreated mental illness and behavioral problems in children follow the trajectory of continued behavioral problems at home and in school (Ackerman, Brown, & Izard, 2003; Keiley, Bates, Dodge, & Pettit, 2000). The president's New Freedom Commission on Mental Health (2003) recommended the promotion of screening, assessing, and providing services for the mental health of young children, in addition to the improving and expanding of school mental health. The commission also proposed the need for empirically based mental health interventions for children and adults. Public and private entities have emphasized the need for researchers and clinicians to demonstrate evidence of treatment effect prior to the dissemination of funding and/or support.

Play therapy has been used as a treatment of choice for young children since the early 1900s. Generally acknowledged as the originators of play therapy, Anna Freud (1928) and Melanie Klein (1932) used play as a substitute for verbalized free association in their efforts to apply analytical techniques to their work with children. Virginia Axline's (1947) use of play to apply nondirective therapeutic principles in her work with children popularized play therapy in the psychotherapy field, heavily influ-

enced by Carl Rogers's (1942) person-centered theory. Her work and writings in the late 1940s and 1950s, including her accounting of play therapy with *Dibs* (1964), increased the knowledge and availability of play therapy. Axline (1949) was among the first to attempt to study the effects of play therapy and extend credibility to the intervention. Although by current standards, Axline's research does not address the rigor of research needed in the psychotherapy field to demonstrate efficacy of an intervention, she set the course for developing protocol and measuring effects of the play therapy approach. Founded in 1982, the Association for Play Therapy (APT) formed to develop and promote play therapy as a separate and distinct psychotherapy modality for treatment. APT currently serves more than 4,500 members identified as play therapy professionals.

META-ANALYTIC SUPPORT FOR PLAY THERAPY

As in most psychotherapy research, play therapy studies are limited by small sample sizes, which lead to a lack of generalizability of results (Ray, Bratton, Rhine, & Jones, 2001). In order to attain generalizable results, sample sizes would be daunting to the typical play therapy researcher. Chambless and Hollon (1998) suggest that treatment groups would need 50 clients per condition in order to reach sufficient statistical power in testing equivalency of groups. Because the necessity of large sample sizes hinders research practicality, psychotherapy has relied on meta-analytic reviews of research to address the effectiveness of interventions. Meta-analytic methodology combines the results from individual studies to produce an overall effect size, thereby determining the efficacy of the model intervention.

LeBlanc and Ritchie (1999) published the initial results of their meta-analysis of play therapy outcomes summarizing the results of 42 controlled studies, with an effect size of .66 standard deviations (SD). The researchers further detailed their study in a later publication, citing that benefits of play therapy appear to increase with the inclusion of parents and optimal treatment duration (LeBlanc & Ritchie, 2001). Using Cohen's (1988) guidelines for interpretation, an effect size (ES) of .66 denotes a moderate treatment effect, similar to effect sizes found in other child psychotherapy meta-analyses (Casey & Berman, 1985, ES = .71; Weisz, Weiss, Han, Granger, & Morton, 1995, ES = .71).

Ray et al. (2001), further detailed in Bratton, Ray, Rhine, and Jones (2005), conducted the largest meta-analysis on play therapy outcome research. This meta-analysis included the review of 180 documents dated

1942 to 2000 that appeared to measure the effectiveness of play therapy. Based on stringent criteria for inclusion, designating use of a controlled research design, sufficient data for computing effect size, and the identification by the author of a labeled "play therapy" intervention, 93 studies were included in the final calculation of effect size. The overall effect size was calculated at .80 SD, interpreted as a large effect, indicating that children receiving play therapy interventions performed .80 SD above children who did not receive play therapy. LeBlanc and Ritchie (2001) and Bratton et al. (2005) both included filial therapy research in their definitions of play therapy. Filial therapy is a parental intervention based on child-centered play therapy from which parents are taught basic child-centered therapy skills to facilitate weekly play sessions with their children.

Bratton et al. (2005) coded specific characteristics of play therapy that affected or had no effect on play therapy outcome. Effect sizes for humanistic (ES = .92) and nonhumanistic play therapy (ES = .71) interventions were considered to be effective regardless of theoretical approach. However, the effect size reported for humanistic approach was in the large effect category, while nonhumanistic was in the moderate category. This difference in effect may be attributed to a larger number of calculated humanistic studies (N = 73) compared to nonhumanistic studies (N = 12). When play therapy was delivered by a parent (ES = 1.15), the effect size was much larger than when delivered by a mental health professional (ES = .72), indicating the importance of involving parents in treatment to increase success of outcome. This finding was similar to the conclusions of LeBlanc and Ritchie (2001), who reported parent involvement as a predictor of play therapy outcome. Treatment duration was also a factor in the success of play therapy. Optimal treatment effects were obtained in 35–40 sessions, although many studies with fewer than 14 sessions also produced medium and large effect sizes. Age and sex were not found to be significant factors from which to predict the effects of play therapy. Play therapy appeared to be equally effective across age and sex. An effect size was not calculated for ethnicity due to the lack of specificity in the reporting of ethnicity in individual studies. In addressing presenting problems, the researchers encountered difficulty distinguishing specific diagnoses and symptoms due to the variation of the studies. However, 24 studies were calculated as investigating internalizing problems with an effect size of .81. Seventeen studies were calculated as examining the effects of play therapy on externalizing problems with an effect size of .78. Sixteen studies addressed a combination of internalizing and externalizing problems with an effect size of .93. These results indicated

that play therapy had a moderate to large beneficial effect for internalizing, externalizing, and combined problem types.

INDIVIDUAL STUDY SUPPORT FOR PLAY THERAPY

The field of play therapy has a history of more than 60 years of continuous research. Discussion of contemporary play therapy necessitates the exploration of this research in the field. Play therapy most likely has the longest history of research of any psychological intervention. In the earliest research I found, Dulsky (1942) attempted to study the relationship between intellect and emotional problems. He inadvertently established the effect of nondirective play therapy, which was to significantly improve social and emotional adjustments, yet no improvement was shown on intellect. Dulsky's study is a typical example of historical play therapy research. Although the research demonstrated a positive effect, neither a control or comparison group nor randomization was utilized, and neither a detailed description of participants nor a detailed description of treatment was published. Since Dulsky's 1942 study, an approximate count of play therapy research, excluding filial therapy research, includes 103 studies, of which 71 were published in professional journals and 32 were nonpublished, remaining in dissertation form. The majority of play therapy studies demonstrate some positive effect of play therapy on the participants. Over the last 15 years, since 1990, 36 research studies (27 published) on the impact of play therapy have been conducted. These most recent studies have demonstrated the positive impact of play therapy on general behavioral problems (Raman & Kapur, 1999; Shashi, Kapur, & Subbakrishna, 1999), externalizing behavioral problems (Flahive, 2005; Garza & Bratton, 2005; Karcher & Lewis, 2002; Kot, Landreth, & Giordano, 1998; Schumann, 2004), internalizing problems (Packman & Bratton, 2003), self-efficacy (Fall, Balvanz, Johnson, & Nelson, 1999), self-concept (Kot et al., 1998; Post, 1999), anxiety (Baggerly, 2004; Shen, 2002), depression (Baggerly, 2004), speech problems (Danger & Landreth, 2005), and diabetes treatment compliance (Jones & Landreth, 2002).

The following section is a review of the play therapy research conducted over the last 15 years. The following criteria were applied when selecting seven studies that exemplify current research methods and reporting: (1) research published in a professional journal, (2) research published since 1990, (3) research published in English, (4) use of a control group or comparison group, (5) sample size of 20 or more, (6) treatment described in detail or manualized, and (7) statistical methods and

results described in detail. Filial therapy research studies were not included in this review due to filial therapy's established power as a standalone intervention evidenced in Bratton et al. (2005) and more specifically in VanFleet, Ryan, and Smith (2005).

Play Therapy with Children Identified as Lacking in Coping Mechanisms

Fall et al. (1999) randomly selected children listed by teachers at three different schools as lacking in coping mechanisms that facilitate learning behaviors. Subjects were stratified by classroom teacher and grade level and randomly assigned to the control (N = 31) or experimental group (N = 31). There were 31 girls and 31 boys in the study. Age distribution was listed in the published article, ranging from 5 years to 9 years. The experimental group participated in six half-hour weekly child-centered play therapy sessions. All counselors were trained in research and child-centered protocol. The control group received no intervention. In a pretest–posttest design, all students were measured on three scales, including a classroom observation, Self-Efficacy Scale for Children (S-ES) and the Conners Teacher Rating Scale (CTRS). The classroom observation was conducted by research assistants trained to conduct a time sampling for off-task behaviors for 20 minutes with an established interrater reliability of 95%. Although both groups were found to increase favorable classroom behaviors through the CTRS and observation following treatment, they found that self-efficacy was significantly increased for those children participating in play therapy as measured by the S-ES.

Play Therapy with Hispanic Children

Participants for this study by Garza and Bratton (2005) were Hispanic children between the ages of 5 and 11 years old who were identified by teachers from three schools as experiencing behavioral problems. They were further screened with the Behavior Assessment System for Children (BASC) and scored in the at-risk or clinically significant range on any of the behavioral subscales. Twenty-nine students were identified and assigned to the either the child-centered play therapy intervention (N = 15) or the curriculum-based small group counseling group (N = 14). There were 17 boys and 12 girls who participated in the study. All participants were identified as Hispanic. Further distribution of age and grade breakdown is detailed in the published article. The child-centered play therapy

(CCPT) experimental treatment and Kids Connection curriculum comparison treatment were detailed in an accompanying manual to the study. Session summaries and videotapes were utilized to ensure treatment integrity. Both groups received 30 minutes of the assigned intervention once per week for 15 weeks. Using a pretest–posttest design, dependent variables were scores on the posttreatment BASC-parent report and BASC-teacher report. Results demonstrated that children receiving play therapy showed statistically significant decreases in externalizing behavior problems, specifically conduct problems, and moderate improvements in internalizing behavior problems, specifically anxiety. Effect sizes for several of the dependent measure scores indicated a moderate to large effect of play therapy, showing clinical significance in addition to statistical significance. Teacher BASC results demonstrated no statistical significance between the two groups.

Play Therapy with Children Diagnosed with Insulin-Dependent Diabetes

This study by Jones and Landreth (2002) sought to determine the effectiveness of play therapy with children diagnosed with insulin-dependent diabetes mellitus. Researchers recruited study participants from a summer camp for children with diabetes. Thirty children were selected for the study based on age (between 7 and 11 years) and other protocol criteria. There were 17 boys and 13 girls in the study. Ages and ethnicities are further detailed in the published study. The children were randomly assigned to the experimental or control group on the first day of camp. Children in the experimental group participated in 12 sessions of CCPT over the course of the 3-week camp. The control group received no additional intervention other than the summer camp. A pretest–posttest design was applied using the Revised Children's Manifest Anxiety Scale (RCMAS), Filial Problems Checklist (FPC), and Diabetes Adaptation Scale child form (DAS) as dependent measures. A 3-month posttest was also administered to participants through mail. Play therapists were trained in advanced play therapy and in issues related to diabetes. According to data analysis, both groups improved anxiety scores with no statistically significant difference in scores between groups. The experimental group showed greater improvement on the FPC than the control group but did not reach statistical significance. The experimental group showed a statistically significant increase in diabetes adaptation as indicated on the DAS.

Play Therapy with Child Witnesses of Domestic Violence

This study by Kot et al. (1998) employed a naturalistic design to accommodate the needs of residents of domestic violence shelters. During a 6-month period, CCPT was facilitated with all children between the ages of 4 and 10 years residing in the domestic shelter and whose parents agreed to be part of the study. Complete data was collected on 22 children in the experimental group. Following the collection of data on the experimental group, data was collected on 11 children who met the same conditions of the experimental group but entered the shelter following the end of residence of experimental group members. The experimental group received 12 45-minute sessions of individual CCPT in a period of 12 days to 3 weeks. Play therapists completed an advanced course in play therapy. The control group participated in regular shelter programs for the same length of time as the experimental group but received no play therapy. Pretest–posttest measures included Joseph Preschool and Primary Self-Concept Scale (JSCS), Child Behavior Checklist (CBCL), and Children's Play Session Behavior Rating Scale (CPSBRS). Raters blindly rated pre- and postintervention play therapy sessions according to the CPSBRS. Interrater reliability was .93 at posttesting. Following a treatment of play therapy, children in the experimental group scored significantly higher than children in the control group on self-concept as measured by the JSCS. Mothers of the children in the experimental group reported that their children exhibited significantly fewer externalizing behavior problems as measured by the CBCL and fewer total behavior problems than the mothers of children in the control group. Children in the experimental group scored significantly higher than children in the control group in physical proximity and play themes as measured by the CPSBRS.

Play Therapy with Learning-Disabled Preadolescents

Packman and Bratton (2003) recruited fourth- and fifth-grade volunteer students attending a private school specializing in the education of children with learning differences. Volunteer students were identified by parents or teachers as exhibiting behavioral difficulties. Thirty participants between the ages of 10 and 12 were randomly assigned to the treatment group ($N = 15$) or control group ($N = 15$). Breakdown of sex, ethnicity, and grade is detailed in the published article. The treatment group was further divided into groups of three and participated in a group play therapy intervention 1 hour per week for 12 weeks. The intervention was based on humanistic play therapy guidelines and is further outlined in

the published article. The control group received no intervention. A pretest–posttest design was used with the Behavior Assessment System for Children—Parent Rating Form (BASC-PRF) and the Child Behavior Checklist—Parent Report Form (CBCL-PRF) serving as dependent variables. Children who participated in the play therapy intervention demonstrated statistically significant improvement in scores on the BASC-PRF on overall composite scores and internalizing problems over children in the control group. Although statistical significance was not achieved on the CBCL-PRF, effect sizes were in the large treatment effect category on total and internalizing problems. Externalizing problem scores also yielded a moderate effect on both the BASC-PRF and CBCL-PRF, although not a statistically significant one.

Play Therapy with At-Risk Students

This study by Post (1999) examined the effects of a play therapy program on children identified as at risk specifically through poverty designation, achieving below grade level, special education identification, and mobility in home environment. All at-risk students in the identified school were recruited to participate in the study. Seventy-seven students were assigned to the experimental group, and 91 were assigned to the control group. Further details on age, sex, ethnicity, and family background are included in the published study. Children in the experimental group participated in CCPT, which was facilitated by graduate students trained in an introductory play therapy course. Children in the experimental group received from 1 to 24 play therapy sessions once per week with a mean number of 4 sessions. The control group received no intervention. Dependent variables included the Coopersmith Self-Esteem Inventory (SEI), the Intellectual Achievement Responsibility Scale—Revised (IAR), and the State–Trait Anxiety Inventory for Children (STAIC). Pretest and posttest scores on the dependent variables were analyzed to determine the effect of play therapy over time. Although there was no difference between groups on anxiety, a statistically significant difference was found between groups on self-esteem and locus of control. Further analysis revealed that children participating in play therapy did not increase self-esteem and locus of control over time but maintained the pretest level. However, children in the control group not receiving play therapy suffered from a statistically significant loss in self-esteem and locus of control. The author concluded that play therapy might be needed to prevent at-risk children from developing lower self-esteem and from reducing their sense of responsibility for their academic progress.

Short-Term Play Therapy with Chinese Earthquake Victims

This study by Shen (2002) investigated the impact of play therapy in an elementary school with Chinese children in Taiwan following an earthquake registering 7.3 on the Richter scale and resulting in the loss of many lives. The researcher recruited child participants from a rural elementary school located in an area of Taiwan that experienced the earthquake and more than 1,000 aftershocks in the subsequent months. Thirty students were identified as being at high risk for maladjustment using the Children's Mental Health Checklist (CMHC). The students, ranging from ages 8 to 12, were randomly and equally assigned to an experimental group and a control group. Breakdown of grade and sex is provided in the published study. The experimental group was further divided into play groups of three children per group. Each experimental small group received 10 40-minute group play therapy sessions during a 4-week span, meeting two to three times per week. Group play therapy was facilitated by a school counselor trained in CCPT. The control group received no intervention. Dependent measures included CMHC, FPC, RCMAS, and Multiscore Depression Inventory for Children (MDI-C). Results of the RCMAS demonstrated a significant decrease in anxiety, as well as a large treatment effect, for children participating in the experimental group as compared to the control group. Suicide risk as measured by the MDI-C was also found to be significantly less in the experimental group as compared to the control group.

Historical Play Therapy Studies

The use of these exemplary play therapy research studies by no means devalues the significant contribution that many other historical play therapy studies have made to the field. A rich history of play therapy efficacy has been established in the areas of hospitalized children with symptoms of anxiety (Cassell, 1965; Clatworthy, 1981; Johnson & Stockdale, 1975; Rae, Worchel, Upchurch, Sanner, & Daniel, 1989), self-concept (Crow, 1990; Gould, 1980; House, 1970; Perez, 1987), social adjustment (Cox, 1953; Oualline, 1976; Pelham, 1972; Thombs & Muro, 1973), and behavioral difficulties (Brandt, 2001; Gaulden, 1975; Hannah, 1986; Quayle, 1991). Detailed accounts of these studies can be found in the compilation of play therapy research summarized in Bratton and Ray (2000).

However, contemporary focus on research design and protocol rigor requires play therapy researchers to address cited flaws in the historical

play therapy research. Ray et al. (2001) pointed to flaws regarding lack of experimental methods, reported statistics, descriptions of treatment, specificity of participants' descriptions, and ill-defined presenting problems as problematic. In the seven exemplary studies detailed in the previous description, historical flaws have been corrected and addressed. Contemporary play therapy researchers are detailing their designs, interventions, protocols, and statistical methods in order to maintain the highest research standards.

EFFECTIVENESS AND EFFICACY

As a result of external and internal pressure to present evidence of psychotherapy treatment, the American Psychological Association (APA) Division 12 Task Force on Promotion and Dissemination of Psychological Procedures issued the first major list of empirically supported treatments in 1995 (Chorpita, 2003). The purpose of defining and identifying empirically supported treatments was to find the most effective treatments for specific mental health problems and to help practitioners in their selection of client treatment (Steele & Roberts, 2003). The most articulated controversy regarding the identification of evidence-based treatments or empirically supported treatments, however, is the possible distinction between clinical trials and real-world interventions: efficacy versus effectiveness (Chorpita, 2003; Nathan, Stuart, & Dolan, 2003; Steele & Roberts, 2003). Nathan et al. (2003) described efficacy research as the focus on measurable effects of specific interventions, whereas effectiveness research focuses on whether treatments are feasible and have beneficial effects in real-world settings. Efficacy studies are well defined, with meticulous controls on inclusion and exclusion and strict adherence to research protocol. Due to the delivery of treatment in a realistic setting, effectiveness studies are plagued with research difficulties such as lack of specific diagnoses and lack of adherence to treatment protocol due to the clinical needs of clients. Some support exists for the lack of impact that efficacy studies have on practitioner settings.

Although Division 12's listing of empirically supported treatments was met with controversy over criteria and qualifications, as well as over the perceived need for such a list, other entities have followed suit. APA Division 53 further defined the criteria for evidence-based approaches and published the website "Evidence-Based Treatment for Children and Adolescents" (Society of Clinical Child and Adolescent Psychology and Network on Youth Mental Health, n.d.). Division 53 defines

two categories of evidence-based approaches, which include "Best Support (well-established treatments)" and "Promising (probably efficacious treatments)." Criteria for Best Support include (1) at least two good between-group design experiments demonstrating efficacy in either demonstrating superiority to a placebo or another treatment or equivalent to an already established treatment in experiments with adequate statistical power, *or* (2) a large series of single-case design experiments ($N \geq 9$) demonstrating efficacy using good experimental designs and compared to another treatment, *and* (3) experiments must be conducted with treatment manuals, (4) characteristics of the client samples must be clearly specified, *and* (5) effects must have been demonstrated by at least two different investigators or teams of investigators. Criteria for Promising include (1) two experiments showing the treatment is statistically significantly superior to a waiting list control group, *or* (2) one between-group design experiment with clear specification of group, use of manuals, and demonstration of efficacy either through superiority to placebo or another treatment or equivalent to an already established treatment in experiments with adequate statistical power, *or* (3) a small series of single-case design experiments ($N \geq 3$) with clear specification of group, use of manuals, good experimental designs, and comparison of the intervention to a placebo or another treatment. Currently, this website lists four major types of disorders, including anxiety disorders, depression, attention-deficit/hyperactivity disorder, and conduct/oppositional problems. Several of the listed disorders identify no Best Support or Promising treatments, indicating the need for additional research on these and other diagnoses. It should be noted that currently no play therapy approaches are considered by Division 53 as Best Support or Promising.

Effectiveness of Play Therapy

Speaking to the issue of effectiveness, the strength of play therapy research appears to be in the history of and continued ability to conduct successful play therapy studies in natural real-world settings of schools, hospitals, clinics, and shelters. The New Freedom Commission on Mental Health (2003) recommended the expansion of preventive, proactive care in natural settings. Of the 103 research studies reviewed for this chapter, 41 were conducted in elementary schools. Five of the seven highlighted exemplary studies were conducted in a school environment with students during the school day. Although conducting research in the school setting presents the researcher with difficulties in controlling research groups and facilitating treatment as dictated by a protocol, it offers the

practitioner a practical method for replicating treatment if it is discovered that treatment was effective. Owens and Murphy (2004) cited that when efficacy studies are conducted by professional researchers, results are often not generalizable because of low caseloads, high levels of supervision, and rigid inclusion and exclusion criteria. As evidenced by the play therapy research, researchers have attempted to provide services to a large number of children, including criteria such as, for example, "children who are identified by parents and/or teachers as exhibiting behavioral problems." This broader inclusion pattern allows the researcher to serve children who are experiencing problems but possibly not identified with a specific diagnosis or not exhibiting only criteria tied to a specific diagnosis. Although this inclusionary pattern dilutes the strength of an efficacy study, it increases the strength of an effectiveness study. For example, in a school setting, students, especially young students, often do not present with specific diagnosable disorders. They typically present with problems and related symptoms that can be associated with developmental issues, familial difficulties, interpersonal challenges, comorbid diagnoses, learning disabilities, and a variety of other associated causes. Treatment provided in school-setting studies can be replicated and provided by a full-time counselor, psychologist, or social worker in the public school setting.

In addition to the natural setting of school, several studies cited with children in hospital settings were conducted with children receiving other hospital services who might benefit from a play therapy treatment provided by hospital staff to reduce their anxiety. Shelters are perhaps the most difficult settings in which to conduct research, yet Kot et al. (1998) and Tyndall-Lind, Landreth, and Giordano (2001) directed research within the highly mobile environment of a domestic violence shelter, while Baggerly (2004) managed to conduct a quasi-experimental design in the mostly transient environment of a homeless shelter. Brandt (2001) demonstrated the impact of play therapy on children who received services from a mental health clinic that served clients of low income and education level.

Additional strengths of play therapy research include the ability to demonstrate effectiveness with younger age groups and diverse populations. Typically, child intervention research has focused on treatment for older children. Among studies highlighted as efficacy studies for the treatment of child depression, the youngest children were in third grade (Kaslow & Thompson, 1998). In a review of studies of conduct disorder in children, Brestan and Eyberg (1998) stated the mean age of children in the 82 reviewed studies was close to 10 years old (9.89 years). Other meta-

analytic reviews of child therapy research outcomes cited similar mean ages, including Weisz et al.'s (1995) review of 150 studies, with a mean age of 10.5 years, and Kazdin, Bass, Ayers, and Rodgers's (1990) review of 105 studies with a mean age of 10.2 years. Play therapy research has, however, established play therapy as an appropriate intervention for younger children. LeBlanc and Ritchie's (2001) review of 42 play therapy studies and Ray et al.'s (2001) review of 93 play therapy studies cited mean ages of 7.9 years and 7.0 years, respectively. Because of the developmental language of play, many of the play therapy research studies investigated the impact of play therapy on children as young as 2 and 3 years old (Cassell, 1965; George, Braun, & Walker, 1982; Kot et al., 1998; Saucier, 1986; Shmukler & Naveh, 1984–1985; Trostle, 1988).

Diversity intervention also continues to be a focus of play therapy research. Play therapy researchers have sought to investigate play not only as a developmental intervention, but also as a universal language for children. Garza and Bratton (2005) demonstrated the positive effects of play therapy on problem behaviors for a sample of all Hispanic children, mostly identified as Mexican American. Shen (2002) confirmed the impact of play therapy in ameliorating symptoms of anxiety and suicide risk with Taiwanese child survivors of an earthquake. Trostle (1988) found that after 10 sessions of nondirective group play therapy, bilingual Puerto Rican children showed significant improvement in self-control and higher developmental level play behaviors when compared to their control group peers. When Post (1999) measured the effect of play therapy with 168 children, 82% of whom were African American, she found that a mean of four nondirective play therapy sessions helped them to maintain a stable level of self-esteem and internal locus of control. Although a large number of play therapy studies have failed to report ethnicity backgrounds for their participants, these few studies offer promising results for play therapy's impact on children of multicultural backgrounds.

Research in play therapy has shown effectiveness in natural settings, with younger children, and with diverse groups of children. Understanding play therapy as a distinct intervention that can be used in a generalized real-world setting with a younger population of varying backgrounds offers the intervention as a viable option for clinicians and practitioners. There are few other interventions that can boast a lengthy history of research with consistent positive results across a variety of populations and presenting problems. Certainly, for younger children, play therapy is unique in its capacity to offer mental health assistance for children who are suffering from a lack of services and interventions.

Efficacy of Play Therapy

Play therapy has demonstrated effectiveness in its ability to intervene with real-world children with real-world problems through a lengthy history of individual research and through a thorough analysis of the research (Bratton et al., 2005; LeBlanc & Ritchie, 2001). The meta-analyses have also helped the intervention of play therapy move toward the goal of efficacy. Chambless and Hollon (1998) provided a comprehensive description of efficacy to demonstrate that treatment benefits are due to the effects of the treatment and not to chance or confounding factors such as passage of time, effects of psychological assessment, or presence of different types of clients in the various treatment conditions. They further identified the need for randomization of the sample to a comparison condition, replication of the study by an independent team of investigators, and use of sound methodology. Sound methodology includes, but is not limited to, specificity in sample population description, selection of instruments that measure the specific focus of the population, follow-up methods, assessment of clinical significance, use of treatment manuals, monitoring of treatment protocol, and credible data analysis. Efficacy can be established through group design methods or single-case experiments.

Chorpita (2003) offered a broader interpretation of evidence-based research methods that includes four types of methods. Efficacy research links treatment with outcome, transportability examines the effectiveness of treatment for real-world settings, dissemination addresses the extent to which treatment can be implemented in real-world settings without researcher support, and system evaluation demonstrates efficacy when the system to be evaluated and the research team are completely independent. Through this continuum, there is a growing link between research and practice, evidentiary of effective treatments. Chambless and Hollon (1998) appeared to describe perfect research in which all conditions can be controlled and examined. The real-world application of play therapy research does not fit this criterion, but play therapy researchers can attempt to address issues noted by the narrow definitions of efficacy in order to strengthen the efficacy base of play therapy. Significant progress has been made in the areas of randomization of sample, addition of comparison groups, and use of credible data analysis and reporting. This progress needs to be maintained and enhanced. Yet, through this review, there appeared to exist three main criteria in which play therapy research has not aligned itself with the psychotherapy research on efficacy: manualization of treatment, specificity of population, and replication of stud-

ies. Several suggestions for improving clinical research in play therapy are proposed below.

Manualization of Treatment

The development and adherence to a treatment manual is a common theme in efficacy literature (Brestan & Eyberg, 1998; Chambless & Hollon, 1998; Nathan et al., 2003). Historically, play therapy has not adopted the use of manuals in specification of research protocol. Although play therapy researchers may identify a theoretical base such as a cognitive-behavioral or child-centered approach to play therapy, detailed descriptions are rarely provided. Play therapy is littered with recurring problems identifying treatment. For example, throughout research studies, child-centered play therapy is referred to as nondirective play therapy, play therapy according to Axline (1947), play therapy according to Landreth (2002), relationship play therapy, and self-directive play therapy, just to name a few. In the most recent research, Garza and Bratton (2005) took a step forward by identifying the use of a manual for a child-centered play therapy intervention. Possibly, play therapists have hesitated in using manuals because of the need to respond to each client as needed, but manuals are not required to be step-by-step outlines of sessions. In order to accommodate treatment, manuals can describe "broad principles and phases of treatment with examples of interventions consistent with these notions" (Chambless & Hollon, 1998, p. 11). This type of manual allows the play therapy researcher to define treatment according to theoretical principles and offer specific interventions to describe those principles, but it also allows for freedom in meeting the needs of the client through the principles outlined in the manual.

Adequate use of a treatment manual includes assurance that the treatment protocol is being followed. Adherence to treatment is a critical piece of conducting solid research, and it has been shown that without monitoring, researchers will drift from manualized treatments (Nathan et al., 2003). Monitoring of treatment goes beyond the general supervision and training of treatment providers in a given study. Steele and Roberts (2003) provided an example of treatment integrity measurement in suggesting randomized observation of recorded sessions by multiple observers. The use of trained observers who establish an acceptable level of inter-rater reliability to observe random sessions ensures that research protocol is being followed and is indeed responsible for outcome changes.

Specificity in Sample Population Description

As recently as a decade ago, researchers failed to include simple descriptive characteristics of the sample population. Play therapy research has greatly improved in the reporting of sex, age, ethnicity, and other distinguishing characteristics, yet improvement has not been made in the area of distinguishing presenting problems and symptoms. Using outcome measures such as the CBCL (Achenbach & Rescorla, 2001) or the BASC (Reynolds & Kamphaus, 1992), play therapy researchers continue to approach research with a broad net, attempting to serve all children with all behavioral problems. Although limiting to the number who can participate in research and the number of children who are served, identifying specific problems and examining only those problems will help build efficacy research in play therapy. This can be accomplished through the identification of DSM-IV diagnoses in children, then measuring the impact of play therapy on those diagnoses. Even though this approach sounds simple, it represents a unique problem for play therapists who provide services to young children, many of whom cannot be designated one specific diagnosis.

Hence, it is recommended that play therapy researchers attempt to study the effects of play therapy on grouped behaviors, such as hyperactivity, depressive problems, and anxiety problems. For example, instead of measuring problematic behavior of children according to the total problems score on the CBCL, a researcher could simply identify children who score borderline or clinically significant on the subscale of attention problems or aggressive problems. The researcher would proceed to measure the impact of a play therapy intervention on that specific scale. The hopeful outcome would be that instead of a general statement from some historical play therapy research studies in which it can be stated, "play therapy had a positive impact on problem behaviors of children," this new type of research would yield a statement such as "the specified play therapy intervention demonstrated a decrease in aggressive behaviors for children identified with clinically significant aggressive behaviors." Creating specificity in play therapy research helps the field to acknowledge how effective play therapy is with specific presenting problems.

Replication of Play Therapy Studies

As highlighted earlier, play therapy has a rich and lengthy history of research on various populations, across various presenting problems, in

various settings, with various treatments. The downfall of such variation is the lack of replication in play therapy studies. Replication of research involves repeating studies on the use of a specific protocol with a specific presenting population in a specific setting. Valid replication also requires that similar studies be conducted by researchers independent of each other (Chambless & Hollon, 1998). Independent researchers are entities that are not working from the same resources or within the same unit. For example, a replicated study conducted by Professor Smith at XYZ University of a study that was conducted by Professor Jones at the same XYZ University would hold little weight as being independent research. However, if separate universities or entities, such as clinics or schools, conduct similar studies in different locations but with the same protocol and same type of setting, it *is* considered independent research. Manualization and specification are required in order for a study to be considered worthy of replication. Without these adherences to proper research protocol, there is no need to replicate a study. At this juncture, replication with loose research definitions and parameters is not particularly beneficial to the play therapy research.

Although play therapy does not have to meet these stringent requirements to be considered promising, best support treatments are marked by their manualization, specification of sample, and replication of results. As play therapy research continues to grow in its ability to present evidence of efficacy, focus must be placed on best efforts so that time, energy, and resources are not utilized in vain. The field of psychotherapy has pressured the field of play therapy to prove its worth. Anecdotal outcomes and historically valid research methods no longer meet the criteria being placed before the play therapy community to demonstrate efficacy. As play therapy researchers have shown, they will meet new standards by changing specific methods of conducting and reporting research, thereby addressing efficacy with a new evaluative audience.

CONCLUSION

Play therapy has an extensive history of research that demonstrates the practicality of using play therapy interventions with children across ages and issues. Play therapy clinicians, whose numbers have grown significantly in the last decade, base their therapeutic practice on known benefits that play therapy provides to young clients. Play therapy has been demonstrated to improve the self-concepts of children, decrease anxious behaviors, lessen externalizing and internalizing problem behaviors, and

increase social adjustment. Play therapy delivered in the group or individual format appears to be equally effective in helping children deal with mental health issues and behavioral problems. An overall summarization of play therapy research over 60 years provides evidence that play therapy has a large beneficial treatment effect over comparison or nontreatment groups. Specific research studies are cited and reviewed in this chapter to reveal the overall impact of play therapy interventions.

The current trend among public and private organizations to move toward support of mental health treatments that have demonstrated efficacy has encouraged such entities to set standards for evidence-based practice. Play therapy research has responded to this trend by applying further rigor to field research. The strength of play therapy research lies in its application to real-world settings that validate play therapy as a usable model in working with real clients. In order for play therapy to be considered a well-established treatment, play therapy researchers must improve specific ways of implementing and reporting research designs. This chapter proposes several methods for addressing efficacy-based issues in play therapy research.

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