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The Impact of Group Play Therapy on Reducing Symptoms of Grief in Bereaved Children.

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by

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ABSTRACT

The purpose of this mixed methods case study was to examine the course of a ten-session play therapy intervention and its impact on the individual symptoms of grief in children. It studied the process that occurred throughout the ten play therapy sessions including themes that manifested during this process. Participants ranged in age from two to ten years old. All had experienced the death of a parent and were recruited through a peer support bereavement program in the community. A multiple case study design was used and several measurements were taken to get a better understanding of the play therapy process and its impact on the symptoms of grief in children. Participants received a pretest which consisted of the parent version of the Child Behavioral Checklist (CBCL) (Achenbach & Rescorla, 2000, 2001) along with the Parenting Stress Index (PSI) (Abidin, 1983). The same assessments were administered at the five-week mark and as a posttest. Five out of the eight participants completed the ten-session intervention. In addition, before and after each session, participants were asked to indicate their current level of pain on the Wong-Baker Faces Pain Scale (Wong & Baker, 1988). Last, play themes and emotions were identified, session transcripts coded, and the data was analyzed using the MAXQDA qualitative software. The results indicated that the process of play therapy with grieving children is unique and a variety of emotions and play themes were exhibited. Emotions included, fear, anger, confidence, curiosity, happiness, hesitation, and sadness. Themes that were played out included aggression/revenge, broken, burying/drowning, cleaning, creative/expressive, death/loss/grieving, exploratory, helpless/inadequate, mastery, messing/creating chaos, nurturing, power/control, relationship, rescue/protect, safety/security, and sorting/organizing.

DEDICATION

To my family.

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Life is a process that is filled with growth opportunities. This endeavor has made me grow and change in ways that I never thought possible; it has forever altered me as a person. I truly thank God for all of the opportunities in my life including being able to pursue my dream of obtaining my doctorate. This process would not have been possible without the help and support of several people.

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CHAPTER I: INTRODUCTION

Introduction to the Problem

With over two million people dying on average each year, it is clear that death is an intrinsic part of human life (U.S. National Center for Health Statistics, 2008). In one way or another, we are all impacted by death at some point in our existence. Individuals' responses to death and ability to cope with the loss of another are influenced by a variety of factors that fall into the emotional, physical, mental and social realms. Many individuals are able to deal with these factors and regain normalcy while others struggle to get back to the life they knew before the death occurred. Children are a particularly vulnerable population as their understanding of death varies with their age and their coping skills and resources are limited. As a result, they may need outside assistance in coping with their symptoms of grief.

Responses to grief are multifaceted impacting individuals emotionally, physically, mentally, and socially. Research, has shown that emotional reactions included shock, numbness, and disbelief or denial (Barbato & Irwin, 1992; Bowlby, 1980; Kagan-Klein, 1998; Kubler-Ross, 1969; Parkes, 1965; Rando, 1984; Worden, 1982); along with sadness, anger, anxiety, guilt, loneliness, yearning, relief (Peretz, 1970; Worden) and depression or apathy (Balk, 1993, 1996; Bowlby; Cerel, Fristad, Verducci, Weller, & Weller, 2006; Osterweis, Solomon, & Green, 1984). Physical manifestations varied and included fatigue, insomnia, breathlessness, or tension in the throat and chest (Barbato & Irwin; Lindemann, 1944; Parkes; Peretz; Worden). Cognitive responses included denial (Barbato & Irwin; Kagan-Klein; Kubler-Ross; Rando), hallucinations, confusion, difficulty concentrating, impaired memory, disorganized thought processes (Barbato &

Irwin; Kagan-Klein) and preoccupation with thoughts of the deceased (Parkes). Lastly, social reactions included difficulty with work, keeping up with everyday activities, and getting along with certain individuals (Scharlach, 1991).

Depending on individuals' abilities to cope with loss, symptoms of grief can take a normal or pathological course. It is expected that individuals will experience a variety of symptoms following the death of a loved one and that over time these symptoms will decrease (Parkes, 1965). Most individuals are able to cope with symptoms over time (Worden, 1982). Some individuals struggle and are not able to deal with these symptoms and as a result, symptoms persist for a prolonged period of time without decreasing (Worden). When this occurs, the reaction is considered abnormal (Worden) or chronic (Parkes). Individuals that fall into this category may need additional assistance in working through and coping with the symptoms that occur.

Studies have shown that following a significant loss, children experienced many of the same symptoms as adults in reaction to grief. These included sadness, shock, relief, disbelief, confusion and anger (Davies, 1991; Mahon & Page, 1995). In addition, they often exhibited behavioral problems (McCown & Pratt, 1985; Bierenbaum, Robinson, Phillips, Stewart & McCown, 1989) as well as mild depression (Dowdney, 2000). Other concerns included withdrawal, sleeping disturbances, decreased appetite, and falling school performance (Van Eerdewech, Clayton, & Van Eerdewegh, 1985).

Though the symptoms are similar, children may lack many of the coping skills which adults possess that assist them in being resilient. Research on child bereavement suggests that bereaved children and adolescents make up a vulnerable population (Black, 1978; Quarmby, 1993). Black (1978) found evidence that children who experienced the

death of a parent were more vulnerable during childhood and in adulthood to other losses. Quarmby (1993) found that if the mourning process was incomplete or inadequate, functioning could be affected on a long-term or permanent basis. Thus, it is important that children have access to effective care when needed.

Play therapy is widely used among clinicians to treat an extensive range of emotional and behavioral problems; these include, but are not limited to, social maladjustment, conduct disorder, aggression, school behavior, emotional maladjustment, anxiety and fear, self-concept, intelligence, and physical and learning disabilities (Bratton & Ray, 2000). In play therapy, play is used as the means of communication between the child and the therapist with the idea that children will use play materials to symbolically or directly act out feelings, thoughts, and experiences that they cannot express through the use of words (Axline, 1947; Kottman, 2001; Landreth, 2002; O'Connor, 2001; Schaefer, 2001).

Though play therapy has been used to treat a variety of issues and concerns, research on its use with bereaved children is limited and not well documented in the literature. Multiple case studies have been recorded on the use of play therapy which produced anecdotal evidence for the effectiveness of play therapy in reducing the symptoms of grief. These symptoms included aggression (Masur, 1999), anger (Bullock, 2007; Sarway, 1999), trouble sleeping, sadness (Oaklander, 2000), nightmares (Webb, 2002; Saraway), withdrawal, guilt, anxiety, depression (Kaplan & Joslin, 1993), problems with school (Masur), clinging behavior (Hurley, 1991), and defiance (LeVieux, 1994). They also indicated that play was a useful means for children to be able to communicate and express feelings following death. These studies provided a base from which to

conduct more formalized, structured research on the impact of play therapy in reducing symptoms of grief in children.

Background Rationale

The death of a loved one is arguably one of the most significant occurrences in an individual's life. It affects individuals emotionally, physically, cognitively, and socially making it a complex occurrence that, for many, is difficult to work through. Models on death suggest that it is an individualized process. This concept applies to children in particular as their ability to understand and express emotions varies and can limit their capacity to cope with death. The negative reactions of children to death are well noted in the literature (Davies, 1991; Mahon & Page, 1995; McCown & Pratt, 1985; Bierenbaum, Robinson, Phillips, Stewart & McCown, 1989; Dowdney, 2000) and the long-term impact suggests that children may be a particularly vulnerable population that requires treatment (Black, 1978; Quarmby, 1993). Because of their developmental levels and different needs, the same treatments that are used to help adults cope may not be effective with children.

Play therapy is a method by which to facilitate the expression of emotions in children and has been used to treat a broad range of emotional and behavioral problems (Bratton & Ray, 2000). A basis for its effectiveness in the treatment of grief symptoms in children has been exhibited through the use of case studies which offer anecdotal evidence as support. Because of the potential long-term effects of death on children, it is important that proven appropriate interventions be implemented. The goal of this study is to better understand the process of play therapy for children that have lost a significant

individual in their life to death and its impact on the behaviors that are identified during treatment.

Statement of the Problem

Grief is a complex occurrence that can have a lasting impact on individuals. Children are a particularly vulnerable population because they rely on others for support, have developmentally different understandings of death, and may have limited abilities to express and cope with the complex symptoms that occur (Black, 1978; Quarmby, 1993). If children are not able to cope with these symptoms, the effects can be long lasting (Quarmby). As a result, it is vital that children have access to treatment that fits with their emotional and developmental needs.

Purpose of the Study

The purpose of this study was to determine the impact and process of child-centered play therapy on individual symptoms of grief in children following the death of a significant individual in their lives. For this study, it was assumed that the behaviors and emotions that manifested during play as well as, the results of the Child Behavioral Checklist (CBCL) and the Parenting Stress Index (PSI) were related to the child's loss. In order to gain a better understanding of the play therapy process for grieving children, sessions were transcribed and the themes and emotions that manifested during these sessions were recorded. Changes in play themes and emotions were tracked across time and analyzed. This study was designed to answer the following questions: 1) How does play therapy facilitate the course of processing through and decreasing the symptoms of grief for children? 2) What are the emotions expressed by children in the play therapy process following the death of a significant individual in their life? 3) What are the

themes that manifest through this play process? 4) How do these emotions and themes change across the ten session treatment? 5) Are there differences in the child's self-reported emotional state before and after each play therapy session and do these emotional states change across time?

Conclusion

Death is an inevitable part of life that produces a complex set of symptoms for those that are left behind. Individuals' ability to cope with these symptoms varies and as a result, they may need assistance with working through and expressing their feelings. Children, in particular, have limited abilities to cope with death because of their developmental understanding of death and reliance on others for support. If children are not given the skills and the means to cope with and process through these symptoms, the negative implications can extend into adulthood. Therefore, it is imperative that they have access to proven treatments for expressing, reducing and coping with the symptoms of grief.

Definitions

For the purpose of this research, the terms are defined as follows:

Externalizing behavior problems refers to the external manifestation of internal problems. Behaviors include aggression, hyperactivity, and conduct problems. For the purpose of this study, externalizing behavior problems was operationally defined by the Externalizing Behavior scale score on the CBCL.

Internalizing behaviors can be characterized as behaviors that are used to cope with experiences. These behaviors may include: withdrawal, anxiety, depression, and

suicidal ideation. For the purpose of this study, internalizing behavior problems were operationally defined by the Internalizing Behavior scale score on the CBCL.

CHAPTER II: LITERATURE REVIEW

Up and down, right and wrong, truth and lies, some might argue that there is a natural balance to the world. Death is the inescapable equilibrium to life; despite modern medicine and people's continual search for the fountain of youth, one thing is certain: we all die. Thus, the question is not if we die, but instead what does the process of death look like? In this examination, the experience of the individuals or loved ones that are left behind is crucial. Individuals react in various ways when faced with death, thus, it is also important to understand exactly what grief and bereavement are and what is considered a normal verses pathological response. Most importantly, it is crucial to understand how to help individuals that are suffering with loss, grief, and bereavement and how to decrease their symptoms.

Given that death affects virtually everyone at one point or another during their life; it is not surprising that it permeates all aspects of our culture including literature, television, movies, and music. A simple search of the word "death" on *Amazon* returns an array of items including CDs, t-shirts, DVDs and of course, books. There are over 100,000 books that can be examined on this single website. Death is a popular topic of research among scholars and the public alike. Given that research on the area of death and dying is vast, the goal of this synthesis of the literature is not to cover all the research that has been done in the area of death, but instead will focus on covering the relevant literature and research that has been done as it relates to the specific area of death and children. These areas include: 1) definition of bereavement, grief, and mourning; 2) history of major theories of grief; 3) children's understanding of death; 4) children's bereavement reactions; 5) history and uses of play therapy; and 7) play therapy and grief.

Definition of Bereavement, Grief, and Mourning

Bereavement, grief and mourning are all terms used to describe the experience that someone goes through when a person that is close to them dies. Each of these terms have been discussed in the literature with a variety of meanings. Some researchers use these terms interchangeably while others offer specific definitions for each of the words. Within these definitions, some authors focus on the physical manifestations, others emphasize the emotional aspects, while others focus on assessing what are considered normal or abnormal expressions of these reactions to death.

One of the first individuals to examine the concept of mourning was Freud (1957) who stated that it was a normal reaction to the loss of a loved one or valued object. Engel (1961) used a similar definition to describe grief when he questioned whether it was a disease. In his work, Engel asserted that grief was a typical response to the loss of a meaningful object whether it was a loved one, a possession, a job, or other important thing (Engel). Furthering the definitions of mourning and grief, Bowlby (1960) described mourning as the mental process that was set in motion in reaction to the loss of a loved object and grief as the "subjective states" that occurred after the loss and accompanied the mourning (p. 11). Rando (1984), described bereavement as the response to the loss of a close relationship and mourning as the process in which the bereaved broke the psychological bonds that connected him to the deceased. In an effort to provide clear, consistent definitions of each of the terms, Osterweiss, Solomon, & Greene (1984) asserted that grief was the emotional response to the loss of a loved one. Mourning included common social ceremonies along with other public displays of grief, while

bereavement was a blanket term that included both the feelings of grief and the process of mourning.

In more current research, individuals have conceptualized grief in terms of an individualized process. Worden (1982) summarized mourning as a process that occurred following a loss and grief as the personal experience of the loss. According to Haig (1990), grief was defined as a personal experience and expression of deep and sorrowful emotion that incorporated affective, cognitive and behavioral components. Haig went on to state that mourning was the socially sanctioned expression of grief while bereavement was the objective state an individual experienced. Attig (1991) stated that for most people grief seemed to be a passive process that happened to individuals and at its best brought individuals back to their original state of health. However, he believed that it was more beneficial to view grief as an active process because it gave individuals the opportunity to take control and move through the process in their own direction.

Barbato and Irwin (1992), described bereavement as state in which an individual has lost someone or something that had personal worth. Shuchter and Zisook (1993) described grief as a nonlinear process with fluid, overlapping phases that differed from individual to individual. Wolfelt (1994) stated that mourning was an outward expression of grief; defining grief as the personal meaning that was given to an external event, death (pp. 26-27). Finally, Hogan and DeSantis (1996) described bereavement as the process that followed the death of a loved one with whom the survivor was and continued to be meaningfully attached.

In an attempt to formulate a succinct and standardized description of grief, Rodgers and Cowles (1991) examined the literature on grief focusing the authors'

definitions of the term. From this analysis, they proposed that grief was a "dynamic, highly individualized, and pervasive process with a strong normative component" (p. 448). They also concluded that grief was characterized by changes that may be classified in many different areas including "physical, social, cognitive, affective, behavioral, and spiritual" (p. 448). Though their aim was to provide a uniform definition, their results proved that it was nearly impossible to describe how the process would be for any one person as it is different for each individual that experiences it.

It is clear that the terms bereavement, grief, and mourning are complex words with a variety of meanings depending on an individual's experiences. Despite this, it is important to have a general understanding of these terms; thus, for the purpose of this study, the following definitions will be used: bereavement is the state of having suffered a significant loss, grief is the personal reaction or experience of that loss (Corr, Nabe, & Corr, 2000) and mourning is the outward or socially sanctioned expression of grief (Haig, 1990; Wolfelt, 1994).

Normal Grief and Pathological Grief

Grief is a multifaceted response that includes many dimensions; as a result, various researchers have focused their energy on defining normal versus abnormal or pathological responses to the loss of a loved one. The multiple factors that influence the effect of grief on the bereaved including gender, age, health prior to bereavement, whether or not the death was expected, the relationship with the deceased, and the perceived social support (Steen, 1998). This is why current research suggests that the course of bereavement is individually determined. However, despite this, there are

common symptoms that can be used to help differentiate between normal and pathological grief.

In order to understand pathological grief, it is first important to define normal grief. Though the reactions to grief may be diverse, there are many symptoms that are commonly noted in the literature. They fall into four main categories: emotional, physical, cognitive, and social. It is expected that individuals would experience a variety of symptoms in these areas and, in the case of normal grief, would be able to cope with them over time.

Emotions are at the core of the grief experience. Individuals may experience any array of emotions in response to the loss of a loved one, but several common feelings are noted in the literature. Initial reactions included shock, numbness, and disbelief or denial (Barbato & Irwin, 1992; Bowlby, 1980; Kagan-Klein, 1998; Kubler-Ross, 1969; Parkes, 1965; Rando, 1984; Worden, 1982). Individuals often yearned for the deceased individual (Bowlby; Peretz, 1970; Worden) and experienced sadness, anxiety, guilt, loneliness, yearning, and relief (Peretz; Worden). Anger was another common symptom (Peretz, 1970; Worden, 1982) sometimes directed at the deceased for dying and sometimes at the bereaved for not being able to save the deceased (Bowlby). Some bereaved individuals also felt depressed or apathetic (Balk, 1993, 1996; Bowlby; Cerel, Fristad, Verducci, Weller, & Weller, 2006; Osterweis, Solomon, & Green, 1984).

Loss also elicited many physical symptoms including breathlessness and deep sighing, tension in the throat and chest, weakness, feelings of emptiness, fatigue, reduced appetite, and insomnia (Barbato & Irwin, 1992; Lindemann, 1944; Parkes, 1965; Peretz, 1970; Worden, 1982). Individuals often experienced trouble sleeping (Balk, 1993, 1996;

Lindemann, 1944; Osterweis, Soloman, & Green, 1984; Parkes, 1965), agitation or irritability (Parkes; Peretz), as well as restlessness and hand-wringing (Peretz). These symptoms often came in waves lasting for variable amounts of time (Peretz).

In addition to the physical and emotional symptoms that accompany grief, there were psychological reactions as well. One of the most common cognitive responses was denial, which is noted throughout the literature (Barbato & Irwin, 1992; Kagan-Klein, 1998; Kubler-Ross, 1969; Rando, 1984). Other reactions included hallucinations, confusion, difficulty concentrating, impaired memory, disorganized thought processes, and thoughts associated with religious beliefs (Barbato & Irwin, 1992; Kagan-Klein, 1998). Individuals were often preoccupied with thoughts of the deceased (Parkes, 1965) affecting their overall functioning by leading to social withdrawal (Abdelnoor & Hollins, 2004; Bonanno & Kaltman, 2001; Parkes, 1965).

Depending on their age and current social interactions, bereaved individuals may be impacted in a variety of social arenas. For instance, adults may have trouble working, keeping up with everyday activities, and getting along with particular individuals (Scharlach, 1991). On the other hand, children have been found to experience academic failure or deterioration in their school work (Balk, 1993, 1996; Osterweis, Solomon, & Green, 1984; Silverman & Worden, 1993).

Freud (1957) was the first person to address the topic of normal and abnormal grief. He asserted that, although mourning was a regular reaction to the loss of a love object, if it turned into or produced melancholia it would be considered a pathological response. Lindemann (1944) described the common physical as well as emotional

reactions to the loss of a loved one. He also looked at “morbid” responses to grief, which he described as distortions of the normal grief reactions.

Like Lindemann, Parkes (1965) described typical grief in terms of symptoms, which included a period of numbness, followed by yearning and anxiety that alternated with longer periods of depression and despair. However, these symptoms decreased overtime reoccurring from time to time. Chronic grief, which was found by Parkes to be the most common, was characterized by a prolonged typical grief reaction with some or all of the symptoms being more pronounced. Inhibited grief occurred when an individual showed little or no reaction to the death. Parkes noted that this was the type of reaction that was typically seen in children under the age of five. Last, delayed grief occurred when a typical or chronic reaction occurred after a period of delay (Parkes).

Peretz (1970) viewed bereavement as an illness because it was a markedly different state of being for the bereaved individual and was associated with physical and emotional symptoms. Thus, an individual recovered from this illness when they no longer exhibited symptoms and when they were fully able to cope with their feelings and environment. However, like an illness, recovery might be full or partial. Peretz likened the loss reaction to that of a wound or infection; he stated that for some, the reaction was minor while to others it was a major occurrence. As a result, for some the healing process was smooth, predictable, and uncomplicated (otherwise known as normal grief) while for others the healing left serious scars that permanently impacted the system.

Condensing the ideas of previous authors, Worden (1982) classified the grieving process into two categories: normal and abnormal grief reactions. Normal grief included the appearance of physical sensations along with a range of emotions and cognitions

about the deceased and behavioral manifestations such as sleep disturbances. Worden noted that the grief experiences were intense for some individuals and mild for others. Although these symptoms were vast and varied, most individuals who experienced normal grief were able to cope with them on their own over time.

Those that were not able to cope with their symptoms over time were likely to experience what Worden (1982) classified as abnormal or complicated grief. Worden described a variety of factors complicating the grieving process. These included relational, circumstantial, historical, personality, and social factors. He also enumerated multiple labels that described abnormal grief including pathological grief, unresolved grief, complicated grief, chronic grief, delayed grief, or exaggerated grief.

A more concrete classification of normal versus abnormal reactions to death is provided by the Diagnostic and Statistical Manual of Mental Disorders, fourth edition, text revision (DSM-IV-TR, 2000), which is used to diagnosis individuals with mental illness. It states that the bereavement category can be used when the focus is the reaction to the death of a loved one. It also asserts that individuals may present with symptoms characteristic of a Major Depressive Episode including feelings of sadness, insomnia, decreased appetite and weight loss, but that a diagnosis of depression should not be given unless these symptoms last more than two months (DSM-IV-TR, 2000, pp. 740). Thus, the DSM recognizes that there were a range of symptoms that are not necessarily pathological unless persistent.

The DSM does, however, specify certain symptoms that are not considered normal; these include: 1) guilt about things other than actions taken or not taken by the survivor at the time of the death; 2) thoughts of death other than the survivor feeling that

he or she would be better off dead or should have died with the deceased person; 3) morbid preoccupation with worthlessness; 4) marked psychomotor retardation; 5) prolonged and marked functional impairment; and 6) hallucinatory experiences other than thinking that he or she hears the voice of, or transiently sees the image of, the deceased person. If these symptoms are present, a diagnosis of Major Depression may be given.

It is expected that individuals will have some sort of response to death. How this reaction is manifested and how individuals respond depends on the individuals themselves. However, in general, normal symptoms of grief fall into four main areas: emotional, physical, mental, and social (Peretz, 1970; Worden, 1982). When individuals are unable or ineffective in coping with these symptoms, their response becomes abnormal or pathological (Parkes 1965; Worden).

History of Theories and Models of Death

Death is universal; it spans all cultures and all living creatures. As a result, there have been many works explaining the death process and the experience of those left behind. This section will focus on the models and theories that have been used to explain this process and how they have changed throughout time. Understanding how people grieve and what to expect in this process is key to being able to treat those who are grieving.

Though death has been written about for centuries, the first person to discuss it from a psychological viewpoint was Sigmund Freud (1957) in his work *Mourning and Melancholia*, as noted above. Freud described mourning as a normal reaction to the loss of a loved one. In general, mourning was not a pathological condition that required medical treatment but was a process that should not be interfered with but left to work

itself out over time. In this process, the individual must come to terms with the loss of the attachment figure and withdraw from this attachment. This process can be difficult and may be carried out slowly. If, however, the response turned into or produced melancholia, then, Freud concluded this was a pathological response.

Though Freud was the first to look at death from a psychological perspective, Lindemann (1944) was the first to study the grief process. In his work, he examined the symptoms and changes in 101 bereaved patients through the use of interviews and observations of their behaviors and experiences following the loss of a loved one. He noted the physical sensations of grief experienced by the participants along with the psychological ones. The duration of the grief process was also discussed; Lindemann suggested that the duration of these grief reactions depended on how much success bereaved individuals had in completing grief work, which freed them from the bondage of the deceased. Bereaved individuals were held back in this process because they avoided the intense distress related to the grief experience and as a result, avoided expressing emotion and working through these feelings (Lindemann, 1944).

A little over 20 years later, Elizabeth Kubler-Ross (1969) conducted similar work and used her findings to write *On Death and Dying.* In it, she described the experience of death as a process that moved through stages. These stages were based on her observations during her work with dying patients. In the preface of this book, Kubler-Ross clearly stated that it was not meant to be a guide on to how to manage dying patients nor was it a comprehensive examination of the psychology of dying. Despite her intentions, her delineation of the stages of death remains authoritative and is still used today by professionals as a guide for understanding how individuals move through the

grieving process. Thus, it is important that her initial research be included in this discussion because it is a pivotal piece in the history of research on death.

According to Kubler-Ross (1969), the first stage of death is denial and isolation; she described this as the "No, not me," reaction (Kubler-Ross, 1969, p.38). She based this stage on the initial reaction she received when patients were told or came to understand that they were terminally ill. During this stage of grief, individuals used denial as a way to cope with and adjust to sudden and life-altering news. Typically, this was a temporary defense that was replaced by partial acceptance. However, throughout the death process it still may be relied on from time to time (Kubler-Ross).

Once individuals accepted that they were really going to die, the next reaction was anger, and thus was the second stage of Kubler-Ross's model. In this stage, denial was replaced by "anger, rage, envy, and resentment" and individuals begin to ask "Why me?" (Kubler-Ross, 1969, p.50). She asserted that this stage was often very difficult to cope with for the family because the anger was often projected in all different directions and seemingly at random. Kubler-Ross stressed that it was important to try to see the dying individual's point of view and to consider what may have triggered the angry outburst; doing this would make it easier for loved ones to cope with this stage (Kubler-Ross).

When dying individuals realized that denial and anger were not working in preventing the inevitable, they entered the bargaining stage (Kubler-Ross, 1969). Since the angry "Why me?" pleas failed, individuals began to try a softer approach in attempting to avoid the inescapable. They looked for ways to buy more time; Kubler-Ross used the example of a woman who made a variety of promises so that she could live to see the day that her oldest son got married. Whatever the method was, the aim was to

postpone inevitable. This postponement included a reward for being good and also had some sort of deadline as well as the promise that the dying individual would not ask for anything else if the wish was granted. However, most did not keep this promise. If their wish was granted they moved toward another bargain and postponement (Kubler-Ross).

Once the terminally ill individual could no longer deny their fate, depression moved in to replace the anger. In this fourth stage, the dying person often experienced two different types of grief according to Kubler-Ross (1969). The first was a reactive depression that was a result of a past loss such as the financial loss that often accompanies an extended stay in the hospital, the loss of a routine life with family roles, or the loss of a career. They second type of depression was described as preparatory depression and was associated with the loss the individual felt as he faced his departure from the world. Unlike the first type of depression that was a loss of the past, preparatory loss was an impending loss. Individuals began to prime themselves to lose "everything and everybody" they loved (Kubler-Ross, 1969, p.87).

When individuals were allowed to express their sorrow in an accepting environment, they were more likely to reach the final stage of death: acceptance. According to Kubler-Ross, if individuals were given enough time and had help in working through each of the previous stages then they would reach a stage during which they were not angry or depressed about the inevitable end of their lives. Instead, having mourned everything they would lose, they were able to face the end of their lives with a calm expectation. It was not a happy stage, but one that was "almost void of feelings" (Kubler-Ross, 1969, p. 113). At this point, the struggle was over for the dying individual. People that reached this stage often began to move away from friends and family seeking

the solace of their acceptance. As a result, it was important that family and friends received extra support and comfort during this period (Kubler-Ross).

Even when individuals reached the acceptance stage, Kubler-Ross (1969) asserted that individuals continued to hold a small amount of hope that there would be a sudden cure or miracle that would allow them to live. Throughout the stages, hope still persevered. According to Kubler-Ross, this hope appeared to be a comfort and strength through their time of suffering. Though she asserted almost everyone went through these stages when faced with death, she also stated that individuals moved through the stages at different rates and that stages often overlapped (Kubler-Ross).

During the 1980's, researchers began to question and criticize the stage models based on evidence that people did not always move through the grieving process in an organized manner (Bowlby, 1980; Parkes & Weiss, 1983; Schneider, 1984; Worden, 1982). At the beginning of this period, John Bowlby wrote on the process of grieving in his book *Loss*. Instead of stages, Bowlby (1980) conceptualized the process in phases; however, he acknowledged that these phases were not clear cut and that individuals could move back and forth between phases. The phases included numbing, yearning, disorganization and despair, and reorganization.

According to Bowlby (1980), the process of grief began with the phase of numbing; this phase which lasted from a few hours to a week varied from individual to individual and often included feeling stunned and experiencing difficulty accepting the news. This phase was often disrupted by eruptions of severe distress and/or anger. As the reality of the loss began to set in, the bereaved began to experience the yearning phase. This occurred within a few hours or a few days of the loss and could last from a few

months to sometimes years. During this time, the individual felt intense longing, pangs of distress, and weeping. Another symptom that accompanied this phase was anger, which came from two sources: feeling responsible for the death or upset at the loss (Bolwlby).

Being able to tolerate and work through the feelings of the previous stages brought the bereaved to the phase of disorganization and despair (Bowlby, 1980). Throughout this time the bereaved struggled with the yearning, and the examination of what went wrong and who was responsible. As this was worked though, the individual began to accept the loss as a permanent part of life. In order to accomplish this task, it was necessary for the individual to get rid of old patterns of thinking, feeling, and acting so that new ones could be formed (Bowlby).

As individuals discarded old patterns, new ones were formed to replace them. When this occurred, the bereaved entered the final phase of reorganization (Bowlby, 1980). During this process, the bereaved often became discouraged, feeling as if nothing could be spared and as a result became depressed and apathetic. When individuals worked through these feelings, they were able to begin to redefine themselves and their situations. This process was often painful but it was crucial to letting go of the deceased (Bowlby).

Like Bowlby, Worden (1982) described mourning as a process that included four tasks. These tasks included accepting the reality of the loss, experiencing the pain of grief, adjusting to the environment without the deceased, and withdrawing emotional energy from the deceased and reinvesting it into another relationship. According to Worden, bereaved individuals began the bereavement process by coming to terms with the fact that the person was dead and that they would not be reunited with them. Once

that occurred, individuals were able to experience the emotional and physical pain that accompanied loss and could start to work through this pain. Next, they began to adapt to the new environment without the deceased and the roles the deceased played in their lives. Finally, individuals began to reinvest their emotional energy into a new relationship, detaching from the deceased. According to Worden, this final step concluded the grief process.

Taking a similar stance, Schneider (1984), argued that grief was a process, debating the use of the terms stages versus phases. Schneider asserted that the term stage implied that a particular symptom or behavior occurred for a set length of time and then would disappear or be resolved. However, Schneider believed that using the word phase implied "a transient quality" that could last from a few minutes to a longer interval of time (p. 66). Phases were used in Schneider's model to convey that an individual might move back and forth in the process and that needs and reactions oscillated throughout the bereavement process. In his model, Schneider included physical, cognitive, behavioral, emotional, and spiritual elements to convey the holistic nature of the grief process. The phases of this model included initial awareness, limiting awareness, awareness, gaining perspective, resolving loss, reformulating loss, and transforming loss (Schneider).

According to Schneider, initial awareness marked the beginning of the grief process. It was during this time that conscious awareness of the loss started to set in and was most often experienced as shock. The next phase often came both before and after initial awareness. In this phase, individuals attempted to limit the awareness of loss by holding on to the deceased or reducing the impact of loss by letting go or minimizing the loss. Once individuals could no longer avoid or deny the loss, the next phase, awareness

of loss, set in and individuals were forced to fully acknowledge the loss. As individuals entered the gaining perspective phase, they terminated their grief process in three different ways: they returned to limiting awareness, they moved though a healing and acceptance process or they moved through a step of self-forgiveness, restitution, or resolution of the loss (Schneider).

The final three phases of the grief process related to coping with and working through the loss (Schneider, 1984). In the resolving loss phase, resolution began to occur and individuals had the opportunity to detach themselves from pieces of their life that no longer had current function or meaning. Next, individuals entered the reformulating loss phase in which they had some sort of resolution and now experienced a change in energy; they were able to focus on potential instead of limits; on growth instead of coping; and on challenges instead of problems. Finally, individuals began to focus on self-awareness as they entered the transforming loss phase. During this time, they began to see the loss as a growth experience and viewed grief as a unifying instead of alienating human experience (Schneider).

Around the same time as Schneider, Rando (1984) proposed three broad categories that normal grief moved through: avoidance, confrontation, and reestablishment. In the avoidance phase, individuals desired to avoid the knowledge that they had lost a loved one and experienced shock, denial, and disbelief in this process. Next, during the confrontation phase, individuals experienced grief most intensely; it was a highly emotional time in which the psychological reactions to grief were felt the most severely. Finally, in the reestablishment phase, grief began to decline and bereaved individuals began to move back into their everyday emotional and social worlds.

Though each of these models and theories attempted to convey different aspects and perspectives of the grief process, one thing that they all had in common was they culminated with the bereaved detaching from the deceased. The focus was letting go and moving on. In a more current model, Silverman and Klass (1996) challenged this viewpoint. They proposed that interdependence was sustained even when one of the persons in the relationship was gone. It appeared that despite theorists' assertion that the completion of the grieving process was detachment, what actually happened was that individuals continued to hold onto the connection and in many cases found comfort from this lasting bond (Silverman & Klass).

The theories of death and its process have grown and changed throughout time. When death was first conceptualized, it was described as a normal reaction to the loss of a loved one (Freud, 1957) with common symptoms (Lindemann, 1944) and a series of stages that individuals moved through over time (Kubler-Ross, 1969). More current theories have focused on death as an individualized process that moves through malleable phases (Bowlby, 1980; Rando, 1984; Schneider, 1984; Worden, 1982) with symptoms disappearing and recurring (Schneider, 1984). While initial theories suggested that grief was resolved with the detachment from the deceased individual (Freud), theories now propose that it is resolved with the acceptance of a lasting bond with the deceased (Silverman & Klass, 1996).

Understanding the process of death is important when treating bereaved individuals. Though the exact process is individualized, it is useful to acknowledge that individuals may move back and forth between feelings of acceptance, anger, and denial with symptoms disappearing and reappearing throughout the process. Though these

models focus on adults, their concepts can be applied to children as well. This knowledge can be used not only to educate the bereaved, but also to decrease frustration when it feels as if the client is moving backward.

Children's Understanding of Death

Multiple studies have been conducted in order to gain a better understand of children's concepts of death. As a result, a large amount of conflicting data has been produced on the subject. Death has been described in the literature as a concept with many components (Kane, 1979; Lansdown & Benjamin, 1985; Melear, 1973). This research indicates that there is a range in which children begin to understand the concept of death to when they fully comprehend its meaning. Understanding how children view and make sense of death is a key component in being able to treat their symptoms; thus, a review of the literature in this area has been included.

In one of the earliest studies looking at children's understanding of death, Nagy (1948) used written compositions, drawings, and discussions to examine this topic. The compositions were written by children age seven to ten years old and were in response to the prompt, "Write down everything that comes into your minds about death" (Nagy, 1948, p. 4). The children were then asked to discuss their work and when they ran out of things to share were asked specific questions by the researcher. A group of three to six year olds was also included, but participated in only the discussion piece of the exercise.

Nagy (1948) classified her findings into three different stages that were broken down by age group. The first stage included children under the age of five; in this stage, children did not have a way to define death and saw it as a temporary state of being and thus could not accept it. The second stage included children age five to nine and in it,

death was personified by the child. Personification is the representation of an abstract concept in a more familiar or concrete form. In this example, the personification took place in one of two ways: death was imagined as a separate person such as the Grimm Reaper or it was identified with the dead. Finally, the third stage of death included children age nine and over and in it children understood that death was permanent. Thus, children's understanding of death increased with their developmental level.

Using a much smaller sample than Nagy, Melear (1973) examined the death concept in 41 children age three to 12 years of age. Children's knowledge of death was classified into one of four categories: relative ignorance of the meaning of death; death as a temporary state; death as final, but with the dead remaining biologically functional; and death as final with the cessation of all biological functioning. In the first category, individuals had heard the word death used but did not have clear understanding of its meaning. They conceptualized death as a phase of life instead of a separate state of being. Six participants between the ages of three and four were placed in this category. Children in the second category saw death as something that could be reversed. Ten participants between the ages of four to seven years were included in this category. Next, individuals in the third category saw death as irreversible but believed that the dead maintained certain biological functions as seeing, hearing, and feeling. In this category, four participants from age five to ten were included. Lastly, 21 children were placed in the final category. Two of these children were between four and five years old, one was between five and six and the rest were age six or older. These children believed that death was final and permanent (Melear). Like Nagy's work, this study indicated that children's understanding of death gradually increased with age.

Using the work of Piaget, White, Elsom, and Prawat (1978) hypothesized that children in the concrete stage of thought would exhibit a greater frequency of understanding of universality of death than those in the preoperational stage of thought. They focused on three concepts of death: irrevocability, universality, and the cessation of bodily functions. In order to test this hypothesis, 170 children were given a concept assessment to determine their level of understanding of the concept of conservation, read a story about the death of an elderly woman and then interviewed. The results indicated that children's understanding of death's universality was connected to cognitive development, but comprehension of the other two concepts was not (White, Elsom, & Prawat).

Expanding further on this idea, Koocher (1973) also used Piaget's structure for conceptualizing cognitive development to examine children's attitudes toward death. His participants consisted of 75 children ranging in age from six to 15 years old. Each child was given the Wechsler Intelligence Scale for Children (WISC), which was used to measure verbal concept formation, abstract reasoning, and general intellectual level. The level of cognitive development was also tested, and the individuals were divided into three groups with 20 at the preoperational level, 35 at the concrete-operational level, and 20 at the formal-operational level. All of the participants were asked the same structured questions with no follow-ups.

The results indicated that children's answers to the questions on the causes of death were related to their level of cognitive development. Children at the higher levels of functioning produced higher-order answers to this question whereas lower level individuals gave highly concrete or egocentric responses. Children were also asked how

long they expected to live; individuals in the concrete operations stage of development had much more realistic estimates than those in the preoperational level of thinking. In contrast to the findings of Nagy (1948), none of the participants in this study gave a personification-type response when asked to describe what would happen after death.

In an attempt to test and expand on Nagy's findings, Kane (1979) interviewed 122 middle class white boys and girls ages three through 12 to determine their understanding of death. Kane asserted that the literature defined ten components of the death concept; these included: realization or an awareness of death; separation which included children's ideas of where the dead were located; immobility included ideas about the movement of the dead; irrevocability was the understanding that death was permanent; causality was the belief about how the deceased died; dysfunctionality dealt with children's understanding of the deceased's ability to use bodily functions or senses; universality was understanding the concept that everyone dies; insensitivity was the ability to have mental and sensory functions; appearance dealt with the perception of how a dead person looked; and personification was the notion of death as a person or thing. These concepts were used to understand the developmental concept of death by looking at which components each children held and to what degree the concept was present.

The results indicated (after dropping the personification component) that children as young as three years of age had some death concept. In the four-year-old group, some held all the components at least incompletely. The five- to six-year-olds, seldom missed a component and at age seven, with the exception of the appearance component, all components were regularly present. For eight-year-olds, again with the exception of the

appearance component, all the components were completely present in every participant. By age 12, there was consistent presence in all of the components (Kane, 1979).

From these results, Kane (1979) suggested that children's death concepts developed in three stages. In stage one, children conceptualized death in terms of structure and held three components: realization, separation, and immobility. They held magical thoughts about death, seeing it as a position. In stage two, children added function to the structural description of death; they began to see it as specific and concrete. This stage was marked by reality and the beginning of logical thought, the previous three components were developed further, and the six remaining components were included. In stage three, children were able to think about death in the abstract. Kane related these stages to Piaget's stages with stage one preoperational, stage two indicating concrete operations, and stage three providing evidence of formal operations (Kane).

Lansdown and Benjamin (1985) found similar results in their study of the developmental concept of death. Their study consisted of 105 children between the ages of five and nine years old who were questioned about their concept of death after reading a story about an elderly woman that dies. Several components of the understanding of death were assessed in order to decide which children fully comprehended death and which ones only possessed a partial understanding. The results of their study showed that 60% of five-year-olds, 70% of six-year-olds, and 66% of the seven-year-olds had a complete or almost complete concepts of death and by eight or nine years of age, the numbers were almost 100%. Thus, according to this research, children as young as five may be able to fully comprehend the meaning of death.

Death can be a complicated concept for children to understand. Speece and Brent (1996) developed several components of death based on the literature on death and children and used these concepts to help describe how children understand death. They include universality, irreversibility, nonfunctionality, causality, and noncorporeal continuation. First, universality was the idea that all living things eventually perish; it included three strongly related dimensions: all-inclusiveness, inevitability, and unpredictability. It was basically the understanding that everyone will die at some point, but that this point could not be predicted. Generally, younger children believed that death was not universal more often than older children. Irreversibility was the concept that death could not be reversed; once someone was dead they stayed dead. Again, younger children were more likely than older children to see death as temporary and reversible. Next, nonfunctionality was the concept that when the body dies all functions cease, i.e. walking, seeing, thinking, hearing, etc. As with the previous two concepts, younger children were more likely than older children to believe that dead individuals could continue to perform a variety of functions. Though there were some differences on what caused the death of the departed, in general the bereaved had an abstract and realistic understanding to the events, both internal and external, that lead to the death of the individual that had passed. Younger children would more often provide unrealistic explanations for death or would focus on specific causes. Lastly, the concept of noncorporeal continuation was the belief that some part or form of the person continued after the death of the body. How children understand this concept has not been investigated and is therefore unknown (Speece & Brent).

The variation in children's understanding of death suggests that there may be other factors that impact understanding. Swain (1979), examined some of these factors including age and sex of children along with parental education and degree of religious influence within the family. In this study, 128 children, ranging in age from two to 16 years old, were split up into five age groups composed of equal numbers of males and females. Parental education was divided into two categories: high school graduation or less and college graduation or more. Religion was categorized as either a strong or a weak religious orientation. A semi-structured interview was given to the participants focusing on what the child thought about death, its universality, causes of death, when it occurred, what happened after people died, and understanding of the afterlife. The results indicated that the only variable which produced a statistically significant difference for each of the concepts was age (Swain).

Children are at various developmental levels and as a result, comprehend death and conceptualize it differently than adults (Masur, 1999). The research on children's understanding of death is diverse; however, in general, understanding increases with age (Swain, 1979). Children as young as three appear to have some concept of death with full understanding occurring between ages of nine and twelve (Kane, 1979; Melear, 1973; Nagy, 1948). These results indicate that children of almost all ages have some understanding of death and therefore may need assistance in coping with and processing through the symptoms that accompany bereavement.

Child Bereavement Reactions

Multiple studies on children's reactions to death have been conducted over the past few decades increasing the amount of information in this area. The results of these studies clearly indicate that the loss of a loved one has a negative impact on children. The literature also suggests that the process of children's grief follows more current models that suggest it is an individualized nonlinear process (Bowlby, 1980; Rando, 1984; Schneider, 1984; Worden, 1982) with symptoms disappearing and recurring (Schneider, 1984). Many of these studies have been focused around particular losses, and as a result, the studies in this area can be split into two main categories: loss of a sibling and loss of a parent which will be discussed below.

Children's Grief Process

Children process grief differently than adults because of a combination of factors. To begin with, how children experience death and move through the process of grief is impacted by their age and stage of development (Masur, 1999). Other factors that influence the process of grief include personality, individual coping skills, ability to form relationships, the closeness or quality of remaining relationships, and the type of relationship with the deceased along with the circumstances of the death (Masur).

Unlike the stages laid out by Kubler-Ross (1969), in their qualitative study of six children who had a family member die within the last 18 months, Andrews and Marotta (2005), concluded that children's grieving was nonlinear, characterized by intermittent episodes of acute mourning, followed by playful manipulation of the intensity of their feelings in the moment. For instance, a child might be both happy and sad when thinking

of the funeral and both mad and happy at God about the future. Thus, children seem to grieve in a different manner than adults (Andrews & Marotta).

Baker and Sedney (1996) reached similar conclusions stating that there were distinct differences in children's reactions to death when compared to adult's. They identified seven core differences; including the length of grief reaction, level of support needed, ability to understand the meaning of death, ways of coping with death, need to identify with lost figure, impact on self-identity, and understanding at which time the grief process ended. First, children's grief reactions appeared to last longer than adult's as they grieved more gradually. Second, children needed a consistently supportive individual with whom they could check in and process feelings. Third, for children under 11 there was a limited capacity to understand death and its implications. Fourth, children coped with loss in a different manner than adults. Next, when children's parents died, their grief reactions were impacted by their need to identify with that parent. Sixth, children's identities were more intensely impacted by a loss in childhood because their self-development was still in progress. Finally, the grieving and developmental process of children became intertwined making it difficult to see where grieving ended and normal development began (Baker & Sedney).

Children grieve differently from adults for multiple reasons. Christian (1997) described six differences between children's reactions to death and adult's. First, she stated that adults knew what it was like to live without another whereas children did not. Next, adults had supports they could seek but children only had what was given to them. Third, adults had the freedom to grieve in their own way while children were influenced by those around them. Next, children were repetitive and needed questions answered

more than once. Fifth, children were physical and thus acted out their feelings rather than spoke them. Finally, children's grief was cyclic meaning that their grief could return multiple times throughout their life (Christian).

As indicated by the research, children grieve differently than adults making it difficult to assess whether or not they are moving through the grief process in a "normal" manner. In order to help make this assessment simpler, Webb (2002), designed a "Tripartite Assessment of Children's Bereavement" (p. 29) that took into consideration individual, family, social, religious and cultural factors along with factors related to the death. According to Webb, the majority of children attempted to avoid grief, and as a result the length of the grief response was not a good way to judge the impact of grief on children. Instead, the extent of intrusiveness of grief reactions into children's lives should be examined; particularly, the degree to which children could carry out their typical activities and continue with their developmental tasks regardless of the presence of grief responses. Webb asserted that children's grief process could be considered "disabling" when there was interference with children's social, emotional, or physical development (Webb). This was similar to the definition of a pathological response in adults which became abnormal or pathological when individuals were unable or ineffective in coping with these symptoms (Parkes 1965; Worden).

These authors clearly suggested that children's grief processes were distinctly different from adults. The length of the grief reaction, amount of support needed, ability to understand the meaning of and cope with death were different in children than in adults (Baker & Sedney, 1996; Masur, 1999). Unlike adults, children inherently rely on others for support and for guidance on how to grieve (Christian, 1997). Children are still

developing and as a result, their grieving process is impacted by a need to identify with the lost figure and their self-identity is impacted by the loss (Baker & Sedney). For children, grief is a nonlinear, cyclic process (Andrews & Marotta, 2005; Christian). Some children may be able to cope with it over time, while for others it may interfere with their social emotional or physical development (Webb, 2002). When this occurs, children may need outside assistance with expressing emotions and coping with the symptoms of grief.

Loss of Sibling Studies

Studies on sibling loss looked at multiple aspects of the impact of death on children. Several studies have focused on age or developmental level (McCown & Pratt, 1985) while others have examined the long-term effects of losing a sibling (Fanos & Nickerson, 1991). These studies have produced an array of results supporting the assertion that bereavement is a complex issue that has a lasting impact on many individuals.

In order to better understand how death impacts individuals at different developmental periods, many studies have broken down participants by age and have focused on the behaviors that are exhibited at these different levels. McCown and Pratt (1985) broke participants down by developmental periods (ages four to five, six to 11, and 12 to 16) and used the Child Behavioral Checklist to examine their behaviors. They found that bereaved children had significantly more behavioral problems than children in the standardized norm group. These issues included withdrawal, clinging to adults, running away, excessive talking, arguing, and hyperactivity. Out of the age groups, children six to 11 years of age exhibited the highest level of disturbance.

In a similar study, Birenbaum, Robinson, Phillips, Stewart, and McCown (1989) also used the Child Behavioral Checklist (CBCL) to look at the impact of the death of a sibling on a child's behavior in children age four to 16 years old. Their results indicated that children who had lost a sibling showed significantly higher levels of internalizing and externalizing behavior problems and significantly lower levels of social competence when compared to normal children.

Combining the data from two different studies, McCown and Davies (1995) examined the behaviors of a total of 90 children two to 24 months after the death of a sibling. The Child Behavioral Checklist (CBCL) was used to examine internalizing and externalizing behaviors. From this data, the authors categorized behaviors that were identified in more than 50% of the bereaved children as common grief behaviors in response to sibling loss. The results indicated that overall the sample of participants mainly exhibited externalizing behaviors that fell into the Aggression subscale of the CBCL. Data was analyzed based on sex; for both boys and girls, "Argues a lot" and "Demands a lot of attention" were frequently identified. For the girls, two additional behaviors fell on the aggression scale and included "Easily jealous" and "Stubborn, sullen, or irritable." The remaining behavior, "Self-conscious or easily embarrassed" was on the depression scale. The boys also exhibited primarily aggressive symptoms; in addition to the two previously mentioned, "Disobedient at home" and "Showing off, clowning" occurred frequently in boys along with "Can't concentrate," which fell within the Attention Problem subscale. When breaking the data down by age, the authors found that the greatest incidence of behavioral problems occurred in preschool and school-age children.

Instead of focusing primarily on behaviors, Mahon and Page (1995) conducted interviews with bereaved children and parents on the children's experience following the death of a sibling. Children's impressions were compared to those of their parents. Children described clear memories of how they learned of the death and their feelings during that time. Almost all of the children reported feeling sad but other feelings were also described including shock, relief, disbelief, confusion, and anger (Mahon & Page).

Other studies, look not only at age, but also at cause of death. Finke, Birenbaum, and Chand (1994) examined children who lost a sibling to a terminal illness. Their sample included 43 siblings from 31 families who had children that ranged in age from birth to 19 years old. Data was collected from the parents prior to the death and two weeks after. The results showed that the most common reaction that was experienced was crying; however, the participants also demonstrated other grieving behaviors that were similar to adults including denial, avoidance, shock and guilt (Finke, Birenbaum, & Chand).

In addition to looking at age and type of death, a few studies have gathered data on the long-term effects of sibling loss with a variety of results. Martinson and Campos (1991) interviewed adolescents seven to nine years following the death of a sibling. Participants included in the study ranged in age from ten to 19 years old at the time of the death. In order to understand how adolescents viewed the impact of the loss of a sibling on their life and relationship with family, a combined measure of the legacy of sibling death was used. The responses to this measure were broken into three categories: positive, mixed, and negative legacy (Martinson & Campos).

The results showed that 15 participants recognized the difficulties of coping with loss but saw these problems in a positive light with positive attitudes toward the family and the support they provided. Those in the mixed legacy category saw the family as a source of emotional support but did not identify positive outcomes that resulted from the death. Last, the five individuals in the negative category identified direct negative effects in their lives that resulted from their sibling's illness and death and were not able to see any positive outcomes that helped lessen the pain that came with their sibling's death (Martinson & Campos).

Davies (1991) also interviewed adults that had experienced the death of a sibling during childhood. In order to be included in the study, the participants had to have experienced the death prior to their 17th birthday. A total of 19 interviews were conducted and the participants' ages ranged from 25 to 75 years. A qualitative design using inductive, unstructured individual interviews was used to gather the data. The data indicated that all the participants believed that their age at the time of the death influenced their grief and made it more difficult. Participants were asked to describe the symptoms that occurred following the death and all described feeling shock, numbness, sadness, loneliness, anger, and depression. In addition, in the first several years that followed, ten out of 12 continued to experience some of these feelings, though much less intensely (Davies).

Multiple long-term outcomes were also noted. First, the majority of the participants viewed the outcome of the death in a positive nature. They described feeling comfortable with death and appreciating life more because they understood how quickly it could end. This knowledge was accompanied by a newly found maturity which

negatively impacted their lives making it difficult for them to relate to their peers. For many this led to withdrawal from activities with peers to more solitary activities. Out of the 12 participants, three reported experiencing long-term effects of sadness and depression that led them to seek professional help. All of these three participants had completely withdrawn from their peer relationships (the remaining nine had experienced withdrawal, but had maintained at least one peer relationship) (Davis, 1991).

Examining a different aspect of long-term reactions to grief, Fanos and Nickerson (1991) conducted a study using 25 participants that had a sibling that died of cystic fibrosis two to 19 years earlier. All participants were under the age of 19 at the time of the death. Interviews were conducted with all of the participants and three measures were administered. Anxiety and depression scales derived from the Hopkins checklist were used, along with a 3-point scale of guilt that was developed specifically for this study. In the analysis, participants were broken down by age groups: latency (nine to 12 years old), adolescent (13 to 17 years old), and late adolescent (18 years of age). For all measures, highly significant differences were found, with those who were adolescent at the time of the loss being more anxious, depressed and guilty than participants in the other two groups.

Participants in the adolescent group described feeling a strong overall sense of guilt including guilt about their relationship with deceased and guilt about out-living their sibling. The adolescent group also experienced higher levels of anxiety. All the members of this group expressed a general feeling that things were always about to go wrong and 63% expressed hypochondriacal concerns related to their bodies and 50% a fear of dying at an early age. A fear of intimacy was also expressed by six of the eight adolescents.

Only one individual in the adolescent group had married compared to 50% of the latency group. Another theme that was expressed was an excessive concern for others. Four out of eight of the adolescent group described overly worrying about other loved ones. Eighty-eight percent of the adolescent group experienced somatic symptoms such as severe headaches, ulcers or chronic muscle and joint pain along with sleeping difficulties that included severe and persistent nightmares (Fanos & Nickerson, 1991).

Loss of a Parent

The death of a parent is a significant occurrence in individuals' lives. The research in this area supports this assertion by examining the immediate and lasting effects of this occurrence on children. The work in this area has indicated that the negative effects of the death of a parent on children include behavior problems (Kaffman & Elzur, 1979), depression (Brent, Melhem, Donohoe, & Walker, 2009; Gray, 1987; Van Eerdewegh, Clayton, & Van Eerdewegh, 1985) with many of these symptoms lasting for extended periods of time.

Following the October 1973 war in Israel, Kaffman and Elzur (1979), examined the grief reactions of 24 normal kibbutz children who had lost their fathers in the war. They ranged in age from two to ten years old and were considered "normal" as they exhibited no problems before the loss occurred. Anywhere between one to six months after the death of their fathers, semi-structured interviews were conducted with the mother and teachers of each child.

From this information, two primary types of reactions were distinguished: grief reactions and additional behavior reactions. Grief reactions related to the children's efforts to cope with the death and included sadness, sobbing and crying, longing, and

other grieving responses. Additional behavior reactions related to children's personal approach to coping with the frustration, pain, and stress; these reactions included aggressiveness, over dependency, anxiety, regressive behavior, psychosomatic problems, difficulties with social adjustment, and school and learning difficulties. The results indicated that there was a significant increase in the average number of behavior symptoms per child. Before the death there was an average of 5.5 behavior problems compared to 12.9 symptomatic reactions after. Also, there was a marked increase in the severity of about half of the preexisting symptoms. The reaction in ten of the participants or 45% was considered a pathological response (Kaffman & Elzur, 1979).

The most common grief reactions included sad feelings and crying, remembering and longing, and denial of death. Many children struggled to understand the concept of death and what had happened. Searching for a substitute father and identification with the father were two other symptoms that were noted. Additional behavior symptoms that were common included reactive symptoms such as aggression, tantrums, increased dependency, separation anxiety, fears, sleep difficulties, restlessness, changes in school performance, discipline issues, wandering, daydreaming, eating problems, enuresis, thumb sucking, tics, and sibling rivalry. The most common symptoms in this category were dependent behavior, fears, and aggressive behavior. The authors summarized these results by stating that losing their father left a mark on each of these children in some way and the impact it had depended on many circumstantial factors including individuals' personalities, families and environments. The one uniting factor was that all individuals experienced a strong emotional response in reaction to the loss of their father (Kaffman & Elzur, 1979).

Following this initial study, Elizur and Kaffman (1982) examined the nature and course of the emotional problems of these children one and a half years and three and a half years after their fathers' death. Results from the initial study indicated that there was a significant increase in the average number of behavior symptoms per child. At the 18 month and 42 month follow-ups these behavior symptoms were persistent and actually peaked with an average of nine recorded at the 18 month mark compared to 5.5 before the loss occurred. The severity of the symptoms, however, did not change in degree. The severe emotional problems or "pathological bereavement" remained elevated throughout the follow-up period with nearly half of the children in all phases of the study. Approximately 40% of the children were included in the category of "pathological bereavement" in at least two of the three stages of the investigation. Almost 70% of the children showed signs of severe emotional disturbance in at least one of the stages. Hence, only a small number of children—less than a third—did not show clear signs of emotional impairment and were able to successfully adjust socially, with their family and in school following the death of their father. The authors also found that there was a wide range of symptomatic responses that varied in intensity and duration depending on the child. Thus, they concluded that there was not a clear uniform path for childhood bereavement (Elizur & Kaffman).

Fristad, Jedel, Weller, and Weller (1993) examined the psychosocial functioning in children following the death of a parent. Their study included 38 children (17 male; 21 female) ranging in age from five to 12 years old. Two age and gender matched comparison groups were used. Four assessments were used: children were assessed using the Diagnostic Interview for Children and Adolescents and the Children's Depression

Inventory; parents were given the parent form of the Diagnostic Interview for Children and Adolescents. Teachers were also asked to assess children's behavior using the Conner's Revised Teacher Rating Scale and the Child Behavior Checklist (CBCL) - Teacher's Report Form. Eight weeks after the death of a parent, bereaved children had fewer problems with school behavior, interest in school, peer involvement, peer enjoyment, and self-esteem than non-bereaved, inpatient depressed children.

Cerel, Fristad, Verducci, Weller, and Weller (2006), examined the differences in psychiatric symptomatology between bereaved children and adolescents and depressed and community controls. They followed a cohort of bereaved children for the two years following the death of a parent. Participants were categorized into two groups: simple bereaved—no significant stressor other than parental death, and complex bereaved—at least one substantial stressor in addition to parental death. Families were also categorized based on anticipated death—family knew for months or years that the death was going to occur or unanticipated death—the family had no warning.

The results show that bereaved group was significantly more impaired than the community control group on all outcome measures but not as impaired as the clinically depressed group. Both the bereaved and depressed groups show significant improvement over the course of two years, but the bereaved group improved more rapidly than the depressed group. In addition, participants with complex bereavement had a slower decline in symptoms than those with simple bereavement. One of the mitigating factors in this study was Socioeconomic Status (SES) with higher status leading to better outcome. Another moderator was the surviving parent's level of depression with favorable outcome

of the offspring being associated with low ratings of depression in the parent (Cerel, Fristad, Verducci, Weller, & Weller, 2006).

In an attempt to better understand why some individuals are able to complete the grieving process and healthily readapt to life while others exhibit ongoing emotional and behavioral difficulties, Gray (1987) conducted a study with individuals under the age of 18 that had experienced the death of a parent. The variables that were measured in this study included personality type, the quality or kind of relationship with both the deceased and surviving parent before the death, the suddenness of death, amount of time since the death, age of adolescent at the time of death, sex of the participant and deceased parent, religious beliefs, and social class. Half of the 50 participants attended a weekly peer-support group that lasted ten to 12 weeks.

The results indicated that 20% of the participants experienced major depression. Also, adolescents who had low social support following their loss had a significantly higher mean score on the Beck Depression Inventory (BDI). Another factor that was significant was religious beliefs. Participants who acknowledged that they had religious or spiritual beliefs had significantly lower mean scores on the BDI, and major depression was found significantly less frequently than those without these beliefs. Individuals that reported having a good relationship with the surviving parent also had lower scores on the BDI. When looking at age, adolescents that were 15 years or younger at the time of the death reported lower grades than those that were older at the time of the death (Gray, 1987).

A connection between social support and depression was also noted by Mireault and Bond (1992). When looking at participants aged 17-25 years old that had experienced

the death of a mother or father before the age of 20; they found that greater levels of perceived vulnerability and lesser levels of social support were associated with more anxiety and depression.

Depression was one of the symptoms noted by Van Eerdewegh, Clayton, and Van Eerdewegh (1985). They examined 105 children ages two to 17 years old one month and 13 months after the death of one of their parents. In order to understand the impact of death on children, the remaining parent of the children and controls were given a structured interview about their children's symptoms, behaviors, school performance, and overall health. They collected data on the physical and mental health in the children and surviving parents. Any symptoms that occurred between the time of the death and the 13-month follow-up were noted. When compared to the control group, children under the age of 12 experienced significant levels of dysphoria, withdrawal, temper tantrums, sleep trouble, decreased appetite, loss of interest in activities, bedwetting, decreased school performance and depressive syndrome defined by having at least three symptoms (Van Eerdewegh, Clayton, & Van Eerdewegh).

Focusing on the type of death, Brent, Melhem, Donohoe, and Walker (2009) examined the impact of the death of a parent 21 months after the loss had occurred. The participants ranged in age from seven to 25 and a total of 176 participated. Parents died one of three ways, by suicide, accident, or sudden natural death. The results indicated that when compared to the nonbereaved comparison group, the total group of bereaved offspring had higher rates of major depression and alcohol or substance abuse.

Combining parent and sibling death, Abdelnoor and Hollins (2004) examined how children did in school following the death of either a sibling or a parent. They found

that there was a significant difference in examination scores of parentally bereaved children and controls, and sibling bereaved girls and controls. Children in the parentally bereaved group scored an average of a half a grade below their controls and those in the sibling bereaved girls group scored almost a full grade below their controls. When looking at anxiety, they also found a difference in anxiety scores with a significant three-point or four-point difference between anxiety scores of parentally bereaved children and sibling bereaved children and their controls. All groups scored as more anxious than their controls (Abdelnoor & Hollins).

Whether it is the death of a sibling or a parent, children's reactions to the death of a loved one is multifaceted. Following death, children are left with a complex mix of symptoms including but not limited to withdrawal, clinging to adults, running away, excessive talking, arguing, and hyperactivity (McCown & Pratt, 1985); sadness, relief, disbelief, confusion, and anger (Mahon & Page, 1995); crying, denial, avoidance, shock, and guilt (Finke, Bierenbaum, & Chand, 1994); numbness, loneliness, and depression (Davies, 1991); anxiety (Fanos & Nickerson, 1991); aggressiveness, overdependency, regressive behavior, psychosomatic problems, difficulties with social adjustment, school and learning difficulties (Kaffman & Elzur, 1979) as well as higher levels of internalizing and externalizing behavior problems and lower levels of social competence (Birenbaum, Robinson, Phillips, Stewart, & McCown, 1989).

This research clearly indicates that children experience a complex mix of symptoms following death. Their ability to cope with these symptoms is not only impacted by their environment, but by their level of development as well. Unlike adults who easily communicate through verbal means, children may need alternative ways such

as play and activities to express themselves (Landreth, 2002). Play therapy is a means by which to bridge the gap between concrete and abstract thought processes so that children can make sense of their world and learn new methods for coping with their problems (Landreth).

Play Therapy History

Play is a natural means of expression for children that has undoubtedly been around since the beginning of time. It was first introduced as a therapeutic means for children by Sigmund Freud during his work with "Little Hans (1909/1955)." Shortly thereafter, Anna Freud (1946) and Melanie Klein (1955) used play as a substitute for verbalized free association. Anna Freud focused on the relationship between the child and the therapist while Klein used play as a means to promote the expression of fantasies, anxieties and defenses.

Moving from this base, others formulated different approaches to play therapy. Advances in the field occurred with the David Levy's (1939) development of release play therapy as well as the structured approach of Gove Hambidge (1955). Like Anna Freud, Hambidge first focused on establishing a therapeutic relationship; this was followed by the construction of an anxiety-inducing state that was played out and concluded with a free play to recover from the process. Levy's approach began with free play followed by the introduction of a stress-inducing situation that allowed children to release anxiety, stress and hurt. In contrast to psychoanalytic play therapy, these approaches structured the play materials, were not concerned with interpretation, and were directive in nature.

The current model of play therapy was formulated in the 1940's when Virginia Axline (1969) applied the client-centered therapeutic principles of Carl Rogers (1942) to

her work with children. The principles of nondirective therapy included the belief that individuals have an innate drive toward growth and a capacity for self-direction. Axline believed that play was a natural way for children to express themselves and that children had the capacity to resolve their own problems through the use of play. As a result, nondirective play therapy does not try to change or control children; instead, its goals are self-awareness and self-direction.

Following the work of Axline (1969), the next significant growth period for play therapy began in the 1980's and continued through the 1990's. During this time, a variety of theorists, academics, and practitioners formulated specific approaches to play therapy based on their theoretical views and personal experiences with children. These included Gestalt play therapy (Oaklander, 1994), Adlerian play therapy (Kottman, 1995), ecosystemic play therapy (O'Connor, 2001), and prescriptive play therapy (Schaefer, 2001).

Expanding on the work of Axline (1969), Gary Landreth (2002) formulated the term child-centered play therapy and refined the process. At the core of the play therapy process is the idea that play is essential for the healthy development of a child. It is a means for children to express their inner world in a concrete manner. Through play, emotionally significant experiences are given meaningful expression. The primary function of play is the changing of what may be unmanageable in reality to manageable situations through the use of symbolic representation (Landreth).

The concepts of play therapy have also been combined with group process to form group play therapy. The literature on the topic of group play therapy is limited. Ginott (1958) described the benefits of conducting group play therapy with children. These

included the facilitation of the therapeutic relationship, the formation of multilateral relationships by children, the stimulation of activity and the diminishment of tension. According to Ginott, the focus of the treatment was always on the individual child, which meant that children could engage in activities that were not related to other members of the group. There were no group goals set and no focus was given to group cohesion. Instead, the group is ever changing, with subgroups being formed and disbanded and individual interests spontaneously changing. Slavson (1948) stated that the primary advantage of group play therapy over individual therapy lay in the fact that in group play, problems and behaviors emerged that were not present in individual play.

Landreth and Sweeney (1999) described the process of child-centered play therapy as a "journey of self-exploration and self-discovery" (p. 39). Throughout this process, the therapist was not interested in the children's problems but in the children themselves and does not direct but instead facilitates the process. This process focused on relationships and their healing power. Summarizing literature on group therapy, Landreth and Sweeney described the rationale for using group play therapy. Children were made to evaluate their behavior in the light of peer reactions. It provided them with the opportunity to try out different ways of relating to peers, and it gave the therapist an opportunity to see how children react in the real world. It also increased spontaneity and accelerated the children's awareness of what was tolerated in the setting (Landreth and Sweeney).

Though the concept of play has been around for centuries, the use of it as a therapeutic means is more recent. Whether structured or nondirective, play is a way for children to express themselves in a concrete manner. Child-centered play therapy

facilitates the expression and processing of a range of emotions and allows children the freedom to work through feelings in their own way. Group play therapy provides many added benefits to this process of expression through the building of relationships with others. Because of the variety of emotions that are manifested by children following the death of a significant individual in their lives, it is important that they are provided with the means to express and process through them. Child-centered play therapy is a medium in which children can communicate what they are feeling inside.

Play Therapy and Grief

Grief may be expressed through a complicated mix of emotions that can be difficult for children to verbalize. Play can be used as a means to facilitate expression. A limited amount of research has been conducted on the use of play therapy in the grieving process and systematic studies on the topic are all but non-existent. Much of the work on play therapy and grief has been done through the use of singular case studies which offer anecdotal support for the effectiveness of child-centered play therapy in treating the symptoms of grief. Other studies look at the use of play techniques with children but do not specifically focus on child-centered play therapy.

Play Techniques

Many studies have examined the use of specific play therapy techniques, while others have looked at combinations of play and various talk therapies used to treat symptoms of grief. Though these studies do not specifically focus on child-centered play therapy, they provide support for the use of play as an effective way of communicating and processing through the feelings that occur following the death of a loved one. Thus,

they have been included in this section to provide support for the idea that play is useful in facilitating expression in children and reducing symptoms of grief.

Using a psychodynamically oriented play therapy in a case of early maternal loss, Masur (1999) conducted play therapy with a 6-year-old whose mother had died when he was 18 months of age. Chris was brought in for play therapy because he was encopretic one or more times a day, was accident prone and when he hurt himself he would lie on the ground crying without trying to get up or help himself. He also had trouble concentrating in school, frequently sucked his thumb and talked in a baby-like manner. During his 1 ¾ years of treatment, Chris played out themes of aggression, while, over time, his concentration improved, he no longer demonstrated self-destructive or accident-prone behavior, and his baby-like mannerisms decreased (Masur).

Applying a different theoretical orientation, Oaklander (2000) conducted short-term Gestalt play therapy with multiple children. First, seven sessions were conducted with 12-year-old Jack who lost his mother to cancer at age seven. He was referred to therapy because he had shown minimal affect immediately following the death and recently his grades began to fall, he had trouble sleeping, and preferred to stay at home instead of playing with his friends. Oaklander a used combination of play techniques including drawing, games, and clay. Following the fifth session, Jack's sleeping had improved, and at the follow-up session a month after therapy it was reported that all was well. Second, five sessions were conducted with Susan six months after the suicide of her father. Susan's mother brought her to therapy because of her angry, aggressive outbursts at home and because her teacher reported she was belligerent at school and had stopped doing her work. Throughout this process, Susan was able to express her anger and

sadness. Third, four sessions were conducted with six-year-old Jimmy following the death of his four-year-old sister in a car accident. Jimmy was brought into therapy because he hadn't spoken of his sister since her death. Through the use of puppets and sandtrays, Jimmy was able to express sadness and anger at the loss of his sister and the withdrawal of his mother since the death. During the final session, Oaklander brought Jimmy's father into the session so that Jimmy could openly express his sadness and his feelings about his mother withdrawing (Oaklander).

A common approach used by authors is to combine talk and play therapy techniques in working with bereaved children. Webb (1993) used this method in the case of nine-year-old Susan, following the death of her friend. Susan was referred to therapy because her mother was worried that she wasn't expressing her feelings and because she was having nightmares following the death. Susan also reported experiencing headaches at school. At the six session mark, Susan was no longer experiencing nightmares or headaches (Webb).

Kaplan and Joslin (1993) also had success in using this combination approach in treating a six-year-old boy, Peter, following the accidental death of his two and a half year-old sister. Before the death, Peter was outgoing and independent but afterward he became withdrawn, sullen, and experienced separation anxiety. During the preliminary assessment, Peter showed guilt, anxiety, depression, repetitive dreams, and confusion. Following six months of play therapy, Peter's symptoms of guilty, anxiety and depression subsided and his recurring dreams and thoughts of his sister and the accident ceased. Peter's previous functioning returned and he was more willing to express his feelings about the death (Kaplan & Joslin).

In another case of sibling loss, Bullock (2007) also used a combination of play and talk therapy. William was referred to the school counselor because he was having difficulty focusing in class, was irritable, and had failing grades. According to the teacher, William was constantly talking about his brother who had died four years early from an asthma-related episode. At the time William's symptoms began to occur, he was the same age his brother had been when he died. After an initial family session to gather information, William was seen for 10 sessions. Throughout the process, William was able to express his anger about not being able to share his feelings at home and gradually his behaviors improved. A family session was conducted to end the therapy process, and in this session it was discussed that William needed to be allowed to express his true feelings at home (Bullock).

In another configuration of play and talk techniques, Bluestone (1991) incorporated these two approaches with peer therapy in a school-based intervention. The peer group examined consisted of a ten and a half year old, Cindy, and a nine and a half year old, Rosa. Cindy had lost her father two years prior to a heart attack, and following this death, her oldest sister's baby died, along with a family friend. Rosa's mother committed suicide at the beginning of the school year. Cindy was referred to the counselor because of withdrawn behavior and academic difficulties. Before her mother's death, Rosa experienced problems with peers including feeling isolated. These issues were exacerbated by the death of her mother. Following 17 sessions, the author concluded that the process was influential in encouraging the two children to express their feelings. The group aspect of the intervention increased social skills along with self-worth (Bluestone, 1991).

Eight years later, Bluestone (1999) contacted Cindy and Rosa's guidance counselors. Cindy had graduated from high school and went to college on a scholarship. She participated in a variety of school and community activities and had a solid group of friends. Cindy's mother reported that she was open and expressive at home but was shy with adults and in the classroom setting. Rosa on the other hand, was not doing as well. According to her school counselor, she had been diagnosed with major depression and was in danger of not graduating because of poor attendance. She did not have any close friends and engaged in dangerous behavior. Bluestone noted that the differences in the girls' degree of success may have been because of differences in their family system and social/cultural contexts (Bluestone).

Child-Centered Play Therapy

Multiple case studies focusing specifically on the use of individual and group child-centered play therapy in the reduction of grief symptoms with a variety of results have been documented in the literature. Several of these case studies have been conducted with children following the loss of a father. Sarway (1999) found that short-term play therapy was effective in decreasing anger and nightmares in two brothers following the death of their father. After only six sessions, the nightmares were extinguished and the intensity of the boys' anger had decreased significantly. Using nondirective and semi-structured play therapy, Hurley (1991) treated a four and a half year-old, Cathy, following the suicide of her father. Cathy was referred for services because of her clinging behavior and crying. Following one and a half years of treatment, it was reported by the family that Cathy was crying less and was more independent around the home doing many tasks for herself and helping others (Hurley).

Six months after the death of her father, five-year-old Celeste was referred to therapy for being defiant, uncooperative, and depressed. LeVieux (1994) conducted child-centered play therapy with her. Outwardly, Celeste appeared happy and energetic, but in the playroom she exhibited feelings of sadness and loss. By the eighth session, Celeste was communicating her feelings about her father's death, and her mother reported that she felt that the sessions were helping Celeste work through her grief.

In a similar situation, Webb (2007) conducted parent-child play sessions with Brett and his mother Diane following the death of his father during 9/11. Brett was referred to therapy because according to his mother he was "rambunctious" and "very loud." His mother reported that she couldn't "stand to be with him" (p. 397). Sessions began about a year and a half after the death of Brett's father. During the beginning sessions, Brett spent the time reenacting the destruction of buildings and stating that the people inside had died. As the sessions continued, Diane became more patient and involved with her son and Brett's expression of death themes decreased. A follow-up was conducted a year after the end of therapy. Brett's mother reported that he seemed to be doing well; he was adjusting to school and seemed to have resolved his issues (Webb).

Group Play Therapy

Studies focusing on the use of group play therapy with bereaved children have also been conducted. Glazer and Clark (1999) conducted a preschool group using multiple mediums including art, music, motion, and puppets. Some directed activities were also implemented. These activities focused on helping children develop an understanding of the components of death. Results were gathered based on the individual observations of the therapists and reports from caregivers. Individual results following

treatment included a decrease in aggressive behaviors and improvement in sleeping through the night.

Tait and Depta (1993) conducted a bereavement group with ten children ranging in age from seven to eleven years old who experienced a variety of symptoms. Participants had experienced the death of a family member eighteen months to three years prior to treatment. Their symptoms included nightmares, angry outbursts, academic and social difficulties, withdrawal, hypervigilance, abandonment, and depression. Eight group sessions were conducted using preplanned play activities. Pre and posttest assessments were given to parents regarding the children's behavior, although the authors did not report specific results and instead reported that the results from the evaluation of this group were "encouraging" (p. 184).

In a similar study, Hickey (1993) implemented an after-school bereavement support group for children ages 11-14. The group met for one hour a week for 9 weeks, and each session was structured with specific activities including drawing, writing, and sharing of experiences. The losses that participants were coping with included parents, siblings, cousins, or grandparents. Following the completion of the group, participants filled out an assessment of the helpfulness of the group. Participants reported that the most helpful aspect of the group was talking about their feelings and the deaths in their lives. Also, they stated that it was helpful to know that they were not the only one their age that had experienced the death of a loved one and that it was okay to be upset. Parent evaluations were also conducted and the results of these reports were also positive (Hickey).

Each of these case studies provided evidence for the effectiveness of play therapy in providing children with an opportunity to express and process through the multiple symptoms of grief. These symptoms included aggression (Masur, 1999), anger (Bullock, 2007; Sarway, 1999), trouble sleeping, sadness (Oaklander, 2000), nightmares (Webb, 2002; Saraway), withdrawal, guilt, anxiety, depression (Kaplan & Joslin, 1993), problems with school (Masur), clinging behavior (Hurley, 1991), and defiance (LeVieux, 1994). Though this data is anecdotal, it provides a solid base with which to begin more systematic look at the process and impact of play therapy on reducing the symptoms of grief.

Current Study

Though some studies have suggested that play therapy is useful in treating the symptoms of grief, this research has several gaps. Prior case study research on play therapy for grieving children focused on singular anecdotal cases. Studies conducted on group play therapy did not focus on the process of play and were not specifically focused on child-centered non-directive play therapy. In addition, previous studies did not examine changes in the child before and after each session. Also, they did not look at the impact that the grief process and symptoms has on the parent-child relationship. This study addressed these gaps in the following way. First, a multiple case study design was used. Second, it focused not only on the symptoms of grief, but also on the process that occurred throughout the intervention. Next, only child-centered non-directive play therapy was used as the treatment. In addition, this study used multiple measures to examine the symptoms that were expressed and the change process that occurred. Last,

this study gathered data on parent-child stress and on changes that the child experienced after each session.

CHAPTER III: METHODS

Design

This study was focused on understanding the process of play therapy in the treatment and reduction of symptoms of grief in children after experiencing the death of a significant individual in their life. For the purpose of this study, it was assumed the behaviors demonstrated by the participants were directly related to grief. A multiple case study design was used to gather the necessary information to understand the process of play therapy in reducing the symptoms of grief in children. When looking at a system that is limited, such as a process, a case study design is traditionally used (Creswell, 2007). Generally, process research for counseling focuses on what happens in the counseling session; what the counselor does, what the client does, or elements of their interaction (Lambert & Hill, 1994). This study primarily focused on the participants, tracking their expression of emotions and play themes across time in order to better understand the change process that occurred.

Participants were assigned to play groups based on their ages; they were assessed using the Child Behavior Checklist (CBCL) and the Parent Stress Index (PSI) before the treatment, at the half-way point and following the treatment. In addition, the Wong-Baker was administered before and after each treatment session to assess units of distress, and these scores were plotted for each participant. In order to track the themes and emotions, each session was audio-recorded. The researcher then transcribed each of these sessions which were then loaded into a qualitative data analysis program. This program was used

to code each line in the session into different categories. These codes were used to better understand the play therapy process.

In addition to the transcriptions, several artifacts were used. First, following each session, the group play therapy checklist was filled out for each participant to track the themes that were noticed and the toys that were used (see Appendix B). These were used to track changes across time and to note key change spots in the process. In addition, some of the themes from this checklist were used to code the transcriptions of each session. Next, before and after each session, a photograph was taken of the playroom to gain a better understanding of what play looked like and to see if the after pictures changed across time. Third, before and after each session the Wong-Baker was administered to obtain a visual representation of the change that occurred during each session. Finally, to get an outside perspective of the change process, parents were asked each week to describe any major events during the week including positive and negative behavioral changes and the researcher recorded these changes.

Researcher Background

The researcher for this study is a master's level licensed mental health counselor in a western state. She has been working in the field of mental health for six years and has received training and practice in play therapy. In addition, the researcher has had experience running groups with children. Throughout her career she has experienced the impact that grief and loss has on children at different stages in life and has seen the positive impact play therapy can have in relieving a variety of symptoms. Thus, this researcher became interested in the specific impact of play therapy on bereaved children.

Instruments

Four different instruments were used in this study. The parent version of the *Child Behavior Checklist (CBCL)* (Achenbach & Rescorla, 2000) along with the *Parenting Stress Index (PSI)* were administered at three points in the study: pretest, half way through treatment and as a posttest to identify the symptoms of grief and to watch how they changed across time. The PSI was also used see if there was a correlation between children's symptoms and level of parent stress. Next, Subjective Units of Distress (SUDS) for each of the participants were measured using the *Wong-Baker Faces Scale* before and after each session to gauge the impact of each session on the child's overall level of current pain or distress (Wong & Baker, 1988). Last, MAXQDA software program was used to analyze the emotions and themes that presented throughout the data and how they changed across time (Kuckartz, 2011).

The *Child Behavior Checklist (CBCL)* is an instrument designed to assess children's problems and competencies that is filled out by the child's parents. The most recent edition includes a version for children ages one and a half to five years (CBCL/1 ½-5) (Achenbach & Rescorla, 2000) and a second version for ages six through 18 (CBCL/6-18) (Achenbach & Rescorla, 2001). The version for preschoolers contains 100 items while the school age version contains 113 items. The instruments take about 15-20 minutes to complete and can be scored by hand or with a computer. The instrument may be self-administered or done through interview. A Likert scale is used for each item with 0 = not true; 1 = somewhat or sometimes true; or 2 = very true or often true. The original checklist was developed by Achenbach, Rescorla, McConaughey, Pecora, Wetherbee, & Ruffle (1980) but the 2000/2001 revised instruments were used for this study.

The reliability of the CBCL is well established. For internal consistency on the CBCL/1 ½-5, coefficient alpha ranged from .66 to .96 for the Syndrome scales, and .63 to .93 for the DSM-Oriented scales. The test-retest reliability for an 8-day interval ranged from .68 to .92 for the Syndrome scales and from .57 to .87 for the DSM-Oriented scales. The Total Problems *r* was .90. The mean stability for the CBCL/1 1/2-5 at a 12-month interval is .61. For interparent agreement (agreement between mother and father) the mean r was .61 (Achenbach & Rescorla, 2000).

For the CBCL/6-18, internal consistency reliability coefficient alpha ranged from .55 to .90 for Competence and Adaptive scales, from .71 to .91 for the Syndrome scales, and from .67 to .94 for the DSM-Oriented scales. The mean test-retest reliability ranged from .88 to.90 for 8- or 16-day intervals. Mean stability for the CBCL/6-18 at 12 months is .65. The mean cross-informant agreement value was .69, for the Syndrome scales was .76, and for the DSM-Oriented scales was .73 (Achenbach & Rescorla, 2001).

Evidence of validity is also well noted. Criterion-related validity for the CBCL/1 1/2-5 is based on multiple regression analyses that yielded percentages of explained variance accounted for by referral status ranging from 2-25% for the individual scales. Construct validity was based on correlations with measures not common in clinical practice and the correlations for series of studies range from .46 to .72 (Achenbach & Rescorla, 2000). For the CBCL/6-18, criterion-related validity is based on multiple regression analyses and indicates that 2-33% of the variance on individual scales is accounted for by referral status. In order to evaluate construct validity, the CBCL was correlated with similar instruments, including the BASC (Reynolds & Kamphaus, 1992), the Conners' Rating Scales-Revised (Conners, 1997), and the DSM-IV Checklist

(Hudziak, et al., 1998). Correlations with the Conners' Rating Scales and the DSM-IV Checklist are moderate; correlations with the BASC are more substantial (Achenbach & Rescorla, 2001).

The CBCL provides scores for three competence scales: activities, social, and school; other areas that are measured include total competence, eight cross-informant syndromes, and internalizing, externalizing, and total problems. The syndromes that are scored include aggressive behavior, anxiety/depression, attention problems, rule-breaking behavior, social problems, somatic complaints, thought problems, and withdrawal/depression. The six DSM-oriented scales are affective problems, anxiety problems, somatic problems, attention deficit/hyperactivity problems, oppositional defiant problems, and conduct problems (Achenbach & Rescorla, 2000, 2001).

The *Parenting Stress Index (PSI)* (Abidin, 1983) was developed to identify parent-child systems that were under stress and at risk for the development of dysfunctional parenting behaviors using a 120-item self-report measure. The test was designed for use with parents of children ranging in age from one month to 12 years. Each item is scored using a five-point Likert scale and takes around 20 minutes to complete. There are two domains that are assessed: the Child Domain and the Parent Domain. High scores in the Child Domain suggest that children exhibit qualities that make it difficult for parents to fulfill their parenting roles. On the other hand, high scores in the Parent Domain suggest that the sources of stress and potential dysfunction of the parent-child system may be related to dimensions of the parent’s functioning (Abidin, 1995).

Each of these domains contain subscales. The child domain includes the following sections: Distractibility/Hyperactivity (DI), Adaptability (AD), Reinforces Parent (RE), Demandingness (DE), Mood (MO), and Acceptability (AC). The parent domain includes sections on Competence (CO), Isolation (IS), Attachment (AT), Health (HE), Role Restriction (RO), Depression (DP), and Spouse (SP). The scores from each of the domains are combined to form a Total Stress score. It is recommended that parents that receive a score that is at or above 260 should be referred for professional consultation. The scores from each of the domains can serve as a guide for professionals of the areas that need to be focused on and the origin of the stress. Typically scores will be higher in one domain than the other (Abiden, 1995).

There is clear, well-established reliability and validity for this instrument. To test internal consistency, coefficient alpha reliability coefficients were calculated for each of the domains, subscales, and the Total Stress score. Based on the responses of the normative sample, the coefficients were computed and ranged from .70 to .83 for the subscales of the Child Domain and from .70 to .84 for the subscales of the Parent Domain. For the two domains and the Total Stress scale, the reliability coefficients were .90 or greater. All of these coefficients are sufficiently large and indicate a high degree of internal consistency for these measures (Abidin, 1995).

In order to establish stability, test-retest reliability coefficients were obtained from four different studies. First, in a sample of 30 mothers who were being seen in a parenting clinic for consultation on child behavior, the PSI was administered twice following the initial administration. Correlation coefficients were calculated between the first and second set of scores and were found to be .63 for the Child Domain, .91 for the Parent

Domain, and .96 for the Total Stress score, which indicated that scores were stable across a one- to three- month period (Abidin, 1995).

Burke (1978) conducted a second test which was done with a sample of mothers visiting a well-care pediatric clinic. The PSI was administered and then re-administered three weeks later. Correlation coefficients of .82 for the Child Domain and .71 for the Parent Domain were obtained (as cited in Abidin, 1995, p. 31). Next, Zakreski (1983) obtained coefficients across a 3-month interval for a sample of 54 parents in a study of the relationship between parenting stress, marital status, and infant development. Test-retest reliability coefficients for the Child Domain were .77, for the Parent Domain were .69 and for the Total Stress score were .88 (as cited in Abidin, 1995, p. 31).

Finally, Hamilton (1980) studied the relationship of stress, coping, and support to the quality of mother-infant attachment. Thirty-seven mothers were readministered the PSI after a one-year interval. The test-retest reliability coefficients for the Child Domain scale was .55, for the Parent Domain scale was .70, and for the Total Stress score was .65. Again, these scores provide support for the stability of scores across a given time period (as cited in Abidin, 1995, p. 31).

The primary goal in the development of the *Wong-Baker Faces Pain Scale* (Wong & Baker, 1988) was to help children effectively communicate their pain so staff and parents could be more successful in the management of this pain. The faces were formulated based on the work of children who were asked to fill in six empty circles by creating facial expressions to indicate no pain to worst pain. Over 50 children participated in the pilot work, and though each of their drawings were unique pattern developed and was used to formulate the final faces. Initially, the numbers 0-5 were used to quantify the

pain, but this was later changed to numbers 0-2-4-6-8-10 because it was more consistent with the numeric scale of 0-10 (Baker, 2009).

Reliability and validity for the scales were established in a study conducted by Wong and Baker (1988) that compared this scale with five other pain assessment scales. In order to establish concurrent validity, the ranking of painful events by each subject was compared with the ranking of pain scores for each pain scale to determine the consistency of each pain scale. If the scale showed a consistent response, then it was given a score of one; otherwise, it was given a score of zero. Then, the number of responses that were consistent for each pain scale was totaled for each age group. Lastly, the percentage of consistent responses were calculated by dividing the number of consistent responses for each pain scale by the total number of subjects in each age group. Reliability was determined in the same manner as validity except that the pain ratings for the painful events on the first test were compared with the pain ratings on the retest. The results indicated that there were no differences between preference, validity, and reliability of the six scales with an alpha level of $p<.05$. However, for each age group and overall, the chi squares for preference ranking were statistically significant at the $p<.001$ with the faces pain scale being the most preferred for all age groups.

In a more recent study, the reliability and validity of the faces scale was again examined. Keck, Gerkensmeyer, Joyce and Schade (1996) investigated the concurrent validity, discriminant validity, and test-retest reliability for the Wong-Baker Faces Pain Scale. First, the concurrent validity was assessed by comparing the measure to other scales that are known to be valid measures of pain in pediatric populations and were supported by high significant Person correlations with $r= .71$ ($p >.01$) for the Total

Sample. Discriminant validity for the Faces scale was supported by lack of correlation between data obtained when a child is not in pain before the procedure (m=.49) and those obtained after the painful procedure (m=1.61). Also, the Pearson correlations between the pre- and post-procedure measurements were low, and nonsignificant with r= -.06 for the Total Sample. There were also significant differences in pain scores between the two measures based on paired *t-tests* ($t = 6.87$; $p<.001$). In order to assess test-retest reliability, data was collected immediately after the painful a painful procedure and again 15 minutes later. Statistically significant Pearson correlations were found between the two post-procedure measures $r =.90$ ($p > .001$) for the Total Sample supporting the test-retest reliability.

The MAXQDA 10 is a program that is used for text analysis and specifically focuses on the social science arena. One of the primary purposes of MAXQDA is the assignment of a "code" to text. These codes are created by the researcher and are a string of up to 64 characters that are then assigned to sections of the text by the researcher. In the program, a color can then be assigned to codes which allows for the researcher to make a color-coded visual map which is another avenue for analyzing trends in the data. These are referred to as "MAXMaps" and make it possible to display the relationships between different codes and categories (Kuckartz, 2011). This tool was used to create and assign the emotional codes and themes and these were then mapped to better understand the changes that occurred across time in the play therapy process.

Participants

The children and adolescents identified as potential participants in this study were those that had experienced the death of a parent, primary caregiver, sibling, or in the case of teens, a close friend. For this study, children ages two to 17 were asked to participate; participants were placed in groups based on their age. They were recruited from a bereavement program that provided peer support for bereaved children and their families. All participants in this study had completed in at least one day of the program at the time of the study.

Initially, twenty-nine individuals signed up to take part in the study but only thirteen consented to participate. Of these thirteen, eight were assigned to the treatment group and five were assigned to the control group. Six participants in the treatment group completed the required number of sessions for treatment. One individual dropped out after attending four treatment sessions and the other participant dropped out after five sessions. For the control group, none of the participants completed the required assessments at the appropriate times and thus, their data will not be included in this study.

Participant 1. Kai is a three year-old male who experienced the sudden death of his father who drowned one year prior to the beginning of his participation in this study. He participated in one peer-support group meeting before taking part in this study.

Participant 2. Cara is a five year-old female who experienced the sudden death of her father to suicide one year and ten months prior to the beginning of her participation in this study. She participated in play therapy sessions with her two older sisters. Furthermore, she attended only one peer-support group meeting before entering this study and had received approximately two months of private counseling one year ago.

Participant 3. Carlin is a six year-old female who experienced the sudden death of her father to suicide one year and ten months prior to the beginning of her participation in this study. She participated in play therapy sessions with her older and younger sister. Also, she attended one peer-support group meeting before entering this study and had received approximately two months of private counseling a year ago.

Participant 4. Corinne is a seven year-old female who experienced the death of her father to suicide one year and ten months before the participating in this study. She participated in a play therapy group with her two younger sisters. In addition, she received two months of counseling a year ago and took part in one peer-support group meeting.

Participant 5. John is a nine year-old male who experienced the death of his father due to kidney and liver failure eight months before the start of this study. Unlike the other five participants, John and his family had around three months to prepare for the death. John participated in one peer-support group meeting before participating in this study and received some individual counseling.

Participant 6. Tyler is a ten year-old male who experienced the sudden death of his father to a drug overdose four and a half months prior to the beginning of his participation in this study. In addition, he attended six peer-support groups before for he entered the study.

Data Collection

All of the participants completed ten play therapy sessions with the exception of Corinne who completed only nine sessions. After receiving a full explanation of the procedures of the study and signing the informed consent forms, parent(s) were asked to

fill out at brief questionnaire to gather demographic data and information about their children and the death that they experienced (see Appendix A). Once that was completed, they were asked to fill out the Child Behavior Checklist (CBCL) either the CBCL/1 ½-5 or the CBCL/6-18 depending on the age of their child. Next, they were asked to complete the Parenting Stress Index (PSI). After they were finished, the researcher asked the following open-ended questions to request feedback: "Do you have any questions for me?" and "Is there anything else you would like me to know?" The CBCL was used to identify the symptoms the child was currently experiencing. The PSI was used to establish parent's current level of stress in the parent-child dyad. Children were asked to give their verbal assent before the beginning of the study. Before and after each group session with the participants, the Wong-Baker Faces Pain Scale was individually administered to the participants to assess the impact of the group session on their current level of pain.

Each group session was audio-taped. At the end of each session, the researcher completed the group play therapy session summary (see Appendix B). In it, significant verbalizations were recorded with quotation marks. Themes of play and interactions between members were also noted. This data was used to gain a better understanding of the grief process and the changes that occurred throughout the treatment.

Mid-point and posttest data were also collected from the parents or guardians at the five-session mark and following the completion of ten weeks of treatment using the same procedures used to collect the pre-test data. Qualitative posttest data was collected from parent comments on the CBCL along with face-to-face questions that included: "Do you have any feedback for me?" and "Is there anything else you would like me to know?"

Treatment

A total of six individuals completed this study. Participants were divided into groups of two or three based on their age; as supported by the literature. It was recommended that children be within one year of one another and that groups were limited to five children or less (Landreth & Sweeney, 1999). This guideline was followed with the exception of one sibling set that were placed together because they started the study late. However, they were within two years of each other. As previously stated, children under the age of ten were given child-centered group play therapy. The group format, procedures and materials followed were drawn from the work of Landreth and Sweeney (1999), Axline (1947), and Schiffer (1969). Sessions lasted forty-five minutes on average and consisted of non-directive child-centered play therapy. The general format of each session included a short introduction to the playroom, followed by a period of child-directed play. Limits were set when necessary and a five-minute warning was given before the session came to a close. Sessions took place in the play therapy room on the university campus (see Appendix C for a list of materials and equipment).

For play therapy, objectives are simple: 1) create a safe atmosphere for the child; 2) accept and understand the child's world; 3) foster the expression of the child's emotional world; 4) establish a feeling of permissiveness; 5) facilitate decision making by the child; 6) give the child the opportunity to assume responsibility and to develop a feeling of control. Through the process of group play and activity therapy, children are provided with the opportunity to meet each of these objectives (Landreth, 2002).

Each play therapy group was facilitated by this researcher who is a doctoral level graduate counseling student with training in play therapy, group therapy, group play

therapy, and group activity therapy. The researcher was supervised by a registered play therapy supervisor (RPT-S).

Data Analysis

The goal of the data analysis of these case studies was to understand the change process that occurred across time. The aim of qualitative research is essentially interpretation of the data that is gathered. This is done by the developing a description of an individual or setting which is done by analyzing the data for themes or categories and then drawing conclusions about the meaning, what can be learned and what further questions that can be asked (Wolcott, 1994). Understanding this process requires the researcher to look at the data from multiple perspectives. This was done through a multi-step process.

After the completion of the study, pre-test, midpoint, and posttest data were hand scored by the researcher for both the Child Behavior Checklist (CBCL) and the Parenting Stress Index (PSI). These scores were then plotted for each participant along with the scores collected each session from the Wong-Baker. Once these scores were plotted, a visual inspection of the scores across time was used to identify patterns of change for each participant.

To further examine changes across time, several means were used. The first step was transcription of each of the audio-taped play therapy session. The researcher listened to each session and personally transcribed the data which provided a first look at the interactions and potential codes that would be formed. Throughout the transcription process, the researcher took notes on information and themes that stuck out in the data. The researcher then loaded each of the transcribed documents into MAXQDA qualitative

data analysis software in order to do a more inductive analysis of the data. Next, the researcher picked a session from each of the participants and while re-listening to the corresponding audio-taped session, the researcher read through the transcriptions line-by-line creating codes for limits, themes, and emotions identified in the data. Once the researcher identified the themes, she consulted prior research on play therapy themes (Hendricks, 1971; Holmberg, Benedict, & Hynan, 1998) and utilized the themes and emotions identified on the group play therapy session summary sheet to finalize the emotion and play theme codes.

Once the codes were constructed, they were put into the MAXQDA software. Each code included a description with criteria that the researcher used to decide if a line fit into the category or not. Using the software, the data was coded through a line-by-line read-through of each transcript. In addition, the researcher listened to each taped session again while the data was being coded to get a better understanding of the emotions that were expressed. After the data was coded, the researcher used the software to look at each code and the lines that were identified under each code. This allowed the researcher to ensure that the data under each code was similar. Lines that were not consistent were re-coded.

After the coding process was complete, the researcher then broke the information down on a case-by-case basis. This allowed the researcher to integrate all of the information that was gathered throughout the play process. This included the before and after pictures of each session and the data produced from the PSI, CBCL, and Wong-Baker instrument. In addition, the play therapy session summaries were examined including the researcher's personal notes and observations taken after each session. Last,

this researcher incorporated information from the Weekly Parent Questionnaire. All of this information was used to gain an understanding of the process of change that occurred for each child.

Finally, after each participant was examined, the researcher looked for similarities and differences among to the participants to gain a better understanding of what the general process of play looks like for grieving children. In addition, this information was used to get a better understand of the change process across time.

CHAPTER IV: RESULTS

The purpose of this study was to gain an in-depth look at the process of play therapy in reducing or changing the symptoms of grief in children following the death of a significant individual in their life. A multiple case study design was used to examine this process. Individual participants were chosen based on experience of loss and their willingness to participate in the ten week study. Information was gathered through multiple means in order to better understand what occurred throughout the treatment.

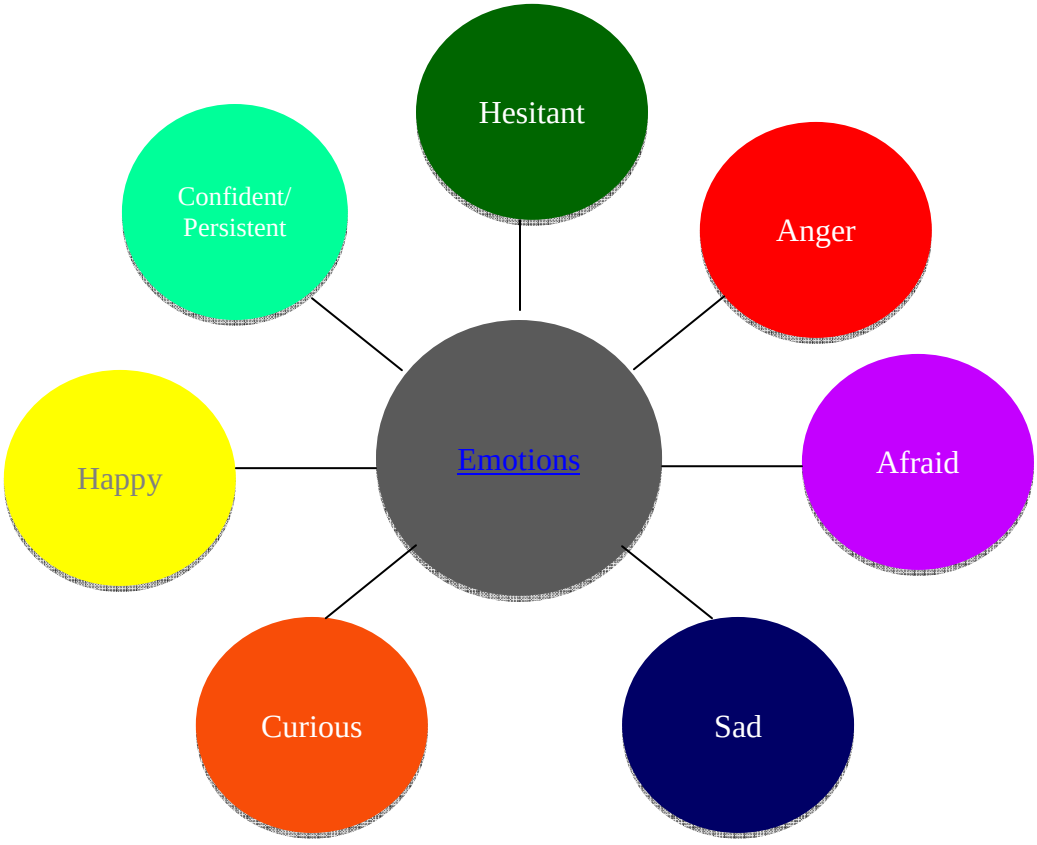
This study examined the process of play therapy for six participants all who had experienced the death of a parent within the last two years. This section will examine the data that was gathered for each of the participants throughout their play process. This includes data from the Child Behavior Checklist (CBCL) and the Parenting Stress index (PSI), scores on the Wong-Baker, information gathered through parents' reports and the researcher's observations which were recorded on the group play therapy summary sheet. Through the qualitative analysis process seven emotions and 14 play themes were identified in the data. These will also be described and discussed in this section.

Because of the amount of data that was gathered throughout this process, the researcher has chosen to report the most salient information from sessions for each participant. After explaining the themes and the descriptions that were used in the coding process, each individual participant will be examined. This examination will include prominent play themes and emotions for each session along with supporting data from assessments and questionnaires that were gathered throughout the procedure. The goal of presenting the data in this way is to help the readers understand not only the process of play therapy but where changes occurred.

Emotions

A variety of emotions manifested throughout the play process and changed throughout the study. For instance, several participants expressed a significant amount of anger during the earlier sessions but this decreased over time. Though the researcher realizes that there are a multitude of emotions, seven primary codes were identified and described (see Appendix F) and used to code the data (for definitions see Appendix F). The most prominent emotions that were expressed by all of the participants were confidence, happiness, and curiosity. Coding emotions was considered a significant piece of the process because play therapy is a method in which the expression of emotions is facilitated in children (Bratton & Ray, 2000).

Figure 1. Emotions expressed and coded during the play therapy process.



Curious

The code curious was described as the child's being eager to learn or know. This was exhibited when children were interested, focused, or watching others. In his last session, John spent time watching Tyler jump on the bop-bag. In addition, this was often displayed by the child's asking questions such as Kai asking where items in the room were located such as "bubbles" and "the drum." It was also shown when a child focused on a particular activity for an extended period of time. In one instance, Cara stated, "I'm focused on this." Curiosity was also expressed about limits in the playroom. Corinne expressed a great amount of curiosity throughout the study, but during her first session was particularly concerned with the rules and at one point asked, "Can you tell me the rules?" Curiosity was the most coded emotion in the study and when looking at all of the participants together it decreased across time.

Happy

For the purpose of coding, happiness was described as feeling relieved, satisfied, pleased, delighted, excited, surprised, silly or content. For example, in Corinne's first session after being in the playroom for a few minutes she exclaimed, "This is awesome in here." Also in her first session, Carlin spontaneously stated, "I'm happy I have two sisters." In other words, it was a positive emotion connected with a sense of wellbeing and indicative of pleasure. In his final session, Kai exclaimed, "That was silly!" Happiness was the second most coded emotion and increased across time when looking at all participants.

Confident/Persistent

The code confident/persistent was described as the participant exhibiting a sense that he or she believed in one's self. This was displayed by a statement that Corinne made in her first session, "I'm a really good face painter. I'm a really good one." In addition, this code was used when a child felt proud, strong, powerful, determined, free and persistent. For instance, a participant might continue to try to figure out how something worked even when frustrated. This was displayed in a session by Kai where he stated "I can learn how to get it." Overall, confidence/persistence was the third most coded emotion. Also, when looking at all participants, the expression of confidence/persistence increased over time.

Anger

Lines that were coded as anger were those in which the participant was considered impatient, annoyed, frustrated, mad, mean or jealous. They were not based purely on the words that were said but on the tone of voice that was used. Carlin frequently verbalized her anger by shouting things such as "You're mean," and "You're evil." In addition, anger was expressed through bodily actions. For example, Kai expressed much of his anger through physical means such as punching and kicking the bop-bag. Additionally, in several sessions with John and Tyler they expressed frustration by wrestling with one another. Anger was the fourth most coded emotion and increased slightly across time overall.

Hesitant

Children that acted timid, confused, nervous, embarrassed, ashamed, undecided or doubtful were coded as hesitant. In her first session in the playroom, Corinne stated "I

don't really know what I am doing." Like other codes, this was not purely coded on verbal expression but also on tone of voice and demeanor. Examples of hesitant expression include Kai saying, "I don't know what's in there" and Carlin stating "And what's going on?" Hesitation was expressed more frequently in the initial sessions in the playroom and decreased across time.

Afraid

This code encompassed children's feelings of vulnerability, helplessness, distrust, anxiety, fear, worry, apprehension, and regret. In one session, Kai expressed: "I don't want monsters. I don't want monsters." In another he stated "He's scary; it's a scary one." This was often manifested through verbal expressions of fear but also physically by way of children hiding in the playroom. The primary way this code manifested was through worry. Children expressed concern about consequences from things such as getting paint on their clothes or having their art or crafts destroyed by others. Expression of fear was the second to the last most coded emotion and increased slightly across time.

Sad

Sadness was expressed as disappointment, hopelessness, pessimism, discouragement and loneliness by the child. During her first session in the playroom, Carlin became upset when her siblings would not listen to her and stated "It hurts here," and then pointed at her heart. In another session she cried in response to her siblings' destroying a painting that she had made. Sadness was also expressed towards toys in the room. For example, in a session Kai became upset about a doll's nose that had been broken off and stated: "Oh, poor baby." Across all participants, disappointment was the

primary way in which sadness was expressed. In addition, sadness was the least coded emotion in the study and it decreased across time when looking at all participants.

Play Themes

Play themes were formulated based on the toys children played with, the manner in which they used these toys and their verbalizations while playing with toys. In addition, some of the codes that were used were based on Benedict's Play Theme Analysis System Codes. These included aggression, nurturing, burying and drowning, broken, cleaning, messing, sorting, safety, rescue, exploration, and mastery (Holmberg, Benedict, & Hynan, 1998). The creative/expressive was a code discussed in previous process research on play therapy (Hendricks, 1971). Several of these codes correlated with the themes on the Group Play Therapy Session Summary (see Appendix B) which is what the remaining codes were based on. These codes included relationship, power/control, helpless/inadequate, and death/loss/grieving. (see Figure 2).

Figure 2. Play themes that were coded during the play therapy process.

Relationship

When children connected, sought approval or assistance, were competitive, collaborative, or shared, this code was used. Kai exhibited this in his first session in the playroom when he invited another participant to play with him. “Wanna do…wanna do the drums?” he asked. In addition, when children expressed care or empathy towards another person or toy it was coded in this category. While playing with the toy food, Tyler stated, “Hold on, let me get you cake. Slice one, slice two, here you go. There you go.” John then pretended to eat the cake and said, “Now let me get some for you.” In this simple interaction, care and connection were expressed by the two boys. Basically, when a bid for connection was made this code was used. This was the most coded expression for all participants except Kai. It was his third most coded which may have been because six out of his ten sessions were spent with just the researcher and no other participants. Overall, it decreased slightly when looking at all participants.

Creative/Expressive

Creative activities such as painting, drawing, playing with musical instruments or bubbles; building or creating something new; acting things out; or digging in the sandbox were all placed under this code. Much of Cara, Carlin, and Corinne’s play fit under this code. They spent time painting, playing dress-up and making new things out of the art supplies. During her second session in the playroom, Corinne announced, “I’m making all different colors that doesn’t exist.” In another session, Carlin used play dough to create cookies. In general, girls exhibited more creative play than boys and it was the second most coded play theme among all participants. In addition, it decreased overall when comparing the first and last sessions for all participants.

Power/Control

This code was used when participants dominated or manipulated others. A clear example of this was seen in Corinne's first session in the playroom. She began getting frustrated when the researcher would not answer her questions and stated, "I'm not coming here again if you won't answer my question I won't be back here anymore." Carlin attempted to exert power and control by threating to "call the cops" on her siblings. "I'm not joking I will call the cops." Tyler and John exhibited a power struggle in a brief interaction in which Tyler wanted information that John would not tell him. John: "No, I can't tell you." Tyler: "You're not my friend." John withheld information as a means to control while Tyler withheld relationship in order to try and get what he wanted. Essentially, when children exerted command over others this code was used. Generally, it was the third most coded play theme for participants. However, it was the second most coded for John and Tyler and code more for boys than for girls overall.

Exploratory

This code was used to describe the behaviors that the child exhibited while getting comfortable and familiar with the playroom such as examining toys or climbing on shelves. Kai spent time climbing on the shelves of the playroom and examining toys. In one instance, after examining an item he exclaimed, "Hey! We can use this…maybe for a baby." In addition, this code included observing and trying to gain information about the room; asking questions about the room and about what materials were available or how objects worked. For instance, Tyler inquired, "Do you think this can be used as a shovel?" All of the participants spent some time exploring the room throughout the

treatment making this the fourth most coded expression overall. However, because of Kai's high numbers in this area, it was the second most coded play theme for boys.

Aggression/Revenge

Actions placed under this code included hostile play such as hitting, kicking, pushing or shoving other children or the bop-bag and throwing or kicking toys. This was the primary way that Kai expressed this theme. In his initial sessions, he spent time hitting, kicking, punching and tackling the bop-bag. John's behaviors were similar in this category but he also expressed aggression towards Tyler several times during their sessions together. In addition, Tyler threw toys at other children. Overall, aggression was the fifth most coded play theme. However, the boys exhibited more aggression than the girls across all sessions but all the participants actions were similar. It was the third most coded for John and the fifth most coded for Tyler and Kai.

Nurturing

When children participated in self-care, reparative, or healing play it was coded as nurturing. For example, Kai, talking about a puppy puppet, stated: "He's just crying on me. I'm just taking care of him." He followed up later in the session stating "He's a baby dog. He likes to climb with me. I'm going to take care of him." In addition, when participants made amends following conflict, this code was used. After ruining her sibling's picture, Cara stated, "Carlin, I am sorry I ruined your picture." Also, when participants encouraged, supported or protected others it was coded as nurturing. In a session with Corinne, she told her sibling that all her paintings were "gorgeous." In essence, any caregiving activities were placed under this category. It was the sixth most

coded theme overall and the fourth most coded for Corinne. In addition, it was coded more often for girls than for boys.

Messing/Creating Chaos

All of the six participants were coded under this theme at some point in the study. This code was described as characters or the child being messy or dumping things out. This was an activity that was done by all the participants at some point during the treatment process. At times, it seemed to be done as a way for the child to exhibit power and control. For instance, Corinne created a mess and stated “I’m going to make a mess for you to clean up.” It involved participants pushing toys off of the shelves and dumping them out of their containers. For Cara and Corinne, this was the fifth most coded play theme in the investigation and the seventh most coded overall. Last, it occurred slightly more for girls than for boys.

Helpless/Inadequate

When participants expressed weakness, dependence, or submissiveness, this behavior was placed under this code. Carlin expressed dependence on her siblings multiple times throughout the intervention. She often asked for help from her older sibling. The same was true for Cara who would often ask, “Could you help me?” or “I need help.” Kai expressed helplessness around opening things such as the bubbles. In his first session he stated repeatedly, “Help me! Help me!” It was the sixth most coded play theme for John and the eighth overall. Furthermore, it was coded more frequently for boys than girls.

Mastery

Mastery was described as actions that were constructive, displayed competence, integration, or resolution or in which the child showed achievement or accomplishment. When a child expressed superiority, victory, or expert skill or showed off abilities and strengths, this code was used. In one session, Corinne showed off her abilities when she stated, “I’m painting this really pretty.” After climbing to the top of the shelves in the playroom Kai exclaimed, “I will get climbed. I climbed really high.” In essence, the code mastery incorporated all ego building activities. This was the fifth most coded paly theme for Kai but ninth overall. In addition, it was coded more for boys than girls.

Cleaning

When participants spontaneously cleaned the play room or engaged in cleaning play this code was used to describe their behavior. For instance, in her first session in the playroom, Corinne used a small broom to sweep sand back into the sandbox and stated, “I’m just sweeping all this so we have more sand.” In another session Cara announced, “I’m cleaning today.” This was an activity that each of the participants did at some point in the treatment process and it was Cara’s sixth most coded play theme but was tenth overall when looking at all of the participants. In addition, it was coded slightly more in girls than boys.

Rescue/Protect

Play was coded as rescue/protect when a child portrayed characters being in danger then rescued or when toys were repaired or protected. At times this was exhibited through the simple fixing of a toy; for example, after repairing the leg of a Barbie doll, Corinne stated, “I fixed the leg.” In another instance, Kai stated, “I wanna fix it for the

baby." It was also displayed through protection. This was a major theme for Tyler in two sessions in which he attempted to keep John from punching the bop-bag which he had dressed up and named "Billy." In one instance, Tyler pleaded, "Don't kick Billy, please don't kill Bill." In another session, he stated, "Don't hurt Billy he didn't do anything to you." In general, this was not a theme that was coded often for participants. When looking at gender, it was coded more for boys than girls and was the eleventh most coded theme in the study.

Death/Loss/Grieving

When death occurred during play, such as the death of an object, this code was used. In addition, talk about death, loss, or grieving was also coded under this theme. Examples of this code included Corinne talking about going to a camp for grieving children "Because our dad died." In another session, Carlin asked the researcher "Is your dad dead?" Other instances included children talking about toys dying such as Tyler, playing with soldiers in the sand, stated, "Some of them died. Those are…this is quicksand. So they're sinking." This code was the twelfth most assigned overall and was more frequent in boys than in girls.

Sorting/Organizing

When participants lined up, organized, sorted toys or objects into categories this was coded as sorting/organizing. Sorting the fake money from the cash register was a common sorting activity done by Tyler, John, and Cara. While sorting the money, Tyler stated, "I'm going to sort this out." John took time during one session reorganizing the art area and Carlin took time to set up a play area to play a game with her siblings. This code

was assigned more frequently for boys than girls and was the thirteenth most coded overall.

Safety/Security

This theme manifested when the child did things like built enclosures and containers for characters, objects or self. In addition, this code was used when a child kept things clearly in or out of spaces; protected or kept characters or things safe; expressed a need to be kept safe, showed invincibility, hiding to be safe, or protected self from things or other people. In his last session in the playroom, Kai buried a car underneath the sand and stated, “That goes in the safe tunnel.” Tyler exhibited this code by hiding when John was throwing toys at him. It was coded more for boys than for girls and was the fourteenth most coded play theme.

Broken

The code broken was used when characters were broken or portrayed as sick, hurt, or in need of repair. There were few incidents of this code during the play process for each of the participants but some examples include, Kai playing with the dolls “That one, that one break apart.” In another incident, John simply expressed “I broke it.” It was coded more for boys and was the second to the last most coded expression.

Burying/Drowning

Play was coded as burying/drowning when characters or toys were buried or drowned. This was not a popular code among participants. Kai was the participant that buried things the most. He spent time burying toys in the sand put soldiers in the bucket of what that is in the sandbox. In a session with one of the participants that dropped out,

Tyler buried one of the soldiers in the sand as well. This was the least coded play theme and was expressed more frequently by boys than girls.

Limit Setting

Landreth (2002) described limit setting as a chance for the child to learn "self-control, that they have choices, what making choices feels like, and how responsibility feels (p. 246). For this study, limits were set in four different areas. First, to protect the child or other children: "Tyler, John is not for kicking you can choose to kick the bop-bag or you can choose to kick the floor." Second, to protect the therapist: "Cara I am not for painting. You may choose to paint the dough or you can choose to paint a piece of paper but I am not for painting Cara." Third, to protect the toys and the room: "Kai the paint is not for pouring in the sandbox. You may choose to pour in the cups or you may choose to pour it in the trash." Last, to provide structure for the environment; each session was begun with the following statement: "This is a special playroom where you can play with many of the toys in many of the ways you would like." Providing these limits and structure helped to formulate an environment in which children were able to safely express themselves.

Case Study I: Kai

Kai is a three year-old male who was brought to play therapy by his mother. He experienced the sudden death of his father who drowned one year prior to the beginning of his participation in this study. He participated in one peer-support group meeting before taking part in this study. He resided with his mother and had step siblings but he was not regularly in contact with them after the death of his father.

Pretest Assessment

Before his first session, Kai's mom was given the Child Behavior Checklist (CBCL) for Ages 1 1/2 -5. In it she expressed concerns about Kai stalking "small dogs" and "being too rough with them." Kai's scores on the DSM-Oriented Scales for Boys and Girls and internalizing and externalizing behaviors all came in the normal range. In addition, all of the scores on the Parenting Stress Index (PSI) were within the normal range. Still these scores were tracked across time to see if there were decreases in any of the scores. These changes will be discussed later along with changes in the Wong-Baker scores for each session.

Sessions One and Two

Kai's first session in the playroom was with a four year-old boy that had also lost his father to death. He dropped out of the study after session four. In Kai's first session in the playroom he was very active and aggressive toward the bop-bag. During his first ten minutes in the session, he spent almost all of his time punching, hitting, kicking, or pushing the bop-bag. In addition, the primary emotion that was indicated on his coding map in MAXQDA was anger which was coded 24 separate times. However, after the first ten minutes, Kai began to explore the playroom and expressed *curiosity* about his surroundings. He participated in creative/expressive play with the bubbles in the room and the musical instruments.

Kai became upset again later in the session when the other participant wouldn't share a toy with him. He eventually got the toy back and stated, "I'm not giving it back to him" (power/control). The other participant then hid behind the bop-bag and Kai hit the bop-bag repeatedly. In addition, toward the end of the session, Kai expressed anger by

throwing toys and yelling when he did not get what he wanted. The anger that Kai expressed correlated with his two most prominent play themes which were power/control and aggression/revenge.

During his second session in the playroom, Kai talked about death twice which was the only time he referenced death during all of his sessions. He stated, “He’s lost” when talking about a soldier buried in the sand. In addition, he said, “I killed the baby.” Each of these expressions was coded under the theme death/loss/grieving. In addition, Kai’s expression of anger and aggression/revenge were similar to that of session one. Also, there was an increase in the code of curious and the theme exploratory play.

Each week the researcher checked in with Kai’s mom to discuss any changes and then recorded them. After his first two sessions in the playroom, Kai’s mom reported that he had been “talking a lot about his dad” and had been saying things like “I don’t like my dad anymore” which was something that he had not said in the past. In addition, she stated that he had been “cranky” and “irritable” during the past two weeks.

Session Three and Four

In session three, Kai’s expression of anger and aggression/revenge play decreased and his curiosity and exploratory play increased. His mom reported that he “stopped making statements about being angry with his father.” Also, in his session summary, the researcher noted that Kai was focused (curious) on the water bucket which he filled with bubbles and overall was more focused and interested (curious) and less aggressive than the first two sessions.

Kai’s two most prominent themes in session four continued to be curiosity and exploratory behaviors. However, the way in which his curiosity was expressed was

different than the previous session where he was focused and interested. In this session, Kai spent time asking questions such as “What is this?” and “How you do that?” One of the most notable things that occurred in this session was that Kai helped the other participant create a mess in the middle of the room (messing/creating chaos). Together they cleared off one set of shelves pilling the toys in the center of the room.

After session four, Kai’s mom reported that during the past week he seemed “to be nicer” to the dog. In the session summary, the researcher noted that Kai seemed less aggressive and did not hit the bop-bag. In addition, he spent time mixing paint (creative/expressive art), climbing on the shelves (exploratory), playing with the dress up clothes (creative/expressive art), and joined with the other participant (relationship). When looking at the data from the codes and themes, parent report, and researcher summary notes there was a notable difference in Kai’s expression of anger starting in session three and continuing into session four.

Session Five

In session five, the other participant that had been in the playroom with Kai dropped out of the study. After being in the playroom for a few minutes, Kai stated, “Where’s, where’s, where’s your friend?” and then later said, “Maybe he has sick.” Overall, the main emotions that Kai expressed were happy, confident, and curious. His most significant statements of confidence were “I’m a big boy. I can do this” and “I did it!” In addition, his main play themes were creative/expressive and exploratory. At one point during the session, Kai painted his hands and expressed excitement (happy) about being able to do this task (creative/expressive). He communicated some anger by hitting and kicking the bop-bag but not at the same level as the first and second sessions in the

playroom. It seemed that Kai became more expressive when he was alone in the playroom and more happy and free.

Midpoint Assessment

After the first five sessions were completed a midpoint assessment was done in which Kai's mom filled out the CBCL and the PSI again. Notable changes included a decrease in his sleep problems score, and an increase in his attention problems score, affective problems score and oppositional defiant problems score. All other scores remained the same (see Table 1). In addition, his mom reported that he was continuing to be "mean to small dogs." Kai's total stress score on the PSI decreased but his mom's score increased which resulted in an increase in their total stress score (see Table 2). Though the majority of Kai's scores hadn't changed, his emotional expression and play themes were different at the midpoint assessment. There was an overall decrease in his anger and aggression and in increase in his curiosity, exploration, and creativity.

Session Six

During session six, Kai's emotions from the previous session continued but there was a notable instance in which Kai expressed both fear and confidence. It went as follows:

Kai: "I don't want monsters. I don't want monsters." (afraid)

Researcher: "Oh, you're scared."

Kai: Spitting sound. "I spitted on them."

Researcher: "Oh, you're strong; you're above them. You're powerful Kai."

(confident/persistent and power/control)

In addition, Kai expressed nurturing towards a dog puppet. The interaction went like this:

Kai: “He’s a baby dog.”

Researcher: “Oh, you decided he's a baby.”

Kai: “He’s just crying on me. I’m just taking care of him.”

Researcher: “You decided to take care of him. You’re choosing to take care of him. You got him right there; no he’s just right with you. You two are together. You decided to climb back there. Ah, you found a nice little safe spot.”

On the whole, Kai seemed to be more verbally expressive than in previous sessions in the playroom. Also, at the end of the session, Kai made a reference to missing the other participant. Kai’s mom reported that after the sixth session he started talking about his dad more. She reported that he stated, “I remember mommy. I remember when I had a dad and a family. I remember my brothers.” In addition, he said things during the week that started with “my daddy said” or “my daddy is going to…”

Session Seven and Eight

In session seven, there was a small increase in Kai’s expression of anger however, unlike previous expressions of anger that were physical, these expressions were verbal. Kai became upset when he got something on his hands and said in a frustrated tone, “It’s very yuck!” Generally, Kai seemed to continue with confident, happy, curious, creative and exploratory play which carried through session eight. There were two incidents that stood out in session seven. The first was related to the expression of sadness, fear, and the themes of nurturing and rescuing.

Researcher: “Oh, now it's broken. Sometimes things break Kai. You're disappointed.” (sad)

Kai: “A poor babies. The baby’s going to cry.” (nurturing and afraid)

Researcher: “Oh, you're worried about what's going to happen to the baby now that that's broken.”

Kai: “That baby is going to be…it wished…sad.” (sad)

Researcher: “Sad. It's going to be sad. You feel sad for the baby Kai. You're worried.” (sad and afraid)

Kai: “Oh, poor baby.” (sad)

Researcher: “You’re trying to fix it.”

Kai: “I wanna fix it for that baby.” (rescue)

Researcher: “You want to take care of the baby.”

Kai’s expression of nurturing in this session and the previous session made a stark contrast to the behaviors that Kai exhibited in his first two sessions in the playroom. The range of emotions that Kai was beginning to convey seemed to have broadened and his expression of empathy increased.

The main theme difference in session eight was an expression of the theme helpless/inadequate. Multiple times, during the session Kai stated things such as “I can’t open this;” “Can you help me?” and “Can you open this?” Kai was exhibiting some vulnerability but also reaching out to the researcher. Last, a major change occurred in session eight. Before the session, Kai picked a four for his level of pain on the Wong-Baker Faces Pain Rating Scale (Wong-Baker) indicating “hurts little more.” All of his previous before scores had been a ten (“hurts worst”) with the exception of the first session which was an eight (“hurts whole lot”). Furthermore, at the end of the session, he picked a zero indicating “no hurt.” Previously, all of his after scores had been tens (see Figure 3).

Session Nine and Ten

After session eight, Kai's mom reported that his "verbal skills" were "increasing" at home and he that he seemed to be talking about things related to his past more "factually" and with less sadness. Throughout sessions nine and ten, Kai remained confident, happy, and curious. In his session summary, the researcher noted that Kai was relaxed, happy and free throughout the session in which he spent much of his time blowing bubbles (creative/expressive).

By session ten, Kai's play continued to be creative/expressive and he exhibited self-assurance stating things such as "I'm stronger to do this" and "I'm get my super muscles on play dough." In addition, he exhibited several incidents of self-nurturing behaviors. When talking about an injury on his leg he said, "I got this little boo-boo" and "That will be okay…it will be okay." These examples show the change from session one in which Kai expressed mostly anger to session ten in which he expressed a range of emotions and was happy, confident and free.

Posttest Assessment

By his final assessment, his mom stated that her concern about his cruelty to animals was "now much better" and had not been "an issue for several weeks." Kai's scores on the DSM-Oriented Scales for Boys and Girls and internalizing and externalizing behaviors stayed in the normal range; however, his internalizing behavior scores and sleep problems scores decreased across time (see Table 1).

Table 1. CBCL 1 ½ - 5 Results for Kai, A 3-Year-Old Male

Subscales	Pretest	Mid-point	Posttest
Syndromes			
Emotional reactivity	50	50	50
Anxious/Depressed	50	50	50
Somatic Complaints	50	50	50
Withdrawn	50	50	50
Sleep Problems	59	57	53
Attention Problems	59	62	62
Aggressive Behavior	55	55	55
Internalizing	37	37	29
Externalizing	57	57	57
Affective problems	52	56	51
Anxiety problems	51	50	50
Pervasive developmental problems	50	50	50
ADHD	54	54	54
Oppositional defiant problems	52	55	55

Note **Represents a clinical level. *Represents a borderline level. Lower scores represent improvement in behavioral problems.

In addition, Kai's scores for stress on the PSI decreased across time and though his mom's scores increased slightly, their overall stress score decreased overall (see Table 2). Also, Kai's mom expressed that she was "happier" and shared that she felt more confident about what she wanted to do with her life. As a result, she believed that Kai sensed this which in turn built his "confidence and security."

Table 2. Parenting Stress (PSI) Results for Kai, A 3-Year-Old Male

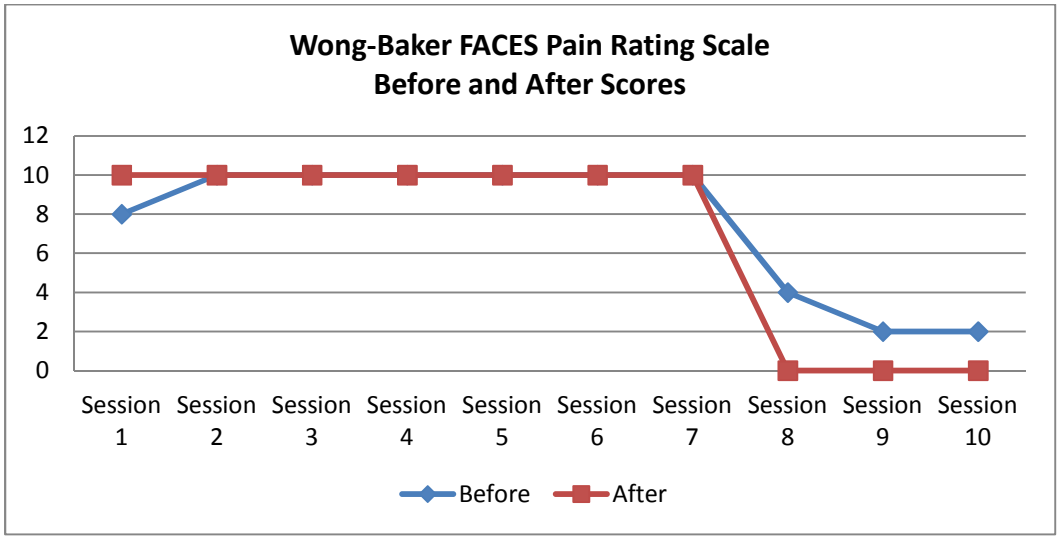
	Child	Parent	Total
PSI standard score (Pretest)	92	116	208
PSI standard score (Mid-point)	89	123	212
PSI standard score (Posttest)	86	118	204

Note **Represents a clinical level. *Represents a borderline level.

Conclusion

When Kai first entered the playroom he expressed anger and aggression. His mom had reported concerns about cruelty towards animals. During the play therapy process he became more verbal both inside and outside of the playroom. Outside of the playroom he seemed to be processing the loss of his dad with his mom. Kai did not ever say a word about the death of his father during any of his play sessions but when he was with his mom he expressed that he remembered his father and talked about the loss of his step-siblings. One of the biggest changes seemed to be on his Wong-Baker scores with the exception of the first session in which his score started with an eight or "Hurts Whole Lot" and increased to a ten or "Hurts Worst", Kai reported a score of ten before and after each session until session eight (see Figure 3). For this session, he started out with a four or "Hurts Little More" but ended with a zero "No Hurt." In his final two sessions, he started out with twos or "Hurts Little Bit" and ended with zeros.

Figure 3. Kai's Wong-Baker FACES Pain Rating Scale: Before and After Scores



At the end of treatment, Kai's mom wrote a simple summary of the changes that she saw in Kai:

> I see Kai as a happy, social child. I have seen a lot of questions/processing in the ten weeks related to the death of his father and the loss of his brothers. He is asking less now and just discusses his loss factually. He is rarely aggressive with our dog and seems to be happy overall.

It is clear that Kai made multiple changes across time as he used play to process through and verbalize his emotions.

Case Study II: Cara

Cara is a five year-old female who experienced the sudden death of her father to suicide one year and ten months prior to the beginning of her participation in this study. She participated in play therapy sessions with her two older sisters. Furthermore, she attended only one peer-support group meeting before entering this study and had received approximately two months of private counseling one year prior to the study. In addition, during the study she attended a weekend grief camp with her two siblings.

Pretest Assessment

Prior to her first session in the playroom, Cara's mom was given the Child Behavior Checklist (CBCL) for Ages 1 1/2 -5. In it she shared that Cara "seems to be internally upset" and that she will spontaneously do things like "change her facial expression" and then "grab and pinch your cheeks or grimace in frustration." Cara's scores on the CBCL and the Parenting Stress Index (PSI) were all in the normal range. Nevertheless, these scores were traced across time to see if there was a reduction in any

of the areas. These changes will be discussed later as well as changes in the Wong-Baker scores for each session.

Sessions One and Two

Cara began her first session exploring the playroom with her sisters. She found a small animal figurine, then a hula-hoop, but quickly moved to the sandbox. She stayed there for a little while but then saw the dress-up clothes and stated excitedly, “Oh! Dress up!” Next, she found the bubbles in the room and again became enthusiastic. In addition, Cara often joined her sisters in activities such as painting, exhibiting a desire for connection (relationship). At one point, she put handcuffs on the researcher but Carlin set her free (relationship). Towards the end of the session, she joined Corinne in dancing (creative/expressive). Overall, Cara expressed happiness and curiosity as she explored the playroom and interacted with her siblings.

In her second session in the playroom with her sisters, Cara continued to join them in activities. Her first task was to help Corinne clean the playroom (cleaning). Shortly after this, she moved to the art desk where Carlin was painting exclaiming, “I did purple and brown” (creative/expressive). All three girls worked on paintings at the same time and were each focused on their own piece of art (curious). Cara stated twice, “It’s fun” (happy). Much of the session was spent painting, but Cara did spend some time exploring the dress-up area with Carlin (creative/expressive). At one point, she spontaneously started to dance and laugh (happy). Later, she went back to trying to get the sand off of the carpet (cleaning). After that, she joined Carlin in mixing paints together to create new colors (creative/expressive). She stayed in this area for the

remainder of the meeting. In general, she continued to express happiness, curiosity, and confidence as she joined her sisters in creative tasks throughout the session.

Sessions Three and Four

Cara's oldest sister, Corinne, was absent from their third session in the playroom. Shortly after entering the room, Cara asked what happened to the color that she mixed last week. When this was reflected back to her she said, "You threw them away" and then said, "I'm mad at you" but then started to laugh. Cara then took some pipe cleaners from Carlin who became upset but Cara did not respond (power/control). After that, she spent time exploring the playroom including the cash register and the dolls. However, when Carlin decided to play with the paints, Cara immediately joined her (relationship).

Later, a limit around keeping the sand in the sandbox was set multiple times before Cara followed through with it. About 30 minutes into the session, Cara figured out how to turn off the lights in the room. The girls then spent time trying to scare one another and the researcher while turning the lights off and on. Next, Cara helped her sibling dump toys on the floor to make a mess (messing/creating chaos). Overall, Cara's expression of emotion was similar to the first two sessions except that she expressed more anger in this session. For instance, throwing a toy down when it didn't work right, getting upset when she couldn't find something and stating, "I'm mad at you Carlin" when her sister pretended like she was going to paint her. Furthermore, her play themes continued to be centered on creativity and relationship but she did use more power and control than in previous sessions.

In the fourth session, all three siblings were reunited. Cara joined her sisters in painting and mixing colors at the art desk (creative/expressive). Shortly after, she took

some paint and painted the researcher. A limit was set and Cara responded in the moment but then tested it again by bringing the paint brush close to the researcher. Cara then turned the light off and while it was dark Corinne got paint on her shirt. Corinne became upset and asked Cara to leave the light on, but Cara exhibited power and control by ignoring her sibling's request and continued to turn the light off and on. When she tired of this task, she joined Carlin in painting dolls; however, when Corinne saw what they were doing she took Cara's doll away from her. Cara did not fight back and instead started to clean the playroom stating, "I'm cleaning today" and later she said, "I needa dust. Dust! Cleaner, cleaner, cleaner, clean today" (cleaning).

Cara's cleaning turned into mess making later when, like the previous session, she began to spread toys around the room. She then moved around the playroom independently for a period of time before joining Carlin in playing musical instruments (creative/expressive). However, Cara decided to turn the lights off again which upset Carlin (power/control). Toward the end of the session, Cara and Corinne worked together to clear the toys off the shelves in the playroom making a large mess in the middle of the room (messing/creating chaos).

Cara seemed to move spontaneously around the room switching activities multiple times. She spent time in the sandbox and limits were set several times around the sand needing to stay in the box. In general, Cara seemed happy, creative and relational as she had been in the previous three sessions. The biggest difference in this session was that Cara seemed to be struggling to control her impulses, and as a result, limits had to be set multiple times around both the playroom and the researcher.

Session Five

Cara started off her fifth session in the playroom by shutting off the lights (power/control). Corinne got upset and told Cara that she could not turn the lights off when they were painting. Cara listened to her and did not turn them off again immediately; however, she turned them off several times throughout the session (power/control). Cara joined with her sisters in painting the dolls' hair and then washing them off in the bucket of water in the playroom. All three worked together at this task (relationship). However, Corinne became upset when Cara shook her doll causing paint to splatter on Corinne's clothes. Cara apologized but then did it a second time (power/control).

Later, Corinne and Carlin found the pipe cleaners. Cara joined them and started to throw them around the room (messing/creating chaos). She then moved to the bop-bag which she spent time punching (aggression/revenge). While her siblings made "cookies" out of art supplies, Cara started to dump toys out around the room (messing/creating chaos). Corinne became upset telling her to wait until the end but Cara didn't listen (power/control). After making the mess, Cara joined her sisters in playing with play dough. A fight quickly ensued when Corinne became upset with how much dough Cara took to use. Unlike the previous sessions, Cara had very little creative play and had a lot more messing/creating chaos. In addition, she continued to express power and control in a covert manner. Her main emotions were happiness, anger, and curiosity.

Midpoint Assessment

After the first five weeks in the playroom Cara's scores on the CBCL had changed as follows: on the Syndromes Scales, there was a decrease in Withdrawn and

Aggressive Behavior and a slight increase in Emotional Reactivity; there was an increase in internalizing behaviors and a decrease in externalizing behaviors; in addition, there was a decrease in Affective Problems and Pervasive Developmental Problems and an increase in Oppositional Defiant Problems (see Table 3). Furthermore, Cara's mom expressed concern about her defiant and impulsive behavior which included "not listening at bedtime" and "refusing to settle down to rest." She noted that a positive change was that she was being more helpful and was "happier to do chores." Cara's score on the PSI had increased but her mom's had decreased, making for a decreased total score (see Table 4). In the playroom, Cara seemed more impulsive and in the last session had made a chaotic mess in the middle of the room.

Session Six

Despite her siblings' protests, upon entering the playroom Cara went immediately to the bucket of water in the sandbox and dumped it in the sand (power/control). She then joined her sisters at the art desk where she covered her hands with paint. Limits were set around touching things with her painted hands and she followed these limits. Later, Cara painted on one of Carlin's pictures; when Carlin became upset Cara ignored her (power/control). Carlin continued to cry for close to ten minutes and at one point Cara stated, "I wished she could stop," followed by, "Stop it!" When this did not work, Cara joined Corinne in trying to make a new picture for Carlin. Furthermore, she apologized to Carlin which seemed to help her calm down (relationship).

Once they were done with the painting, the three sisters united to play with bubbles together. This peace quickly dissipated when the girls moved back to painting. Cara exerted power and control by turning the lights off and on while her siblings tried to

paint. Her sisters became upset but Cara ignored their pleas for her to stop. Later on, Cara spilled bubbles on the floor but joined Corinne in cleaning them up (cleaning). With less than five minutes in the session, Cara again joined Corinne but this time it was to clear all of the toys off of the shelves in the room (messing/creating chaos). Overall, Cara continued to express happiness and curiosity, but, like the previous session, her creative play was limited and she continued to use covert control throughout the meeting.

Session Seven and Eight

Cara began session seven in the same way that she started the previous one by dumping the bucket of water into the sandbox despite her siblings' request for her to save it (power/control). When Carlin invited her siblings to play with her, Cara joined her and the two acted out scenes with the dolls in the dollhouse (relationship). Next, she found some hairstyling toys and asked for help. Corinne stepped in and pretended to curl Cara's hair (relationship). While Corinne worked on her hair, Cara continued to play with Carlin and the dolls. When Corinne and Carlin got in a fight over a toy and ruined the bed for the dolls, Cara stepped in and made a new one out of a shoe (relationship).

After that, Cara started acting impulsively, and limits were set around her throwing toys at and hitting the researcher. This behavior correlated with Cara's mom's pretest comments that at times she seemed to be happy but then become aggressive. Cara responded to the limits by pretending to brush the researcher's hair (nurturing). She then spent time playing musical instruments with Carlin (creative/expressive). Again, her siblings fought over the toys and Cara stepped in giving Corinne an instrument to play with and stated, "Corinne, for you." The girls then played together for an instant before Corinne and Carlin moved on to other activities (relationship).

Cara continued to express relational play when she joined Carlin in trying on dress-up clothes and masks (creative/expressive). However, she became upset when Carlin stated that a hat the Cara was trying on belonged to her. Cara responded with frustration and then stated, “I’m going to make a mess” (messing/creating chaos). This happened another time during the session. Ultimately, she continued to exhibit some impulsive behaviors and seemed to express her frustration by creating a mess in the room. However, overall her primary emotions continued to be happiness and curiosity which were consistent with her previous sessions. In addition, she engaged in multiple creative activities throughout the session.

Cara’s impulsive behaviors continued in session eight. After entering the playroom, she took a paintbrush with paint and while moving toward the researcher stated, “Now I’m going to paint your face.” When a limit was set she shifted her focus to the toys. Another limit was set and she was able to follow through and paint a piece of paper instead. Later, when she was creating “chalk paint” with her siblings, she got paint in Corinne’s hair and on her shirt. She then turned and painted a chair. When she settled into doing art activities with her siblings her focus increased (curious). For the majority of the session, Cara concentrated on creative play activities such as painting, play dough, and playing with musical instruments; as a result, she was much less verbal than during previous sessions. One big difference was that she did not spend time dumping toys on the floor to create a mess which was something that she had done in the previous four sessions.

Session Nine and Ten

At the beginning of her second-to-last session, Cara went straight to the bucket of water in the sandbox, but instead of dumping it out, as she had done in previous sessions, she began to fill the bucket with sand. When her sibling became upset and stopped her, Cara helped her to remove the sand from the water (relationship). Cara then moved to the art table where she began to paint (creative/expressive). When Corinne took over Cara's project she did not get upset but instead watched Corinne work (curious). She tried to add things to it on several occasions but Corinne wouldn't let her. Cara became upset when she got her clothes dirty because her mom had asked the girls to keep them clean for this session. Both of her siblings attempted to ease her worry:

Cara: "Corinne! Mom said you don't, she didn't want me to get dirty."

Corinne: "You aren't dirty."

Cara: "Yes I am! Look it."

Carlin: "You call that dirty Cara. That's not even dirty." (relationship)

She became upset again when Corinne would not give her back her project but eventually decided to make a new one.

Shortly after, Cara joined her sibling in making bubbles. The two girls worked together creating and then bursting them (relationship). Cara got excited and, in the impulsive nature seen in previous sessions, put bubbles in the researcher's face. A limit was set but, shortly after, she did it again. Another limit was set and she responded. Later, when her siblings went to the bathroom, Cara stated, "It's only me and you time." She then looked around the room in which Corinne had cleared the majority of the toys off of

the shelves and onto the floor and stated, “Why did Corinne make this mess?” (curious). She went onto say, “I’m glad I didn’t do it today” (happy).

Though Cara exhibited some impulsivity in this session, overall she was calmer and more focused. She engaged in primarily creative, relational play with her siblings. In addition, she seemed proud that she did not make a mess in the playroom which was something that she had done in the four of the last six sessions. Furthermore, throughout the session, Cara expressed confidence and happiness.

In her final session in the playroom, Cara and her siblings went straight to the art desk. After working for a while, Cara asked, “Look it. You like it?” Carlin responded, “It is terrible” (anger). Cara replied by hitting Carlin; a limit was set and she responded. She then continued to work on her project but got paint on her shirt and started to cry (sad). Corinne comforted her and helped her to clean it off but Cara continued to express fear, “It won’t come off.” After many words of reassurance and time spent cleaning, Cara calmed down. However, shortly after, her impulsivity kicked in and she began to test limits.

First, Cara painted the researcher; when a limit was set, she painted one of the toys. Another limit was set and she put the paint brush down, and then moved to the sandbox. There she started to fill up buckets with sand but got sand on the floor as she dug. Limits were set twice around this behavior and on the third time the researcher stated, “Cara, the sand is for staying in the sandbox. If you choose to throw it out of the sandbox again, you choose not to play in the sandbox for the rest of our playtime.” She stopped and then, shortly after, hit the researcher and subsequently tried to put a toy in

the researcher's mouth (power/control). Again limits were set around these behaviors and she followed through with these limits.

When Corinne started to make a mess in the room by pushing toys off of the shelves, Cara joined her. The two girls worked together clearing shelves and spreading toys across the room (messing/creating chaos). Once they were done, Cara started to walk around the room. Limits were set about her stepping on the toys. She became frustrated after this limit was set several times and stated, "I'm go…I'm trying to…" She stopped stepping on toys but then later she impulsively hit the researcher with a toy. She then used the stethoscope from the medical kit to listen to the researcher's heart stating, "I'm gonna see if your heart is okay" (nurturing). She then went on to say, "I have to test people's hearts so make sure their don't be dead" (death/loss/grieving).

Cara's impulsivity seemed to have increased in this session; as a result, more limits were set in this session than in any of the previous meetings. In addition, Cara appeared to get angry more often however, her prominent emotion continued to be happiness. Her play throughout the session was creative and at times she was relational with her siblings. This included joining Corinne in making a mess of the playroom. Overall, she was happy, creative and curious which has been consistent across time.

Posttest Assessment

When comparing the pretest and posttest scores on the CBCL for Cara there were several changes. On the Syndromes scales, there was an increase in scores in the areas of Emotional Reactivity, Anxious/Depressed, Somatic Complaints, and Aggressive Behavior. There was a decrease in scores in the Withdrawn area and the other scores stayed the same (see Table 3). In addition, there was an increase in both internalizing and

externalizing behaviors as well as Anxiety and Oppositional Defiant Problems; there was a decrease in Pervasive Developmental Problems and the other scores stayed the same (see Table 3). In the concerns area, Cara's mom put "defiant" and said that Cara had "picked up the pet lizard this week and "accidentally" squeezed it."

Table 3. CBCL 1 ½ - 5 Results for Cara, A 5-Year-Old Female

Subscales	Pretest	Mid-point	Posttest
Syndromes			
Emotional Reactivity	50	51	55
Anxious/Depressed	50	50	52
Somatic Complaints	50	50	53
Withdrawn	61	52	52
Sleep Problems	50	50	50
Attention Problems	50	50	50
Aggressive Behavior	55	52	63
Internalizing	43	43	53
Externalizing	52	50	59
Affective Problems	51	50	51
Anxiety Problems	50	50	51
Pervasive Developmental Problems	53	50	51
ADHD	50	50	50
Oppositional Defiant Problems	51	59	55

Note **Represents a clinical level. *Represents a borderline level. Lower scores represent improvement in behavioral problems.

The results of the PSI showed an increase in stress scores for both the child and parent which means there was also an increase in the total stress score (see Table 4). This may have been because the family had a rise in stressors at home. Cara's mom reported that they moved into a house with her boyfriend and his children, which meant that Cara was not only adjusting to the move but to a new family situation as well. Furthermore, as a result of the move, she also changed schools.

Table 4. Parenting Stress (PSI) Results for Cara, A 5-Year-Old Female

	Child	Parent	Total
PSI standard score (Pretest)	92	149	241
PSI standard score (Mid-point)	97	141	238
PSI standard score (Posttest)	112	164	276

Note **Represents a clinical level. *Represents a borderline level.

Conclusion

In her initial two sessions in the playroom Cara seemed to be adjusting to the environment. She expressed primarily happiness and curiosity and did creative activities with her siblings. In the third session, some different play themes emerged. While her creative, relational play continued, she also exhibited more power and control and expressed more anger in this session. Her impulsivity seemed to increase in her fourth session in the playroom as evidenced by an increase in limit setting. In this session, Cara discovered how to turn the lights off and used this as a means of power and control over her siblings. This behavior continued in her fifth session as Cara used the lights to exert power over her siblings. In addition, she spent a portion of the meeting dumping toys on the floor creating a chaotic mess. Furthermore, this was the first session in which she did not spend a significant time participating in creative play.

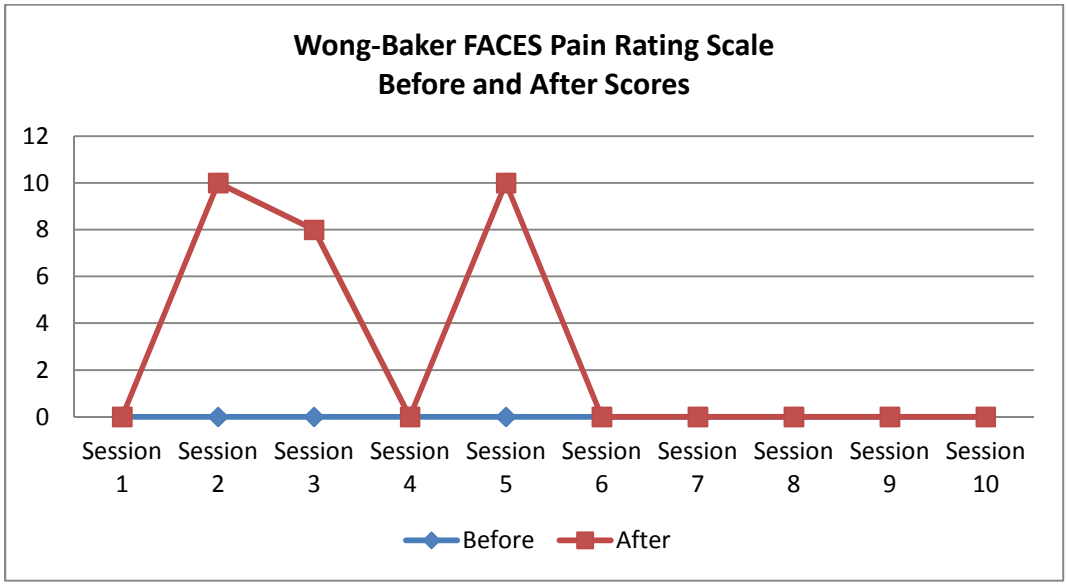
After the midpoint, Cara's exertion of power and control continued. She started this session by dumping the bucket of water in the sand despite her sisters' requests to leave it. In addition, she painted on one of her sibling's pictures, and turned the lights off and on while they painted. She also continued her theme of messing/creating chaos.

There was a decrease in power and control in the next session but her impulsivity continued. Furthermore, she expressed more creative and nurturing behaviors but, as in the previous session, spent time creating a mess in the room. In the next session, she spent more time in creative focused play but was still impulsive. In addition, she did not make a mess during this session. In her second-to-last session, her impulsivity was still present but it was not as frequent. Instead, Cara spent time in the focused creative play that was seen in some of her earlier sessions. Additionally, she did not participate in creating a mess in the room.

In her final session in the playroom, Cara's impulsivity was the most extreme that it had been. As a result, more limits were set in this session than during any other. Moreover, she participated in creating a mess which she had not done for the past two sessions. Still, happiness was her most prominent emotion; Cara's emotions throughout all of the sessions were fairly steady, with happiness and curiosity being the two most coded ones. The same was true for her play themes which were creative/expressive and relationship. Although there were some sessions in which her creative play was low, it was still the second most prominent theme overall.

Cara's scores on the Wong-Baker varied. She started each session by picking zero or "No Hurt" and, with the exception of three sessions, picked the same after. In sessions two and six she picked a ten or "Hurts Worst" for her after score and on session three she picked an eight or "Hurts Whole Lot" for her after score (see Figure 4).

Figure 4. Cara's Wong-Baker FACES Pain Rating Scale: Before and After Scores



Case Study III: Carlin

Carlin is a six year-old female who experienced the sudden death of her father to suicide one year and ten months prior to the beginning of her participation in this study. She participated in play therapy sessions with her older and younger sister. Also, she attended one peer-support group meeting before entering this study and had received approximately two months of private counseling a year previously. In addition, during the study she attended a weekend grief camp with her two siblings.

Pretest Assessment

Carlin's pretest data on the Child Behavior Checklist (CBCL) for Ages 6-8 contained multiple scores that were in the clinical range. On the Syndromes scale, her Anxious/Depressed, Somatic Complaints, Social Problems, Thought Problems, and Attention Problems were all in the clinical range. In addition, on the DSM-Oriented Scales for Girls, her scores on the Affective, Anxiety, and Somatic Problems were in the clinical range. Also, several scores were in the borderline clinical range (see Table 5).

Furthermore, in the concerns section, Carlin's mom wrote that she "cries more than normal." Moreover, she expressed that Carlin has a hard time focusing and when she is upset she "tears things up in small pieces." She also shared that Carlin has stated that she is "no good" and that she "doesn't like herself."

When looking at her scores on the Parenting Stress Index (PSI), Carlin's score, the parent score and the total score were all in the clinical range. All of the scores were tracked across time as well as her scores on the Wong-Baker before and after each session. These results will be discussed later.

Sessions One and Two

Carlin immediately found a toy when she entered the playroom. She attempted to gain her sister's attention by stating, "Cara found a dog, I found a dog" (relationship). Her younger sibling was exploring the playroom and went to the sandbox ignoring her. Carlin quickly joined her there and dumped the bucket of water into the sand (relationship). When her sibling left the sandbox, Carlin stayed quietly digging. She then asked where the bucket of water came from; this question was reflected back and she didn't respond. Next, she stated, "I need more water!" (anger). When she did not get a response she raised her voice and said, "I need more water and more room!" (anger). The researcher reflected back to her but her siblings did not respond.

When her younger sibling became excited about the dress-up clothes, Carlin exclaimed, "I love dress-up!" Each time her sisters changed activities Carlin would follow them (relationship). She seemed to be trying to connect with them, and at one point stated, "I'm happy I have two sisters" (relationship). All three of the girls played in the sandbox together; when they got out they struggled to get the sand off of their hands

and feet. Carlin said, “I wished I never got into the sand” (sad). Later in the session, Carlin spent more time with the dress-up clothes (creative/expressive), trying on several items at once which caused all three girls to laugh together (happy). She expressed anger by punching the bop-bag and shouting, “Die, die, die!” twice during the session. In all, Carlin expressed a variety of emotions in this first session including happiness, curiosity, confidence and anger. Furthermore, her main themes were relationship, exploration, power/control, and creative/expressive play.

When Carlin entered the playroom for her second session with her siblings, she immediately went to the art desk and began to paint (creative/expressive). Soon after, both of her sisters joined her and the three of them painted together (relationship). She became frustrated when Cara attempted to paint on the same piece of paper as she did (anger) but eventually settled in and focused on her work (curiosity). After painting she moved on to the dress-up clothes (creative/expressive). Cara joined her and they spent time trying on different hats. Carlin then joined Corinne in the sandbox where she was trying to make a sandcastle (relationship).

After playing in the sandbox, Carlin asked the researcher if she could help her clean the playroom at the end of the playtime. She then stated, “I’m going to make a bigger mess for me to clean.” However, she moved back to the art desk where she began mixing paints together to create new colors (creative/expressive). Carlin then made a bid for connection with the researcher; it went like this:

Carlin: “Does this look like a pretty color to you?”

Researcher: “Oh you're wondering if I like that Carlin.”

Carlin: “I’m making it for you.”

Researcher: “You created it just for me.”

Carlin was seeking approval and attention; something that she seemed to struggle to get from her siblings. For the remainder of the session, Carlin stayed in the art area mixing colors. When Corinne joined her and Cara began telling both of them what to do, Carlin accepted these directions without a fight.

Sessions Three and Four

Carlin’s creativity continued in her third session in the playroom with her younger sister. Upon entering the playroom she went immediately to the art desk and started to make things with the pipe cleaners. She continued with this task for the first ten minutes in the playroom until she got it how she wanted it and stated, “There. Done.” Next, she moved on to the paints; before she started, she expressed some insecurity stating, “I’m going to make my own color you better not laugh about it.” She then settled into mixing paints (creative/expressive). Shortly after, Cara asked, “What does your daddy look like?” This was reflected back to her and then Carlin asked, “Is your dad dead?” (death/loss/grieving). This is the only time either of the girls mentioned anything about a father figure. In addition, Carlin’s mom shared with the researcher that in the week before this session, Carlin started crying when they were out to lunch and said it was “because she missed daddy.”

Carlin became upset with Cara multiple times throughout the session. About half way through the meeting, Carlin stated, “I think I want to ruin this place so you have to clean up a mess and I don't care how long it takes” (power/control). Later, she became upset and put a toy snake around the researcher’s neck and said, “You’re choking. You’re dead” (death/loss/grieving). She then continued to explore the room asking questions as

she went (curiosity). When her sister discovered how to turn off the lights, Carlin tried to scare the researcher by putting a lizard on her shoulder in the dark (relationship). She then worked with Cara to dump toys out on the floor and said, “Let’s make a bigger mess so you have to clean” (power/control).

In this session, Carlin seemed to exert more power and control than in previous meetings which may have been because her older sibling was not present. In addition, she asked more questions than in the first two sessions. She also seemed to get more irritated and frustrated with her younger sibling. Throughout the session, she expressed happiness and confidence and was creative and relational in her play.

Corinne returned for the fourth session in the playroom bringing the trio back together. When Carlin entered the room she immediately went to the art desk and began mixing paints together to make new colors (creative/expressive). Carlin focused on this activity ignoring the distractions of her siblings. Eventually, she moved from painting paper to painting a doll with no clothes. At one point, she became upset with the researcher and stated, “You’re a scorpion.” She then expressed her frustration by punching the bop-bag (aggression/revenge). After this, she moved onto playing with musical instruments (creative/expressive) attempting to form a band with her siblings who ignored her requests to join (relationship).

On the whole, Corinne exhibited less power and control than in the previous session. She continued to engage in creative play through the use of paint and musical instruments, and she attempted to engage with her siblings (relationship). In addition, she expressed less anger than the earlier sessions. One thing that she did express was

boredom though she quickly found a new activity. This is something that she had voiced in all of the sessions to this point.

Session Five

When she arrived in the playroom for her fifth session, Carlin became excited when she saw the bucket of water in the sandbox. “Corinne! Look at the water, Corinne” (relationship). The two girls then worked together to clean the dolls’ hair that they painted during the previous session (cleaning). Next, she and her sisters found the pipe cleaners. Carlin took a package and hid them to keep them safe. She then joined Corinne at the art table where she painted and mixed new colors (creative/expressive). A limit was set when Carlin tried to cut a dolls hair. She responded by saying, “But this girl’s hair is too long!” Still, she followed through with the limit. She then moved back to the art table where she used play dough and other supplies to make “cookies.” Corinne joined her in this task (relationship).

Carlin became upset when Cara made a mess in the room (anger) and apologized several times to the researcher for her sister’s behavior (relationship). She then demanded that Cara clean up the mess. When Cara didn’t respond, Carlin threatened her, “Cara now I’ll call the police if you don't clean up” (power/control). Cara continued to refuse and Carlin stated, “I’m going to really say it. Cara, I’m going to lie. If she says, ‘Cara killed somebody in my family; she, she, killed my father.’” Still, Cara ignored her. Thus, Carlin’s attempts at control failed. Overall, anger and curiosity were the primary emotions that she expressed, and relationship, power/control and creativity were her main play themes.

Midpoint Assessment

At the midpoint, the majority of Carlin's scores remained in the clinically significant range; however, all of them with the exception of two had decreased or stayed the same. On the syndromes scale, Somatic Complaints increased and on the DSM-Oriented Scales for Girls, the Hyperactivity Problems score had increased (see Table 5). On the PSI, both Carlin and her mom's score decreased making for a decreased total stress score (see Table 6). In addition, Carlin's mom reported that she was concerned about her "high anxiety" and that she "doubts herself even when she is succeeding." Some positive changes that she noted were that Carlin was "going to bed on her own" and completing "chores with a good attitude."

Session Six

Carlin's creativity continued in her sixth session in the playroom. When she entered, she sat down at the art desk and began to paint. Shortly after Carlin completed a painting, Corinne decided to paint on it as well (power/control). Carlin became angry and upset and expressed this in the following way:

Carlin: "You're evil! And this one's broken."

Researcher: "You're mad at Corinne."

Carlin: "Corinne's the worst sister ever."

Researcher: "You do not like her right now."

Carlin: "And I know she heared that but I don't care because she's mean."

Corinne did not respond to Carlin and instead continued to mix paint (power/control). Carlin then moved to the dress-up area. While she was their Cara painted on another one of Carlin's paintings. When she saw this she became upset again and began to cry (sad).

Corinne responded to this by saying, “You’re fine you can make a new one.” Carlin continued to cry and then yelled at Cara, “Jerk! You’re a big jerk” (anger). However, when Cara and Corinne joined together to make her a new picture and Cara apologized, Carlin began to calm down.

After Carlin composed herself, all three of the girls joined together to play with the bubbles (relationship). This harmony was short-lived as they returned to painting and Cara began to turn the lights on and off again. Carlin became angry again but Cara ignored her requests to stop (power/control). When Carlin’s siblings left the room for a bathroom break, she took the opportunity to ask the researcher some questions, “Is Cara in trouble for ruining my picture? Or is she a bad girl?” She then exhibited power and control; the following is an excerpt:

Carlin: “At least she can’t ruin this one or I’ll call the cops on her.”

Researcher: “You’re going to make a new one and you’re going to protect it.”

Carlin: “And if Cara ruins it I’m going to call the cops on her and I’m not joking I’ve really called the cops on people.”

Researcher: “Hmm…”

Carlin: “If I’m super upset. I called the cops on a kid and he's in jail.”

Researcher: “Oh.”

Carlin: “Only he’s not a kid now he’s a teenager now.”

Researcher: “You know how to protect yourself.”

She then expressed multiple insecurities which seemed to correlate with her mom’s concerns about Carlin “doubting herself.” She asked the researcher, “Am I good at

drawing?" When she did not receive the response that she wanted she threatened to "call the cops." She made reference to calling the cops several more times during the meeting.

Carlin's emotions seemed to run high in this session. This was the first time she had expressed her anger and frustration by crying. Neither one of her siblings seemed to be empathetic toward Carlin even though they had played a chief role in her becoming upset. Furthermore, Carlin seemed to feel helpless and attempted to use the power of the "cops" to gain control. It is also important to note that her mom shared that during the past week at home she had seemed more "anxiety driven" and expressed concern that her mom wasn't going to "come home from work." Overall, she expressed more anger and sadness in this meeting than in the previous five.

Session Seven and Eight

When Carlin entered the playroom for her seventh session with her siblings she went straight to the dolls and the dollhouse. She worked to organize them (sorting/organizing) and then asked, "Who wants to play with me?" (relationship). Cara responded and joined Carlin in acting out scenes with the dolls. The two of them played together peacefully for over ten minutes until Corinne disrupted them by taking a toy from Carlin:

Carlin: Screams: "Hey!"

Researcher: "Carlin you're frustrated she took that from you."

Corinne: "It was laying there."

Carlin: "No it wasn't."

Researcher: "Corinne, hey, Carlin people are not for hitting in the playroom."

Corinne: "You just broke the bed. You just broke the bed."

Carlin: Yells: “I didn’t (inaudible).”

Researcher: “Hey, hey, girls. Carlin, Corinne is not for hurting. Okay. You may hit the bop-bag or you may hit the floor but Corinne is not for hitting.”

Carlin: “Worst sissy ever!”

Corinne: “She does it every day. It just gets annoying it doesn’t hurt anymore.”

Like the previous session, Carlin struggled to regulate her emotions and escalated quickly. However, this time instead of crying to express her feelings she hit Corinne.

Later, she set a boundary around some of the toys and Corinne violated it. This time, however, Carlin’s frustration was short-lived and she quickly moved onto playing musical instruments with Cara (creative/expressive). Nevertheless, Corinne followed Carlin and attempted to take another toy from her (power/control). Carlin became upset but her anger was not as intense as before. Cara gave Corinne a toy, and for a fleeting moment the three girls played together (relationship) before Carlin moved on to the dress-up clothes. There she played with Cara but became upset when Cara had a hat that she wanted.

In all, this session had similar themes and emotions as the previous meeting. Carlin expressed anger multiple times throughout the session particularly at her siblings. She also expressed insecurity asking, “Am I beautiful?” She seemed to have a wide range of emotions, but often quickly reverted to the expression of anger. As in the last session, her siblings were not compassionate when Carlin became upset and instead expressed indifference towards her feelings. Last, her mom disclosed that Carlin stated during the past week that she is “being treated bad at school” but would not give details.

Carlin began her eighth session in the playroom at the art desk where she quietly painted a picture (creative/expressive). After, painting for a while (curious) she stated, “I’m making this for my teacher” (relationship). Each of the girls focused on different art projects for a period of time (curious & creative/expressive). Carlin then joined Corinne in making “chalk paint.” She expressed confidence in her ability stating, “I’m going to make a pretty color.” She worked on making pictures with “chalk paint” and sand for the first half of the session until she discovered the play dough (creative/expressive).

While playing with the play dough, she took some of the army men and covered them with it. She then said, “There’s a…everyone, everyone, in army mans are dead. Even the bazooka guy cause he got stabbed by him” (death/loss/grieving). After this, she moved onto the dress-up clothes (creative/expressive). When her siblings went to the bathroom, Carlin pretended to be a robber and said to the researcher, “Show me where the money is.” When she did not get the response she wanted, she pretended to cut the researcher with a knife (power/control). She quickly switched to a different scenario in which the researcher was her boss:

Carlin: “You were a mean boss to me.”

Researcher: “Oh you don’t like me.”

Carlin: “You’re a terrible boss and you yell at me.” (Pretends to cry).

Researcher: “Oh you’re sad because I’m so mean.” (helpless/inadequate)

Then, as in the previous two sessions in the playroom, she asked a question about her appearance. “Do I look pretty?” Next, she asked the researcher to open something for he,r and when this was reflected back to her, she stated, “Okay you better open it by the count of five or I’ll called the police.” She then counted from five to one and when she was

done she pretended to call the police (power/control) and then said, “They’re coming to kill you” (death/loss/grieving). During the brief time her siblings were gone, she expressed more than she did throughout the majority of the session.

Generally, this session felt calmer than previous ones. The girls spent most of their time in focused, creative play. There was less conflict than in previous sessions. In addition, Carlin seemed to be less angry and emotionally reactive when conflict occurred. When looking at the number of times anger was coded in each of the previous sessions, this session was the lowest. Instead, the main emotions that she expressed were confidence and curiosity. Furthermore, her play themes were creative/expressive and relationship.

Session Nine and Ten

Carlin began this session at the art table where she added stickers to her project and stated, “I like putting these on more because I’m not a good artist.” This provided yet another statement to support her mom’s assertion at the midpoint assessment that Carlin “doubts herself even when she is succeeding.” She quickly became worried when Cara started painting and yelled, “Cara no paint! Cara’s painting.” She was concerned about Cara getting paint on her clothes because they were going to an activity after the play session and their mother had asked them to keep clean (afraid). Corinne clarified, stating that their mother said they could paint as long as they did not get any on their clothes.

Carlin stopped doing art and began to explore the shelf of animals. While looking at them she spontaneously stated, “I miss mom. I love mommy. I love mommy. I love mommy” (relationship). She returned to her art and when she completed the piece, she asked, “Can I go give it to my mom?” (relationship). While her siblings worked on a task

together, Carlin focused on her art separately. After completing a project, Carlin saw that she had paint on her hands and became upset shouting, “I gotta get this off!” and “My mom’s gonna be so angry at me” (afraid). She calmed down after she cleaned herself up and went back to working on art. At one point, she announced to her siblings that she was going to make some flowers and then stated, “And it’s going to look very pretty and you better not laugh of it” (afraid).

After painting, Carlin moved on to playing with dolls. She gathered supplies to take care of her “baby” (nurturing). When she was done with this, she joined Cara in blowing bubbles (relationship). The two girls laughed together as they blew bubbles then tried to pop them. Eventually, Corinne joined them and all three girls played together (relationship). Carlin became alarmed when she got some of the bubble soap in her hair (afraid) but was able to clean it out. She became upset again when her Corinne started to push toys off of the shelves and in the process ruined her picture. Carlin took revenge and the interaction went as follows:

Carlin: “Okay Corinne. Here’s your picture. How would you like this?”

Researcher: “Oh, you decided to take, to do the same thing to hers.”

Carlin: Laughs.

Researcher: “And you threw it right there.”

Corinne: “How would you like that if you crumbled it up?” (aggression/revenge)

Carlin: “Ahh!”

Researcher: “Oh Corinne you decided to fight back.” (crumbles Carlin’s painting)

Carlin: “How would you like it if I dropped it in the sand? Ha, ha. I dropped it in the sand, Corinne.”

Corinne did not respond and instead went back to clearing toys off of the shelves. When Corinne was done with the mess, Carlin said, “You guys made the biggest mess ever. I’m so sorry” (nurturing).

Overall, Carlin’s play was similar to the previous sessions. She spent time doing activities with her siblings (relationship) and the majority of them were creative. In addition, she expressed confidence, happiness, anger, and curiosity throughout her play. With the exception of Corinne’s dumping the toys off the shelves, the session seemed calm. When Carlin did get angry it was short-lived and less extreme than some of the previous sessions.

When she entered her final session in the playroom, Carlin went directly to the art desk. She quickly became discouraged stating that she had “ruined” her painting. She then became upset when the researcher would not help her open a package of wipes so that she could clean herself. “Open it!” she shouted. However, she continued to try and then exclaimed, “Hey! I got it open!” (confidence/persistence). After she got cleaned up, she continued to work on her art. She painted for a while and then exclaimed, “Look at mine!” followed by, “Mine’s more prettier” (confidence/persistence). Carlin continued to work quietly making paintings for the majority of the session. She was focused and persistent even when her sisters cleared off the shelves making a mess in the playroom.

Carlin’s attention waned when Cara started to throw toys in her direction. She yelled at her to stop, but she continued and got something on Carlin’s painting. Carlin became even more upset and shouted, “I cannot fix it now there’s a big rip!” She looked for ways to fix it and was able to calm down. Later, she played a game with Corinne in which Carlin was the mother of a Cara who was ill and Corinne was the doctor

(relationship). However, Carlin quickly changed roles and decided to be a dog chasing a butterfly. She made up a story and acted it out alone (creative/expressive).

Carlin was focused and determined throughout this session. She spent the bulk of the meeting doing creative expressive art and was not easily distracted. There were times when she became upset but she was able to resolve her concerns relatively quickly. In addition, she expressed more confidence in her work than in previous sessions. Generally, she seemed calm and relaxed during the session and participated in creative tasks joining with her siblings for brief periods of time.

Posttest Assessment

Carlin's pretest and posttest CBCL scores indicated that changes had occurred in several areas. First, when looking at the Syndromes scales there was a decrease in Anxious/Depressed, Thought Problems, Attention Problems, and Rule-Breaking Behaviors. However, there was an increase in Somatic Complaints and Social Problems. All other scores were the same. In addition, both the internalizing and externalizing scores decreased. When looking at the DSM-Oriented Scales for Girls, there was a decrease in Affective, Anxiety, Somatic and Conduct Problems while the other two scores stayed the same (see Table 5). Furthermore, in the concerns area, Carlin's mom wrote, "anxiety."

Table 5. CBCL 6-18 Results for Carlin, A 6-Year-Old Female

Subscales	Pretest	Mid-point	Posttest
Syndromes			
Anxious/Depressed	93**	88**	86**
Withdrawn/Depressed	66*	60	66*
Somatic Complaints	70**	74**	76**
Social Problems	79**	77**	84**
Thought Problems	77**	71**	66*
Attention Problems	87**	87**	77**
Rule-Breaking Behavior	55	52	52
Aggressive Behavior	60	60	60
Internalizing	83*	80**	82**
Externalizing	59	58	58
DSM-Oriented Scales for Girls			
Affective Problems	81**	79**	78**
Anxiety Problems	80**	77**	75**
Somatic Problems	70**	67*	67*
Attention Deficit/ Hyperactivity Problems	68*	73**	68*
Oppositional Defiant Problems	52	51	52
Conduct Problems	60	50	56

Note **Represents a clinical level. *Represents a borderline level. Lower scores represent improvement in behavioral problems.

On the PSI, Carlin's stress score decreased but her mom's increased slightly. Still there was a decrease in the total stress score (see Table 6). The family had moved to a new home during the previous week and the girls had started a new school. This change seemed to have more of an impact on her mom than on Carlin.

Table 6. Parenting Stress Index (PSI) Results for Carlin, A 6-Year-Old Female

	Child	Parent	Total
PSI standard score (Pretest)	157**	158**	315**
PSI standard score (Mid-point)	149**	153**	302**
PSI standard score (Posttest)	152**	161**	313**

Note **Represents a clinical level. *Represents a borderline level. Lower scores represent improvement in behavioral problems.

Conclusion

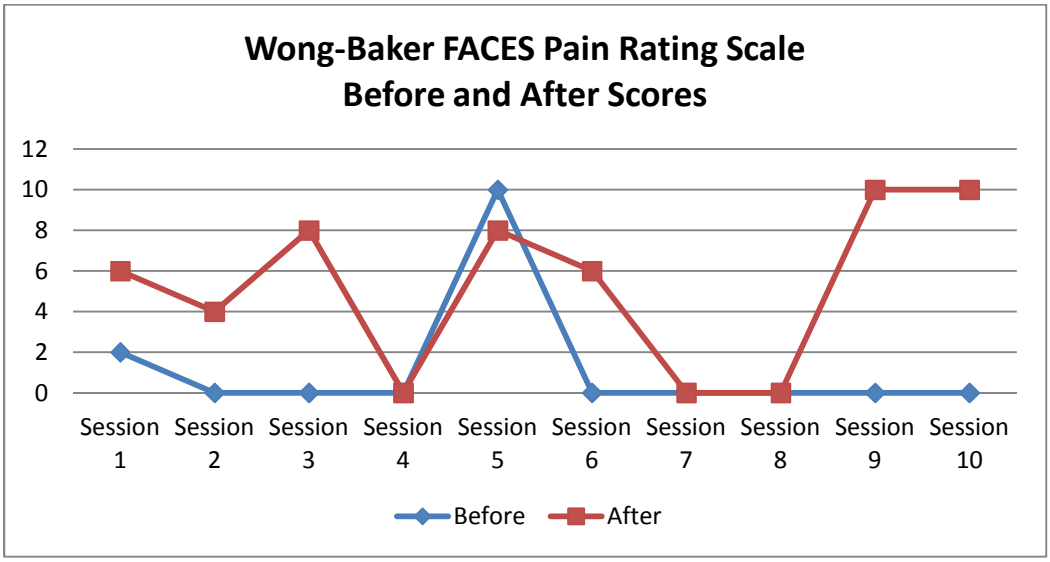
Relationship was the theme that predominated Carlin's first session in the playroom. She seemed to follow her sisters attempting to engage with them as they changed activities throughout the session. In addition, she spent time exploring the room and participated in creative play. Her creativity continued in the next session as well as her bids for connection. She expressed curiosity as she continued to acquaint herself with the room. This creative theme continued in the next session but there was also an increase in power and control. This may have been because her older sibling who dominated previous sessions was absent. Moreover, she expressed more curiosity in this session as well. There was a marked decrease in her expression of power and control in the fourth session but there was an increase in her expression of aggression/revenge. Her confident, creative, relational play continued. These themes carried into her fifth session in which Carlin made "cookies" out of art supplies. She became upset several times with Cara's behavior and attempted to control it; however, these attempts were ignored.

Following the midpoint, Carlin seemed to struggle to regulate her emotions. In this session her siblings painted on her art and Carlin cried for over ten minutes before calming down. In addition, she seemed to feel helpless, threatening to “call the cops” as a means to control her siblings. She had a notable jump in both anger and sadness in this meeting. Her anger continued in the next session, but instead of crying she became physically aggressive when her sibling upset her. In addition, she seemed to anger easily when things went wrong. In the eighth session, however, Carlin’s emotion regulation increased while her expression of anger decreased. In general, this session was calmer than the previous one with the girls focusing on making paint with chalk and water.

Carlin’s final two sessions in the playroom had similar themes and emotions. In her second-to-last session, she continued to engage in expressive activities with her siblings. When she became angry, it was quickly resolved and less extreme than in the previous two sessions. This continued in the final session in which Carlin spent the majority of her time doing art. While conflict did occur, it was promptly solved. Overall, she seemed calm and relaxed throughout the session. She exuded a sense of stability and confidence that was not felt in her first sessions in the playroom in which she seemed to seek approval from her siblings.

Carlin’s Wong-Baker scores changed across time; with the majority of her after scores being higher than her before scores with the exception of sessions four, seven, and eight in which both her before and after scores were zero. In addition, in session five, her before score was a ten or “Hurts Worst” and her after score was an eight or “Hurts Whole Lot.” During sessions seven and eight, her before and after scores remained zero (see Figure 3). Session eight was the calmest session in the playroom during the whole study.

Figure 5. Carlin's Wong-Baker FACES Pain Rating Scale: Before and After Scores



Case Study IV: Corinne

Corinne is a seven-year-old female who experienced the death of her father to suicide one year and ten months before the participating in this study. She participated in the play therapy group with her two younger sisters. In addition, she received two months of counseling a year previously and took part in one peer-support group meeting. She also went to a grief camp the year before and attended it for the second time during this study.

Pretest Assessment

Corinne's pretest scores on the Child Behavioral Checklist (CBCL) for Ages 6-8 were all within the normal range with the exception of Rule-Breaking Behavior on the Syndromes Scale which was in the borderline clinical area. In the concerns area, Corinne's mom stated that Corinne "dislikes" her middle sibling and "is passive aggressive with her to purposefully hurt her feelings." Furthermore, on the Parenting Stress Index (PSI) her stress score was in the normal range but her mom's score was in

the clinical range. As in the previous cases, this data along with the Wong-Baker were tracked across time and will be discussed later.

Sessions One and Two

Corinne expressed curiosity the moment she stepped in the playroom. In fact, the first words out of her mouth upon entering the room were in the form of a question. When this question was reflected back to her, she made her own decision. Corinne continued to ask questions about limits in the playroom and if there were certain toys (curious). The majority of her verbalizations in the first ten minutes were questions. Thus, it is not surprising that the primary emotion that she expressed in this session was curiosity.

Throughout the meeting, Corinne seemed to take a parental role with her two siblings; for instance, telling them how to clean themselves when they got out of the sandbox and helping them accomplish tasks (relationship). At one point in the interaction, her youngest sibling stated, “Corinne always bes the mom.” Her other sibling confirmed this saying, “She knows what’s going on.” Corinne’s curiosity correlated with her need to know what was going on and to be in control. For instance, at one point in the session she stated, “Can you tell me the rules?” She then continued to ask the researcher to tell her the rules over and over. The researcher reflected this back each time and Corinne then asked, “Do you know the rules?” Later, Corinne tested the rules by deciding that she was going to paint the researcher’s face; she brought the brush close to the researcher’s cheek but then became hesitant and asked, “Will I get in trouble?” (afraid).

Towards the end of the session, Corinne’s questions began to decrease and she started to explore the playroom more freely (exploratory). At one point, she

spontaneously started to dance while playing with the dress-up clothes (happy). She found a pair of shoes that she liked and attempted to persuade the researcher to let her take them home by saying things such as “Do people use these high heels?” Last, as it came closer to the time when the session would end, Corinne started to ask questions about who had to clean up the playroom and expressed not wanting to clean it (afraid).

Corinne’s caretaking role continued in the second session with her sisters. Upon entering the playroom, she decided that it was a mess and started to clean it up (cleaning). After that, she joined Carlin in painting and when there wasn’t enough room she stated, “Uh-oh there’s not enough room. Carlin you're going to have to stand” (power/control). Once she sorted out the space issue, she was able to focus on her art (curious).

When she was done with that, her siblings moved to the dress-up area but Corinne went to the sandbox where she tried to make a sandcastle. She expressed disappointment that Cara had dumped out the bucket of water and asked if she could get more. Carlin joined her in the sandbox and Corinne instructed her how to do make the castle (power/control). Carlin left and Corinne continued to work, again asking for more water. She did this while her siblings mixed paints at the art desk. When she was done, she stated, “No one mess up my castle please” (afraid).

Corinne then joined her siblings at the art desk and began telling them how to change their colors by adding different paints to them (power/control). Before she joined her sisters, they were each working independently without help. Corinne did art for the remainder of the session. When Carlin got paint on her shirt, Corinne comforted her (nurturing). She instructed Cara to be careful, not to get paint on her clothes, saying, “Cara, Cara, Cara, Cara. Be very careful with that shirt. I don't think you should do it

with that shirt on anymore because that's a brand new shirt. Okay" (nurturing). Finally, Corinne expressed confidence stating, "I would make a good art student."

Throughout her first two sessions in the playroom, Corinne exhibited inquisitive, confident play. She spent much of her time doing creative activities while trying to manage and take care of her siblings. In order to accomplish this task, she often told them what to do and how to do things. Both of her siblings acquiesced and acknowledged that Corinne regularly acted in a parental role.

Sessions Three and Four

Corinne was absent from the third session in the playroom. Therefore, the fourth session for her sibling was actually her third. When she returned for her third session, she told the researcher about the presents she had received for her birthday (relationship). She went to the art desk and started to paint a picture while she shared (creative/expressive). Corinne returned to her parental role when Cara painted the researcher. She stated, "Cara, that was mean. You know not to do that. Why would you do that, Cara?" Later, Corinne got mad at Cara when she turned the light off and Corinne got paint on her shirt. "Look what you did. Now I have to wash the shirt again," she scolded. When Cara didn't respond, Corinne became even more upset (anger).

Later, Corinne returned to the questioning that was prominent in previous sessions. She asked the researcher where she lived, if she was renting the room and if she bought all the toys inside of it; she became frustrated when these questions were reflected back to her. When she saw that her sisters were painting dolls, she immediately took over. She grabbed a doll from her youngest sibling (power/control) and instantly started to clean it. She instructed her siblings on the colors that they could use and the parts that

they could paint (power/control). When her siblings became tired of the activity, Corinne continued to clean up the mess that they had made (cleaning). At the end of the session, Corinne worked with Cara to remove the toys from the shelves making a considerable mess in the middle of the room (messing/creating chaos).

A large amount of this session was devoted to Corinne's cleaning up the mess that her siblings had made (cleaning). She was focused on this activity for over half of the session (curious). In addition, she often stepped into her sisters' activities taking control by telling them how to do things (power/control). When they did not listen or did things that she did not approve of, she became angry. This occurred more frequently than it had in the past. In addition, she continued to express curiosity throughout the meeting which was consistent with her first two sessions in the playroom.

Upon entering the playroom for her fourth session, Corinne started to set limits for her siblings. "Cara, when someone's painting you absolutely can't turn the light off. These are our new school clothes" (power/control). Carlin excitedly called her attention to the water bucket in the sandbox and the two girls collaborated to clean the dolls' hair from last week (cleaning). Cara joined the girls, and Corinne quickly became upset when she shook the doll after dipping it in the bucket causing paint to fly across the room. "If you do that one more time I'm telling mom. I'm going out there and telling mom" (power/control). Corinne was worried about the new outfit she was wearing (afraid).

While playing with the dolls, Corinne shared about her first day of school. She then asked the researcher questions about herself such as "Aren't you still in college?" and "You're an adult, right? How old are you?"(curious & relationship). Next, she found the pipe cleaners and inquired about taking them home (curious). After that, she went to

the art desk where she mixed paints together to create new colors (creative/expressive) while continuing to ask the researcher questions (curious). In addition, she became upset with her siblings multiple times throughout the session (anger).

Eventually, she joined Carlin in making "cookies" out of play dough and other art supplies. Corinne became upset when her youngest sibling started to make a mess and said, "Cara, please stop because we're going to try at the end of our special playtime" (power/control). When Cara didn't respond, Corinne threatened, "I'm never going to let you go in our room" (power/control). Overall, Corinne continued to be relational throughout the meeting but expressed more power and control than previous sessions. In addition, her primary emotion continued to be curiosity followed by anger and happiness.

Midpoint Assessment

On her midpoint assessment which occurred after completing four sessions in the playroom, many of Corinne's scores had remained the same; however, there were a few changes. On the Syndromes scale, there was a decrease in the Attention Problems and Aggressive Behaviors scores and an increase in the Rule-Breaking Behavior score. Externalizing behaviors decreased as well as Affective, Hyperactivity and Conduct Problems (see Table 7). All other scores remained the same. On the PSI, Corinne's score increased but her mom's score decreased resulting in a decrease in the total stress score (see Table 8). Furthermore, Corinne's mom expressed concerns about her being "bossy" to siblings and "argumentative" with her mom. Still she shared that Corinne had been doing her chores without being reminded and was helpful at home. This bossiness was also seen in the playroom as Corinne told her siblings what to do and attempted to manipulate situations to get what she wanted.

Session Five

Corinne's parental behavior continued in session five. When the girls entered the playroom, Cara dumped the bucket of water into the sandbox and Corinne instantly scolded her (power/control). She then settled into painting with Carlin (creativity/expressive), and started talking about what she was going to do this weekend (relationship). She stated, "Because our dad died. We have to go to Solace Camp. We don't have to but we like it." This is the first time she talked about death and the only time she referenced her father in all of the sessions.

Later, she painted on one of Carlin's paintings and when Carlin became upset Corinne was dismissive stating, "I just added on to it and made it prettier." However, as her sister continued to cry, Corinne eventually stepped in and tried to comfort her. When this did not work she became dismissive again stating:

Corinne: "She always does this when she gets mad."

Researcher: "Oh you don't care that she's sad Corinne."

Corinne: "Not really."

She then went on to say, "Cause I get so sick of it because she does it all the time." This behavior fit with her mom's statements that Corinne was passive aggressive toward Carlin and "purposefully" hurt her feelings. However, Carlin continued to cry and Corinne responded by trying to make her a new picture. When this did not sooth her, Corinne said, "Carlin, would you quit." Her sister eventually calmed down when Cara joined Corinne in making her a new picture. When the picture was complete, she held it up and asked Carlin if she liked it better than the original. She confirmed that she did and Corinne responded by saying, "But this is actually for me. I'm going to make one, or an

exact replica of this" (power/control). Nevertheless, she did not follow through with a replacement painting and later she changed one of Cara's pictures under the guise of "helping" her (power/control).

Shortly after this, Corinne and her siblings played with bubbles together (relationship) but then moved back to the art desk where conflict quickly ensued around Cara's turning the lights off and on. Corinne continued to try and manage her siblings. For example, when Cara spilled the bubbles Corinne cleaned them up, and when her sister needed to go to the bathroom she took her (nurturing). Last, with less than five minutes left in the session, Corinne joined Cara in removing all of the toys from the shelves making a large pile in the middle of the floor (messing/creating chaos).

Session Six

Corinne began her sixth session in the same inquisitive manner that dominated her previous meetings in the playroom. She started out by asking several questions but then settled into the art desk (creative/expressive). When her siblings started to play with the dollhouse and dolls, Corinne became curious and joined in; however, when Cara asked for help with a toy Corinne quickly switched to assisting her (nurturing). As she worked on her sister's hair, she continued to ask questions about a variety of things and commented on the happenings of the room (curiosity & relationship).

On the whole, the first ten minutes of the session were relatively calm and quiet. This changed, however, when Corinne took a toy with which Carlin had been playing. She became upset but Corinne was not empathetic. Carlin escalated further and hit Corinne. She dismissed this stating, "She does it every day. It just gets annoying it

doesn't hurt anymore." The girls then moved to different activities; however, Carlin came back to play with the dolls again and this time communicated a boundary with her sisters:

Carlin: "You guys now I'm being her (referring to a doll). Corinne all these stuff my hands are touching you can't use unless you, we live together."

Researcher: "Hmm…"

Carlin: "Corinne!"

Researcher: "Corinne you decided not to listen."

Corinne: "You weren't even touching it."

Carlin: "Everything in my pile I use and the baby."

Corinne almost immediately violated the boundary that Carlin set (power/control). Carlin moved onto another activity, and again Corinne attempted to take a toy away from her (power/control). For a brief moment, all three girls played musical instruments together (relationship) but then Corinne became interested in a hula-hoop stuck behind the sandbox. She then moved onto cleaning pen off of the desk (cleaning).

Throughout this session, Corinne continued to act as an authority figure to her siblings but seemed to focus much of her energy in this session on Carlin. Power/control was her prominent play theme for the session. She continued to express curiosity consistently throughout the interaction. As in the previous six sessions, this was the primary emotion that she manifested. In addition, she continued her creative activity of mixing paint and exhibited some nurturing behaviors toward her siblings.

Session Seven and Eight

Corinne began her seventh session in the playroom with a statement of power and control: "She's not allowed to do it. She's grounded." She was referring to Cara's trying

to dump the bucket of water into the sandbox. She then became engaged in art activities and decided to make chalk into paint by mixing it with water (creative/expressive). She expressed excitement and pride about her creation, “You have to tell everybody about my new invention.” Her siblings joined her and shortly after Corinne began to tell them what to do, “No that’s not what you're supposed to do. Watch. Don't do anything.” She then got angry when Cara accidentally got paint in her hair and on her shirt (anger).

As she continued to work with her “chalk paint,” Corinne made her siblings laugh when she began to copy the researcher (happy). Later, she became upset when Cara wouldn’t get a bucket of water for her (anger). She worked on her “invention” for the entire session and expressed multiple times that she was proud of it:

> Corinne: “Chalk paint would…wouldn’t be a secret if everybody knew but everybody doesn’t know.”
>
> Researcher: “You are excited about your invention, Corinne.”
>
> Corinne: “Actually I’ve known this since I was four. No one taught me.”

She even offered a “chalk class” for her siblings to attend if they wanted to learn about her creation (confident/persistent).

Though Corinne expressed some power and control over her siblings, it was much less than in previous sessions. She spent all but a few minutes of the session making her “chalk paint.” Yet while she worked, she was still able to ask an abundance of questions making curiosity the primary emotion that she expressed. In addition, she spent time helping her siblings during the session and taught them about her invention. As a result, relationship and creativity were the themes that predominated this session.

At the beginning of her second to last session, Cara dumped sand in the water bucket. Corinne became upset and spent time trying to separate the sand out (confident/persistent). She then moved on to the art desk and while she worked, she continued to manage her siblings. When Carlin got upset because Cara was painting, Corinne stepped and explained that it was okay that she painted as long as she did not get any on her clothes. She then took over Cara's art project stating, "Don't waste. Here do you want me to do a quick one? I'm super good." When the researcher reflected that she was taking over the project, Corinne replied, "I do this every time I come here" (power/control). When Cara tried to work on the picture, Corinne stopped her saying, "Hang on. Don't, don't, don't do that. After the sand you can do it" (power/control).

Eventually Corinne moved back to her original art project which she confidently worked on as her siblings played with bubbles. "I'm trying to make this the bestest!" she exclaimed (confidence/persistent). When she completed it, she proudly stated, "Look what I made." She then joined her siblings in playing with the bubbles (relationship). After doing this for a while, Corinne announced, "Let's not waste our time and let's knock everything off the shelves okay" (messing/creating chaos). She then began to clear off the shelves in the room despite Carlin's protests.

As she cleared off the shelves, she pushed toys onto Carlin's art project ruining it. Carlin took revenge on one of Corinne's paintings and she responded by crumbling up Carlin's painting (aggression/revenge). Carlin retaliated by putting Corinne's painting in the sand (aggression/revenge). Corinne did not respond and instead returned to clearing the toys off the shelves (messing/creating chaos). While she did this, she asked the researcher, "Are you sure you're going to be able to sort this out?" (power/control).

Although Corinne still seemed to act as a parent to her two siblings, in general she was relational and creative throughout this session. She had several instances in which she engaged with her siblings in a happy, free manner. In addition, she worked to create a mess in the playroom which she had not done in the previous two sessions. Last, she continued to ask questions as she did in all of the sessions to this point, but they were not as frequent as in the past.

Session Nine

Corinne began her final session with the creative play that had dominated her previous eight sessions in the playroom. Within a minute, she was already correcting Cara about something that she said (power/control). She then asked the researcher a question and when it was reflected back to her she shouted, “I demand to know!” (power/control). However, she quickly returned to her painting. As she worked, she expressed insecurity “Do you think I do bad on drawings?” (afraid). She continued to ask questions, and when the researcher did not answer she threatened again, “If you don’t answer me I will tell mom and go screaming” (power/control). Corinne did not follow through with her threat but instead returned to her art.

Throughout the session, Corinne continued asking questions and became upset when they were not answered. In addition, she maintained her role as an authority figure to her siblings, making comments on their art and coming to their aid when they needed help (nurturing). For instance, when Cara got paint on her shirt Corinne spent time helping her get it off while reassuring her, “It’s gonna come off. This part will be harder to get off probably but it's washable. Don't worry look I got some on my pants” (nurturing).

Later, Corinne became upset when she wanted Cara to watch her do something but she would not respond. She then set all of the art they had been working on by the door and announced, “We are about to make a disaster.” She proceeded to push the toys off of the shelves and onto the floor (messing/creating chaos). After, clearing off several shelves she stopped and said:

Corinne: “I take everything and spread it out.”

Researcher: “Hmm…”

Corinne: “I don’t want things in the same spot.”

Researcher: “Ahh…”

Corinne: “Because it makes it easier for you to clean.” (power/control)

Once she had cleared the remaining shelves with the help of Cara, she began to walk around the room. Limits were set around stepping on the toys in the room which was difficult because of the mess. Corinne became frustrated and stated, “I’m not stepping on them.” Later, she became excited and invited her siblings to play a game, “Okay. Ooo…guys. How about we play a game? How about we play a game?” She was frustrated when her siblings ignored her request and attempted to explain the game to them but they were not cooperative. Corinne yelled, “Cara! If you want to play the game listen up” (anger & power/control). She tried for several minutes to organize her siblings, even attempting to assign roles but when Cara refused to play Corinne gave up and moved onto another game. She stated, “Who needs medicine? I’m the doctor in the game.” Both of her siblings responded and the three played together for a brief moment (relationship) before moving onto separate tasks.

Corinne's play themes and emotions in the final session did not vary much from those exhibited in previous sessions. She continued to express curiosity about things in the room as well as in the researcher, and she communicated confidence. In addition, she attempted to control her siblings throughout the meeting but also cared for them when they needed help. She was creative and expressive throughout the meeting even in her mess making.

Posttest Assessment

Corinne's mom did not complete her posttest data because she ran out of time. She agreed to mail it to the researcher but unfortunately it was not received. However, other information will be discussed. On Corinne's Wong-Baker scores before and after each session she chose zero for all of the nine sessions that she attended.

Table 7. CBCL 6-18 Results for Corinne, A 7-Year-Old Female

Subscales	Pretest	Mid-point	Posttest
Syndromes			
Anxious/Depressed	51	51	00
Withdrawn/Depressed	50	50	00
Somatic Complaints	50	50	00
Social Problems	52	52	00
Thought Problems	51	51	00
Attention Problems	55	52	00
Rule-Breaking Behavior	66*	68*	00
Aggressive Behavior	57	51	00
Internalizing	43	43	00
Externalizing	59	57	00
DSM-Oriented Scales for Girls			
Affective Problems	52	50	00
Anxiety Problems	50	50	00
Somatic Problems	50	50	00
Attention Deficit/ Hyperactivity Problems	55	52	00
Oppositional Defiant Problems	52	52	00
Conduct Problems	66*	63	00

Note **Represents a clinical level. *Represents a borderline level. Lower scores represent improvement in behavioral problems.

Table 8. Parenting Stress Index (PSI) Results for Corinne, A 7-Year-Old Female

	Child	Parent	Total
PSI standard score (Pretest)	90	148**	238*
PSI standard score (Mid-point)	102*	133	235*
PSI standard score (Posttest)	00	000	000

Note **Represents a clinical level. *Represents a borderline level.

Conclusion

When looking at the emotions she expressed and her play themes across time, there were not many changes. Carlin consistently expressed curiosity throughout the

process; in fact, this was the most frequently coded emotion in every single one of her sessions. In addition, she conveyed confidence in each of the meetings in the playroom. Her play themes were consistent as well; each session she participated in creative, relational play and regularly attempted to control her siblings. Though there was consistency through the sessions, the eighth one stood out. In this session, there was a decrease in power and control, and in the session summary the researcher noted that it was calmer throughout.

Case Study V: John

John is a nine year-old male who experienced the death of his father due to kidney and liver failure eight months before the start of this study. Unlike the other five participants, John and his family had around three months to prepare for the death. John resided with his mother and her boyfriend and has two older siblings that are not in the home. John participated in one peer-support group meeting before taking part in this study and received some individual counseling.

Pretest Assessment

John's pre-session scores on the Child Behavior Checklist (CBCL) for Ages 6-8 all were in the normal range. In the section related to concerns about your child, John's mom stated that John had been "getting sassy/lippy" and "back talking adults lately." In addition, all of the scores on the Parenting Stress Index (PSI) were within the normal range. Like the previous cases, these scores along with the Wong-Baker scores were tracked across time. This data will be discussed later.

Sessions One and Two

John's first session in the playroom was with an eight year-old girl who had also lost her father to death (Kate). She dropped out of the study after her fifth session. Both children seemed calm at the beginning of the session and started out playing in the sandbox. John joined with the Kate during the first five minutes of the session but then began to play with the box of musical instruments (creative/expressive). At times throughout the session, he would play independently but when the other participant would invite him to play he accepted.

In general, the session felt calm and was relational but seemed to be dominated by the Kate; however, John seemed content to do what she wanted. John's primary emotions that were expressed were happy, curious, hesitant, and confident. Furthermore, his play themes included exploratory, relationship, and aggression/revenge. The aggression/revenge theme was played out predominantly through the bop-bag.

In session two, the dynamics changed because another participant, Tyler, was added to the group. Tyler was loud, aggressive, and tested many boundaries in the playroom. During this session, there were several limits set around "wrestling" in the playroom. John's expression of happiness in the session decreased and his aggression and exertion of power increased. For instance, while fighting over the bop-bag with Tyler, John stated, "No, I have the control." In addition, at one point in the session John repeatedly said, "John's heart is mad. John's heart is mad." Still, John was relational towards others and helped Tyler on tasks when asked. Toward the end of the session, all three participants played musical instruments together.

Sessions Three and Four

During session three, much of the aggressive behavior and power struggles that were seen in the previous session continued. In the session summary, the researcher noted that Tyler attempted to assert control over others, particularly over John. Still, John attempted to fight back and stood up to Tyler more than in the first session. For example, when Tyler threatened to "kick him in the balls" if John wouldn't give him a toy, John responded by stating "You can't kick me in the balls." Still, at times John joined Tyler in play and helped him clear off multiple shelves in the playroom (messing/creating chaos). Despite the fighting and the assertion of power and control, John's most prominent emotion throughout the session was happiness followed by anger.

Session four brought a feeling of calm compared to the previous two sessions. This was John's first session alone in the playroom as Tyler was absent and Kate had dropped out of the study. At the beginning of the session, John complained that he was alone but then he figured out how to turn the lights off and spent time throwing toys at it to try and turn it off. When he hit it he expressed excitement and confidence:

Researcher: "Oh! You got that from across the room."

John: "I nailed it."

Researcher: "Oh man! That took some skill."

John: Laughs. "I got some skill."

Researcher: "You got it. That was impressive. You're proud."

John: Laughs. "That was awesome." (happy)

John also spent time playing with the puppets and pretended that the puppet was telling him things that the researcher couldn't hear. In general, John's play was confident, happy, curious and relational.

Session Five

John's fifth session was his first in the playroom with only Tyler. John started this session by throwing toys at the light to turn it off and Tyler eventually joined him. John got hurt when he attempted to take play dough from Tyler. However, for the most part, much of the session was spent with the boys doing tasks jointly (relationship). At one point in the session, the boys worked together to clear the toys off of the shelves (messing/creating chaos). John seemed to have more of a balance with Tyler and was able to stand up for himself. For instance, John expressed worry about Tyler's clearing off a shelf and the mess that they were making and Tyler laughed at him. John replied by stating, "I actually care about people you know Tyler" (relationship). When Tyler had to leave the play session early for breaking limits, John came to his defense: "Give him one more chance…please" (relationship). In addition, after Tyler left, John referred to him as "One of my best friends" (relationship). John's previous themes of power/control and aggression/revenge when interacting with Tyler were replaced with relational and exploratory behaviors. In addition, happiness was the emotion code that was the most consistent throughout the session.

Midpoint Assessment

At the midpoint, John's scores on the internalizing scale had increased but his externalizing scores had decreased (see Table 9). All of his scores on all of the scales remained in the normal range except for one on the DSM-Oriented Scales for Boys, the

Somatic Problems scale, where his score increased to a level that put him in the borderline clinical range. On the question about what concerns you most about your child, John's mom stated that he "plays too many violent video games" and spends "too much time on them." Also, John's mom noted that her boyfriend who had been living in the home with her and John would be moving out at her request. In addition, she shared that she and John had stayed at her mom's house because of the deteriorating situation at home. This ended with John's witnessing a fight between his older brother and his mom's boyfriend. John did not talk about any of these changes during his sessions and did not seem to express any differences through his play. Last, his stress score on the PSI decreased while his mom's increased; however there was still an overall decrease in their total stress score (see Table 10).

Session Six

The relational theme seen in session five carried into session six. Like the previous session, John started out by throwing toys at the light to turn it off. However, he quickly changed tasks and invited Tyler to join him (relationship). This happened multiple times during the session with both children inviting each other to play. At one point in the session, Tyler joined John who was blowing bubbles and started popping the bubbles he was blowing (creative/expressive). Later in the session, Tyler gave John an examination with the medical kit and expressed concern for his wellbeing (nurturing). Throughout the session there was collaborative pretend play including the boys playing robbers (creative/expressive). A shift in the boys' play seemed to occur in this session; when they first met in the playroom, they were aggressive and controlling towards one

another. Now, they were more relaxed with both boys being more creative, expressive, and free and conveyed an overall feeling of happiness.

Session Seven and Eight

John continued to be creative and expressive in session seven which was his second alone in the playroom. He appeared calm and focused and moved throughout the room with happy, confident play. In addition, he did more nurturing and creative play activities such as acting out scenes with the puppets and the dolls. This was also one of the few sessions in which he made a reference to death. While playing with the baby doll and a monkey puppet he acted out a scene where a parent leaves their baby with a monkey. He then switched the doll out for a skeleton toy and stated, “That’s what happens to the baby if you leave a monkey with it.” Next, he took the baby and had the monkey beat it up then said, “Now this is me if I were the baby. See right here.” (Monkey threw the baby down). “And then I go up into heaven.” Finally, John ended the session by playing catch with the researcher. He expressed confidence when he caught the ball with one hand and stated, “I feel so powerful when I catch with one hand.”

John’s relaxed creative play changed in session eight. He entered the playroom and almost immediately went to the bop-bag and started to punch it. He explained that it was a kid from school and focused on it for the first five minutes of the session. Tyler then decided to dress the bop-bag up and John helped him. Throughout the session Tyler spent time protecting the bop-bag from John. In addition, John seemed to assert more power and control in the session by doing things such as arresting Tyler. One of the scenes looked like this:

John: “You’re under arrest.”

Tyler: “What did I do?”

John: “You’re with the man with the gun.”

Tyler: “What?”

John: “Billy had a gun.”

Researcher: “Oh Billy had a gun and you were there Tyler.”

Tyler: “I didn’t know.”

John: “Yeah but you were with him. He told me everything.”

Tyler was then arrested by John and taken to jail. Furthermore, John continued to return to punching “Billy” the bop-bag and at one point stated, “Billy’s dead.” Tyler responded by saying that Billy wasn’t dead and John answered this by attacking “Billy” and saying, “Die, die. Don’t live. You’ll die! You’ll die!” On John’s MAXQDA map for this session power and control was the most prominent theme, and it occurred more than it had in any other session.

Session Nine and Ten

During the next, session there was a decrease in power and control but it was still present. John and Tyler collaborated to beat up the bop-bag while pretending to be tag-team wrestlers (relationship). At times, Tyler attempted to manipulate John, but he continued to stand-up for himself. The following excerpt is an example of this:

John: “Can you please give me that?”

Tyler: “No! You don’t get it because you’re not my friend.”

Researcher: “Oh you don’t like him.”

John: “Hey! I am so your friend.”

Researcher: “John you think Tyler is your friend.”

Tyler: “Hey look at this! Wanna watch me jump?”

Researcher: “You have an idea Tyler.”

John: “I don’t know you, said I’m not your friend.”

Researcher: “You’re excited, Tyler.”

Tyler: “You’re my friend.”

Instead of just following along with Tyler, John challenged him by saying, “I don’t know, you said I’m not your friend.” This contrasted to the beginning sessions in which John was more submissive when Tyler attempted to manipulate him. Nonetheless, throughout the session John expressed happiness while engaging in relational activities with Tyler.

In his final session in the playroom, John joined with Tyler in punching and kicking the bop-bag. Later, they took turns throwing toys at the light switch to try to turn it off. Both were successful in doing this and celebrated with laughter. In addition, the two boys expressed happiness when playing with a spider that shot water. Their amusement continued as they moved on to play dough. Unlike previous sessions where they would play together for a time and then do independent activities, in this session they moved from activity to activity together. In the session summary, the researcher noted that there was less aggression, mess, and chaos and more relational play and care expressed towards one another. During his first sessions with Tyler, John seemed intense and displayed aggressive themes; however, by the last session he seemed more relaxed and balanced.

Posttest Assessment

On his posttest assessments, comparing pretest and posttest scores, for the CBCL syndromes scales there was a decrease in Anxious/Depressed, Social Problems, Attention

Problems, Rule-Breaking Behavior, and Aggressive Behavior (see Table 9). His scores for both internalizing and externalizing behaviors also decreased. Also, on the DSM-Oriented Scales his scores in the areas of Anxiety, Oppositional Defiant Problems, and Conduct Problems decreased as well. All other scores either stayed the same or increased (see Table 9).

Table 9. CBCL 6-18 Results for John, A 9-Year-Old Male

Subscales	Pretest	Mid-point	Posttest
Syndromes			
Anxious/Depressed	57	53	50
Withdrawn/Depressed	50	58	50
Somatic Complaints	50	61	53
Social Problems	62	58	58
Thought Problems	58	61	64
Attention Problems	51	50	50
Rule-Breaking Behavior	53	53	51
Aggressive Behavior	64	52	55
Internalizing	50	58	45
Externalizing	61	53	55
DSM-Oriented Scales for Boys			
Affective Problems	56	62	60
Anxiety Problems	55	51	51
Somatic Problems	50	65*	57
Attention Deficit/ Hyperactivity Problems	50	50	50
Oppositional Defiant Problems	62	55	58
Conduct Problems	63	57	51

Note **Represents a clinical level. *Represents a borderline level. Lower scores represent improvement in behavioral problems.

On the PSI, his total stress score decreased, but his mom's stress score increased. This most likely was due to the changes in her relationship with her boyfriend and the chaos that occurred that was previously discussed. As a result, their total stress score stayed the same (see Table 10).

Table 10. Parenting Stress (PSI) Results for John, A 9-Year-Old Male

	Child	Parent	Total
PSI standard score (Pretest)	98	94	192
PSI standard score (Mid-point)	86	103	189
PSI standard score (Posttest)	91	101	192

Note **Represents a clinical level. *Represents a borderline level.

Last, John's scores on the Wong-Baker did not change. Before and after each of his sessions he picked zero with the exception of the last session where he picked a two "Hurts Little Bit" before the session and then picked zero after. On the final assessment, John's mom shared that she noticed that often after sessions John was excited and took a long time to calm down. In addition, she stated that she didn't see much difference in John but that he enjoyed coming to sessions.

Conclusion

In his initial session in the playroom, John expressed aggression toward the bop-bag but otherwise the interaction was calm and relational. This quickly changed in the second session when Tyler entered the picture. John's aggression and power/control increased, as well as his expression of anger. This continued in session three, but by the fifth session both boys seemed to relax more and joined together on tasks. In session eight, John's anger, aggression and power/control spiked when he pretended the bop-bag was a peer from school. He repeated this behavior in the remainder of his sessions; however, in the final session he seemed to join more with Tyler in collaborative relational play. Though his mom did not note many changes outside of the playroom, in the

playroom John exhibited a range of emotions and seemed to build confidence as he interacted with Tyler.

Case Study VI: Tyler

Tyler is a ten year-old male who experienced the sudden death of his father to a drug overdose four and a half months prior to the beginning of his participation in this study. He resided with his paternal aunt, his uncle, and older and younger cousins. He was adopted and thus, his aunt will be referred to as "mom." In addition, he attended six peer-support groups before for he entered the study.

Pretest Assessment

All of Tyler's pre-session scores on the Child Behavior Checklist (CBCL) for Ages 6-8 were in the normal range. In the section related to concerns about your child, Tyler's mom stated that he had been "keeping his feelings about his dad's death all bottled up." In addition, all of the scores on the Parenting Stress Index (PSI) were within the normal range. Again, these scores along with the Wong-Baker scores were tracked across time and will be discussed later.

Sessions One and Two

Tyler's first session in the playroom was with John and Kate. This was John's second session in the playroom and Kate's third. Tyler's entrance into the playroom changed the calm relational dynamic that was seen in the previous session with Kate and John. Tyler was loud, aggressive and dominating. He started the session by exploring the playroom and asking questions about limits. John arrived to the session late; shortly after he entered, Tyler and John got into a power struggle (power/control). This occurred several times in the session and the researcher set limits around "wrestling" in the

playroom. Tyler expressed anger by shouting at his peers and exerted power/control by taking things from others and making threats such as “I’ll whack you with this.” Overall, the main emotions that he expressed were curiosity, happiness, and anger. In addition, the primary themes were aggression/revenge, power/control, exploration, and relationship.

During session two, Tyler continued to attempt to manipulate situations with threats such as “Hey, I’ll slap you, I’ll kick you in the balls” (power/control) and showed aggression towards others by throwing toys at them and pushing them during the meeting. Though his overall expression of aggression decreased, multiple limits were set to protect the participants. Nevertheless, at times Tyler engaged in relational behavior such as playing hide-in-go-seek with Kate and John. Two separate times, Tyler showed empathy toward both participants. Once when Kate got stuck, he stated, “Are you okay Kate?” In another incident when John got hurt he asked, “John are you okay?” (relationship). Tyler seemed to be adjusting to the boundaries of the playroom and continued to express both happiness and anger throughout the interaction.

Sessions Three and Four

John was absent for Tyler’s third session in the playroom which again altered the dynamic. The beginning of the session was much calmer than the previous two sessions with Tyler. Kate started out playing with pipe cleaners and Tyler joined her. He then moved onto independent play in the sandbox where he set up mounds of sand with toy soldiers on each side making a “battlefield.” Kate joined him and the theme of this play interaction was death/loss/grieving but it also showed the relationship being built between the two children. These two themes were also the most prominent for Tyler during the session. The interaction went as follows:

Tyler: “He died. Now put some guys in here. Put the guys inside the sand. It looks like they’re dead. Like this.”

Researcher: “You’re adding some more Tyler.”

Kate: “This is perfect.

Tyler: “We got the little grave for them.”

Kate: “Put it here; where my finger is. Yeah, yeah.”

Researcher: “You have an idea Kate. Tyler you covered that one up.”

Tyler: “Okay put…

Kate: “Two guys here and two guys here.”

Tyler: “Okay I got it. Two guys, two guys. Got it Kate. Two guys, two guys.”

Researcher: “Some of them are alive and some of them are dead.”

Tyler: “Very good. Put one guy there; one guy there.”

Kate: “No. We have way too many.”

Tyler: “Way too many that are dead.”

Kate: “Oh my God.”

Researcher: “A lot of them are dead.”

Tyler: “Some of them died. Those are…this is quicksand. So they're sinking.”

Researcher: “Oh sometimes people die.”

Kate: “Yeah this one died too.”

Researcher: “Oh that one’s dead too.”

Tyler: “This guy’s throwing a grenade at this guy.”

Researcher: “Hmm…”

Tyler: “So it's going to take out like three of those guys.”

Researcher: “Oh so some more might die.”

Tyler: “This guy is going to throw out these three and these two are left.”

Researcher: “They’re fighting.”

Tyler: “And that guy’s left so that guy shoots him and then this guy is starting to shoot them and this guy throws another grenade and hits those guys so they blow-up. One grenade blows all those guys up. One grenade hits this guy.”

Kate: “Another guy died.”

Researcher: “Another one died Kate.”

Tyler: “This guy gets a head shot. This is the quicksand that's all you can take out of the quicksand. Just leave this like this now.”

Tyler then moved onto another activity.

Later in the session, Kate and Tyler played store together both taking turns at the cash register. Toward the end of the session, Tyler threw blocks at Kate, and she used one of the playroom shelves as a shield and threw blocks back. Tyler then cleared off a shelf to shield himself with and put on a soldier hat. Kate wore a fireman’s hat. At the five minute warning, Tyler started throwing toys all around the room and made a large mess (messing/creating chaos). Unlike the first two sessions, Tyler’s main emotions for this session were happiness and curiosity.

Tyler’s fourth session was his first alone with John. The beginning of the session was much more relaxed than the previous sessions with John and Tyler. Tyler joined with John in throwing toys at the light switch in order to turn it off (relationship). Both boys spent time laughing throughout the session (happy) and seemed be enjoying each other’s company. Conflict occurred over play dough but Tyler eventually shared with John

(relationship). Toward the middle of the session, the boys worked together (relationship) to clear the toys off the shelf (messing/creating chaos). Tyler broke two toys in the playroom and then the ultimate limit was set: “The next time you break something your playtime will be over for today.” Shortly, after the 30 minute mark in the session Tyler stepped on a toy and broke it. At that time the researcher stated: “Your special playtime is over for today because you chose to break another toy.” Tyler apologized for making the room a mess and asked how much time John got to stay in the playroom but left the session without a fight.

Session Five

Tyler started session five by apologizing to the researcher; however, he quickly jumped into a power/control role. He took a set of handcuffs and told John to “Sit down and shut-up.” However, this changed when John stood up to him and Tyler ended up with the handcuffs on him. Though there was some power/control in this interaction, it felt more relational than the first two sessions with Tyler and John. In addition, Tyler took part in more creative activities such as playing with the play dough, bubbles, and using the dress-up clothes on himself and on the bop-bag (creative/expressive). Tyler expressed nurturing behavior when he brought out the medical kit and did an examination on John. “You’re sick,” he stated and then proceeded to give John shots to heal him (nurturing). In the session summary, the researcher noted that this was the calmest session with the two boys together and that it seemed more relational and collaborative.

Midpoint Assessment

At the midpoint assessment, Tyler’s Internalizing scores had decreased but his Externalizing scores had increased. Other scores that had increased included Social

Problems, Rule Breaking, and Aggressive Behavior on the Syndromes Scale and Conduct Problems on the DSM-Oriented Scales for Boys (see Table 11). This correlated with his play in the first five sessions. When Tyler did not get what he wanted he often became threatening or aggressive. In addition, a change had occurred at school. His mom reported that he was rushing though his work and "not staying focused." Finally, his total stress score on the PSI had decreased (see Table 12).

Sessions Six

In session six John's behaviors became more aggressive and controlling while Tyler seemed to continue the relational, creative activities from the previous session. In the beginning of the session, Tyler and John worked together to dress-up the bop-bag and Tyler asked John, "Can we take turns so we both can fight him?" (relationship). Tyler took the first kick but then when John started to punch the bop-bag Tyler came to its rescue saying, "What did he do to you? Give him his hat back. Be very nice to him" (rescue/protect). Later in the session, Tyler named the dressed up bop-bag "Billy." Several times during the session, Tyler defended the bop-bag when John tried to attack it. At one time he stated, "Stop! I'm helping Billy; I'm helping Billy; I'm helping Billy."

In addition, to the rescue/protect theme, Tyler also expressed nurturing behaviors. For instance, he pretended to make soup and the said, "Hey want soup? Get a bowl. I'll get you soup. Hey John there's a bowl." Moreover, he invited John to join in activities such as turning the bop-bag on its side and bouncing on it (relationship). He also set boundaries in a kind manner with John; in one instance, he stated, "Please don't throw stuff at me" (relationship). Tyler's expression of power/control and aggression was decreasing while his range of emotions and play themes expanded.

Session Seven and Eight

In the next session, Tyler started out by defending “Billy” the bop-bag but then later jumped on it punching and shouting, “Billy die Billy!” (aggression/revenge). Tyler and John worked together to beat up the bop-bag (aggression/revenge). In addition, they pretended to be wrestlers together (relationship). Tyler attempted to control John at times and insulted him several times in the session saying things such as, “No! You don’t get it because you’re not my friend” and “Get your own chubby.” Despite this, for the majority of the session the boys did activities together and it was less chaotic and messy than previous meetings.

Relationship was the theme that dominated Tyler’s eighth and John’s final session in the playroom. At the beginning of the meeting, the boys played with the bop-bag taking turns punching and kicking it as in the previous session. Shortly after finishing with that, they took turns throwing toys at the light switch to try to turn it off. This was followed by laughter as they took turns playing with a toy that shot water. While doing this, Tyler said, “Okay it's my turn. Hey, fill it up for your best friend” (relationship). At times there were confrontations, but in general these were promptly resolved. For instance, at one point in the session John wanted some of the play dough that Tyler was playing with:

Tyler: “Stop.”

Researcher: “Oh John, you wanted some.”

Tyler: “We can both get some.”

John: “Dude equal, equal.”

Researcher: “Oh you decided to share with him Tyler. Now you each have your own.”

Instead of turning into a physical altercation or a drawn out argument as it might have in the past, the boys were able to resolve the issue in a fair manner. Overall, the boys seemed to move from activity to activity together and there was a decrease in aggression when compared to their first session together in the playroom.

Session Nine and Ten

Tyler’s final two sessions in the playroom were alone because he started the study two weeks after John. Session nine began with Tyler telling the researcher about a school activity. In the past, Tyler did not interact much with the researcher though this had slowing increased over time. He then found the toy that squirted water and sprayed it at the researcher. A limit was set and Tyler followed through with it. Next, Tyler asked the researcher to play with him. They tossed a ball back and forth and Tyler said “roar” when he caught it and told the researcher to say “meow” (relationship). Tyler seemed to enjoy this and laughed several times during this interaction (happy). In addition, Tyler expressed themes of power and control when he turned off the lights in the room and told the researcher to “scoot back.” He then sprayed water in the dark but again responded when the researcher set a limit. Throughout the session, Tyler expressed confidence, happiness and curiosity.

In his final session, Tyler began by inviting the researcher to play basketball (relationship). Next, Tyler said “roar” while shooting and told the researcher to say “meow” when she shot the ball. As in the previous session, Tyler found this funny and spent time laughing and shooting the ball (happy). After this, Tyler moved on to playing

dodge ball with the researcher. Playing these games together facilitated the relationship process. The following is an excerpt from the interaction:

Tyler: “You caught it. Now you have to throw them at me.”

Researcher: “Nice.” Laughs.

Tyler: Laughs.

Researcher: “That was a good block. You liked that. That’s funny.”

Tyler: “I was quick.”

Researcher: “You’re fast.”

Tyler: “I, I, what is it called like…

Researcher: “Good reflexes.”

Tyler: “Yeah.”

Researcher: “Mmm…hmm…I noticed that. You’re making it tough.”

This is an example of the calm, easy flow that developed between Tyler and the researcher. While playing these games, Tyler added on rules throughout in an attempt to control the situation. For instance, while playing basketball he stated, “Scoot back. Every time you miss though, you have to scoot. Okay? Go! Back!” Tyler added on several rules for example, when the researcher missed a shot he received a point. In all, the overarching theme of this session was relationship. In addition, Tyler showed mastery and expressed confidence and happiness throughout the session. This was a stark difference to the aggressive, anger behavior that he expressed during his first sessions in the playroom.

Posttest Assessment

When looking at his posttest assessments, Tyler's scores on the CBCL decreased in many areas. On the Syndromes Scales, his Withdrawn/Depressed, Somatic Complaints, Attention Problems, and Rule-Breaking Behavior decreased. In addition, he had a decrease in his Internalizing scores and a slight increase in his Externalizing scores. On the DSM-Oriented Scales for Boys, he had a decrease in Somatic Problems, Hyperactivity Problems and Conduct Problems. All of his other scores either stayed the same or increased (see Table 11).

Table 11. CBCL 6-18 Results for Tyler, A 10-Year-Old Male

Subscales	Pretest	Midpoint	Posttest
Syndromes			
Anxious/Depressed	50	50	50
Withdrawn/Depressed	54	50	50
Somatic Complaints	61	53	53
Social Problems	51	56	53
Thought Problems	50	50	50
Attention Problems	59	57	55
Rule-Breaking Behavior	51	54	50
Aggressive Behavior	50	51	53
Internalizing	50	40	40
Externalizing	48	51	51
DSM-Oriented Scales for Boys			
Affective Problems	50	50	50
Anxiety Problems	50	50	50
Somatic Problems	65*	57	57
Attention Deficit/ Hyperactivity Problems	62	56	58
Oppositional Defiant Problems	52	52	58
Conduct Problems	51	54	50

Note **Represents a clinical level. *Represents a borderline level. Lower scores represent improvement in behavioral problems.

When looking at the PSI, Tyler's total score decreased along with the parent stress score and the overall score (see Table 12).

Table 12. Parenting Stress (PSI) Results for Tyler, A 10-Year-Old Male

	Child	Parent	Total
PSI standard score (Pretest)	105	126	231
PSI standard score (Mid-point)	106	125	231
PSI standard score (Posttest)	103	121	224

Note **Represents a clinical level. *Represents a borderline level.

Conclusion

When Tyler first entered the playroom he exhibited anger and aggressive behaviors that switched the dynamic in the playroom. Multiple limits were set for Tyler throughout the play process including the ultimate limit that was set in session four. After this session, Tyler seemed more calm and eventually started to expand his expression of emotions and the variety of his play themes. Before his first session, his mom expressed concern about Tyler keeping his feelings inside however, his posttest assessment scores indicated that this was changing across time. Tyler had the least amount of time to grieve out of all the participants but seemed to be able to express his emotions through the use of play. Finally his scores on the Wong-Baker were all zeros with the exception of session three where he reported a two or “hurts little bit” before the session.

Summary

This chapter outlined the themes, emotions, and changes that were identified during the play therapy process. A total of 16 play themes were identified to describe the interactions in the playroom. Some of these such as exploratory, relationship, power/control, aggression/revenge and creative/expressive play were more prominent

than others. In addition, seven primary emotions were recognized. As with the play themes, some of these were expressed more frequently than others. These included confidence, happiness, anger, and curiosity. The results indicated that these changed across time and these changes were different depending on the participant. Verbatim examples from the play sessions were used to describe how these themes and emotions were coded. Furthermore, changes in scores on the CBCL and PSI were examined along with the Wong-Baker results from each session to better understand what changes occurred and when they occurred during the study.

CHAPTER V: DISCUSSION

This study sought to determine the impact of the process of child-centered play therapy on the individual symptoms of grief in children following the death of a significant individual in their lives. Prior case study research on play therapy for grieving children focused on single anecdotal cases. Studies conducted on group play therapy did not focus on the process of play and were not specifically focused on child-centered non-directive play therapy. The current study implemented child-centered, non-directive play therapy in a multiple case study design. In addition, it focused not only on the symptoms of grief, but on the process that occurred throughout the intervention. The results of the study indicated that children processing through grief experienced a range of emotions. In addition, they participated in a variety of play activities throughout the process, producing numerous play themes. There were some similarities across participants but many differences as well, emphasizing the uniqueness of the grieving process for each individual.

Understanding of the impact of the process of play therapy on symptoms of grief was explored through five research questions: 1) How does play therapy facilitate the course of processing through and decreasing the symptoms of grief for children? 2) What are the emotions expressed by children in the play therapy process following the death of a significant individual in their life? 3) What are the themes that manifest through this play process? 4) How do these emotions and themes change across the ten-session treatment? 5) Are there differences in the child's self-reported emotional state before and after each play therapy session and do these emotional states change across time?

Contextualization of the Findings

Prior research in the area of child-centered play therapy and grief focused primarily on unsystematic case studies with results based on observations. This study aimed to address these limitations by implementing a clear, systematic, group, design that relied not only on observations but on several other means of assessment. Furthermore, previous research focused primarily on outcomes while this study looked not only at the results but at the process that occurred.

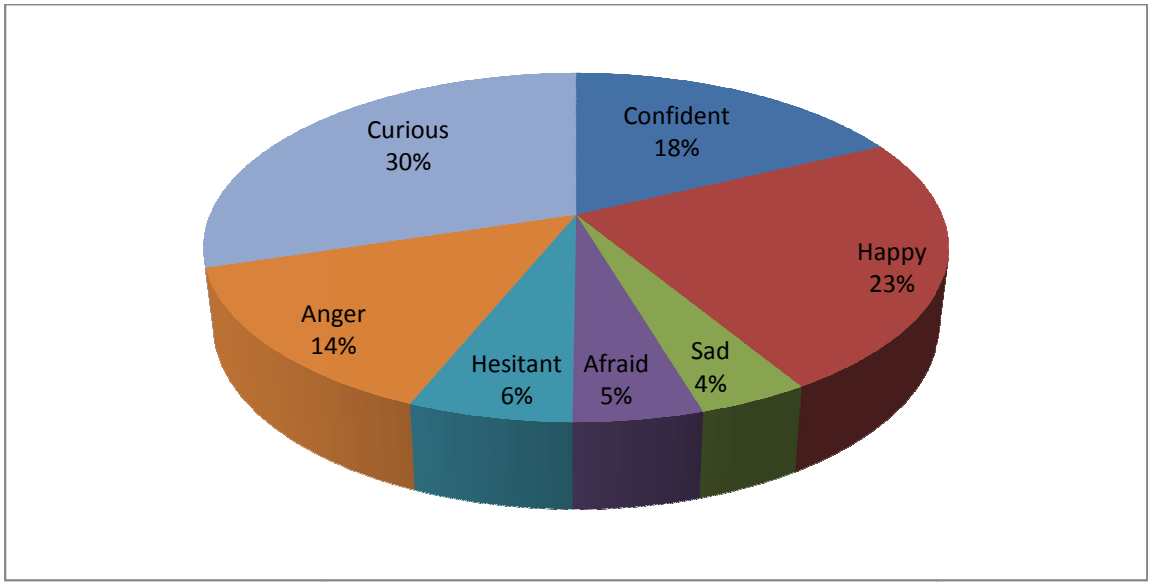
Past studies indicated that play facilitated emotional expression in grieving children (Kaplan & Joslin, 1993; Levieux, 1994; Masur, 1999; Oaklander, 2000; Webb, 2002). This study confirmed this assertion, identifying seven primary emotions that were expressed throughout the ten-week play process. Moreover, this investigation identified and tracked the themes that manifested through play during the course of therapy. This has not been done in previous work on grieving children. In addition, this study was unique in including the perspective of the child by implementing the Wong-Baker before and after each session.

The previous chapter outlined seven emotions and 16 play themes that were exhibited throughout the ten-week play therapy intervention. The manner in which these emotions and themes were expressed was also explained. In addition, changes that occurred throughout the play therapy process were examined. The following section will summarize the significance of these emotions and themes in the process of play therapy for grieving children and will look at how they fit with existing research. Furthermore, it will describe how symptoms and stress levels changed across time, exploring similarities and differences among participants.

Emotions

One of the goals of this study was to identify the emotions expressed by grieving children during the play therapy process and to describe how they changed throughout treatment. Previous research on grieving children indicated that they exhibited a variety of feelings. These included sadness, shock, relief, disbelief, confusion and anger (Davies, 1991; Mahon & Page, 1995). The present study showed that through the process of play, bereaved children expressed a far wider range of emotions including confidence, happiness, anger, curiosity, sadness, fear, and hesitation. Of these, the ones that were expressed the most frequently were confidence, happiness, curiosity and anger (see Figure 6).

Figure 6. Percentage each emotion was expressed for all participants in all sessions (see Appendix H)



When looking at the expression of emotion in grieving children, previous research relied on parent report (Finke, Birenbaum, & Chand, 1994; McCown & Davis, 1995; McCown & Pratt, 1985) and a combination of parent and teacher report (Fristad, Jedel,

Weller, & Weller, 1993; Kaffman & Elzur, 1979). Those that examined the perspective of the child primarily relied on the memory of the youth years after the death (Davies, 1991; Fanos & Nickerson, 1991; Mahon & Page, 1995). This study also used parent report, but additionally, it incorporated the perspective of the child through the use of the Wong-Baker. Furthermore, the researcher's observation of emotional expression during the play therapy process was systematically examined through the use of transcription and a line-by-line coding process.

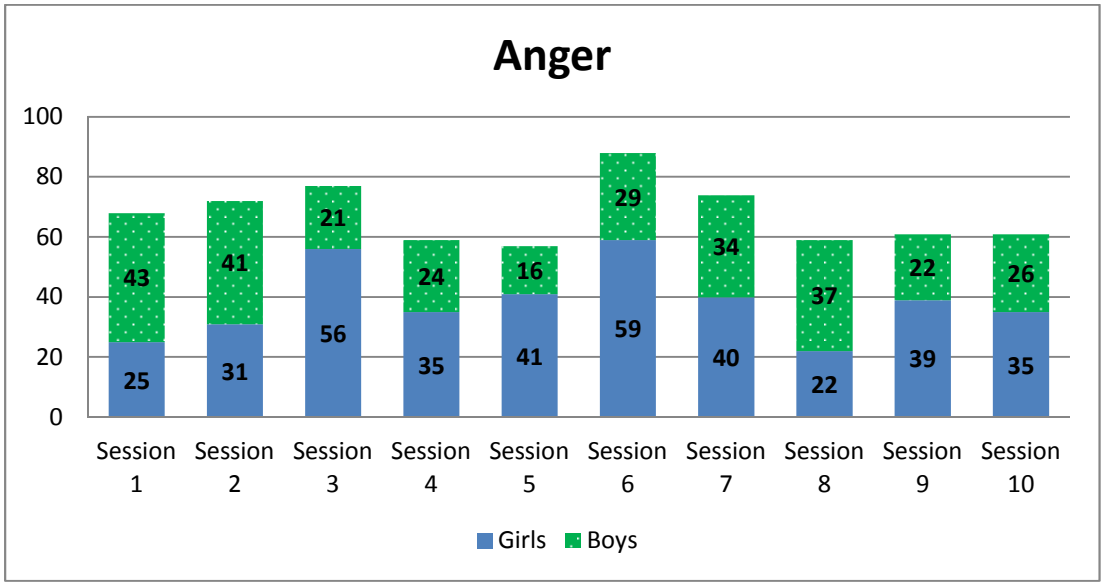
Prior research on child-centered play therapy with grieving children focused primarily on anger (Bullock, 2007; Oaklander, 2000; Saraway, 1999; Tait & Depta, 1993) and sadness (Hurley, 1991; Levieux, 1994; Oaklander, 2000) as the emotions that were expressed during the play process. Though anger and sadness were exhibited in the current research, a broader range of emotions was identified. This suggests that when processing through the symptoms of grief, children's manifestation of emotions is not concentrated in a singular area but is actually multifaceted.

Anger

The results of the present study supported previous research which indicated that play therapy was an avenue for expressing anger (Bullock, 2007; Oaklander, 2000; Saraway, 1999; Tait & Depta, 1993). Each of the six participants expressed anger in all sessions in the playroom, but the amount expressed varied for each child. For Kai, this emotion was prominent in his first two sessions but decreased across time. John was relatively calm in his initial sessions, but his expression of anger spiked in session three and dominated his final meetings in the playroom. Tyler expressed a substantial amount of anger in his first two sessions but by the end of the ten weeks expressed very little.

Both Cara and Corinne had gaps in which their anger was low but, Carlin expressed consistently high amounts of anger through all ten sessions. For boys and girls, the number of times that anger was coded in each session ranged between one and 24 with the exception of session six for Carlin in which anger was coded 43 times. When looking at all participants across time, anger was expressed consistently throughout the intervention. However, girls expressed anger more frequently than boys. In addition, girls' expression of anger increased across time while boys' decreased (see Figure 7).

Figure 7. Number of coded expressions of anger-boys compared to girls



Sad

Although sadness is an emotion that is typically associated with death, it was not frequently expressed during the play therapy process in this study. In fact, it was coded the least throughout the intervention. Still, it was shown by all children confirming prior research that play facilitated its expression in grieving children (Hurley, 1991; Levieux, 1994; Oaklander, 2000). Sadness was expressed in many ways, including crying,

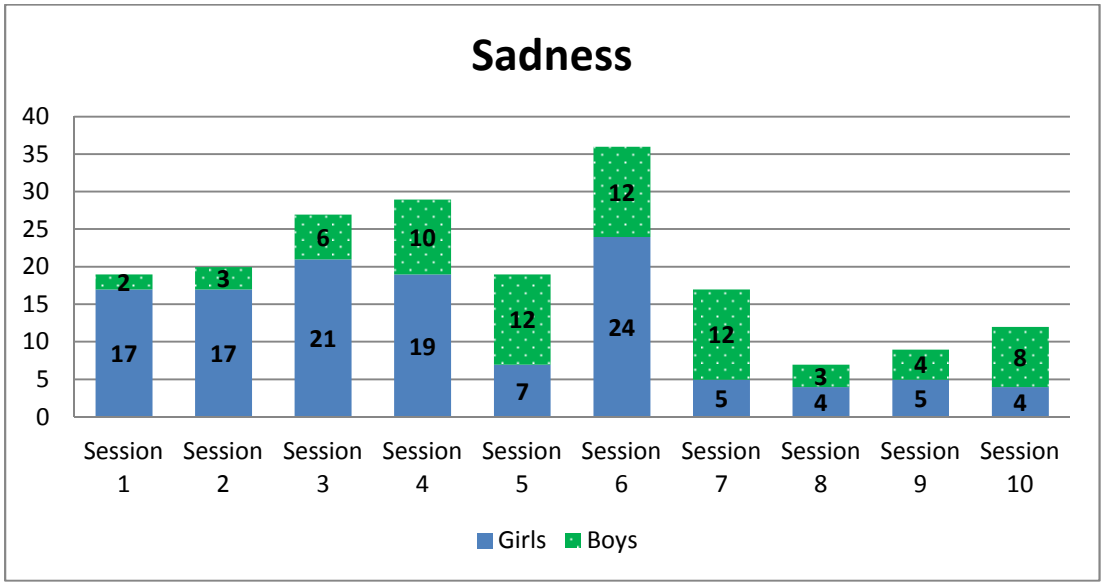
disappointment, self-report, and through objects or toys “feeling sad.” For instance, Kai, holding a baby that’s nose had broken off stated:

> Kai: “A poor babies. The baby’s going to cry.”
>
> Researcher: “Oh, you're worried about what's going to happen to the baby now that that's broken.”
>
> Kai: “That baby is going to be…it wished…sad.”

Kai expressed concern about the toy being sad and worked to try to fix it so it would feel better.

Carlin expressed the most sadness out of all the participants particularly in session six when her siblings painted on her artwork. Kai came in second with 46 coded expressions total. Tyler conveyed the least amount of sadness with 10 coded expressions in all. It could be argued that length of time since the death occurred might correlate with the expression of sadness. In this case, however, Tyler had the most recent death while Carlin had the greatest amount of time since her loss. Sadness decreased across time when looking at all the participants (see Figure 8).

Figure 8. Number of coded expressions of sadness-boys compared to girls



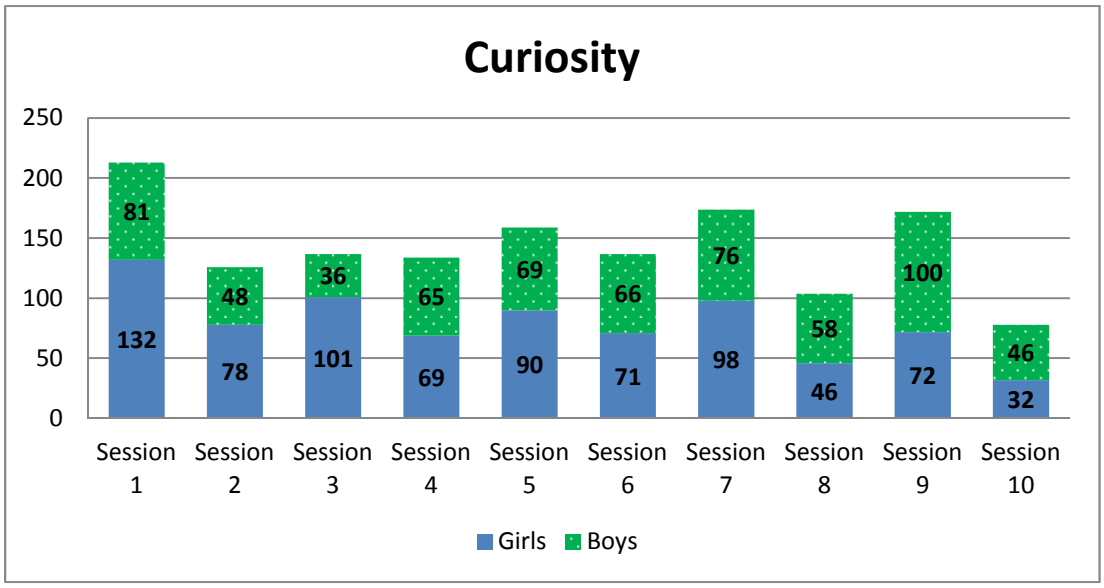
Curiosity

Curiosity is not an emotion that was discussed in the previous research on grieving children. However, Hendricks (1971) conducted a study on the process of play therapy with boys aged eight to ten who had emotional and/or social maladjustment problems. In it she stated that in sessions one-four in the playroom children expressed curiosity about their surroundings. In addition, Withee (1975) replicated Hendricks work but included girls and stated that in sessions one-three curiosity was expressed. This was partially true in the current study. When looking at the total number of times curiosity was coded across all participants, it peaked in the first session with 213 coded expressions. It dropped to 126 in the second session but then, unlike the previous two studies, persisted across time. In fact, it was the most coded emotion in the entire investigation.

Out of all of the participants in this study, Corinne expressed the most curiosity. She asked questions about the playroom, “Do you guys have a sink here?”; questions

about limits, “Are we really allowed to paint on the walls?”; questions about the researcher, “How many years of college have you lived?”; and questions about anything else she could think of, “What? Why are looking at me like I’m crazy?” The frequency of her questions decreased across time but was still present throughout. Overall, girls had more coded expressions of curiosity but both boys’ and girls’ expressions decreased across time (see Figure 9). Curiosity is a natural way to gain understanding about the world around you. The participants’ expression of curiosity in this study suggests that they were each trying to gain an understanding of their environment and events that occurred throughout the intervention.

Figure 9. Number of coded expressions of curiosity-boys compared to girls



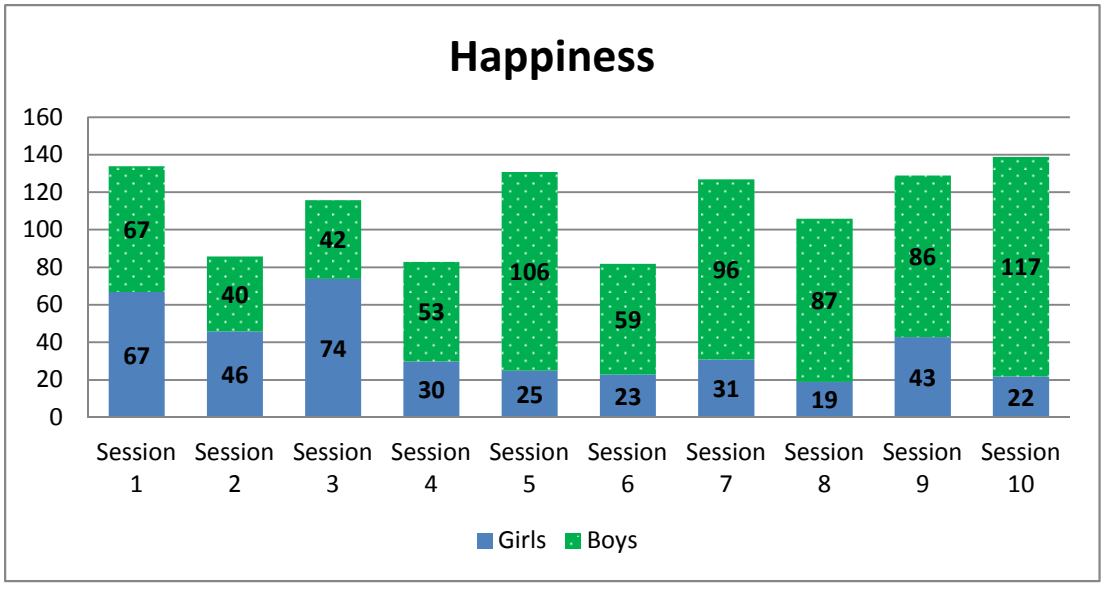
Happiness

Happiness was also an emotion that was not mentioned in the literature on grieving children. However, like curiosity, it has been noted in process research on maladjusted children. Again, like curiosity, Hendricks (1971) indicated that happiness was expressed in the first four sessions in the playroom. Still, unlike curiosity, it carried

through to session 20. This finding was confirmed in the current study. Happiness was the second most coded emotion, and its expression was consistent throughout all ten sessions. In fact, happiness peaked in session ten. It was commonly expressed through excitement around toys in the playroom and laughter about stories told by participants or in response to the actions of others in the room.

Although happiness was expressed by all participants, John conveyed it the most frequently. When he was alone in the playroom, he often tried to make the researcher laugh by acting out silly scenes or telling funny stories. Researcher: Laughs. “You’re being silly again, John. You like to make people laugh.” John: “Yes, I do. Especially girls.” When looking at the overall trends, the boys expressed more happiness than the girls (see Figure 10).

Figure 10. Number of coded expressions of happiness- boys compared to girls

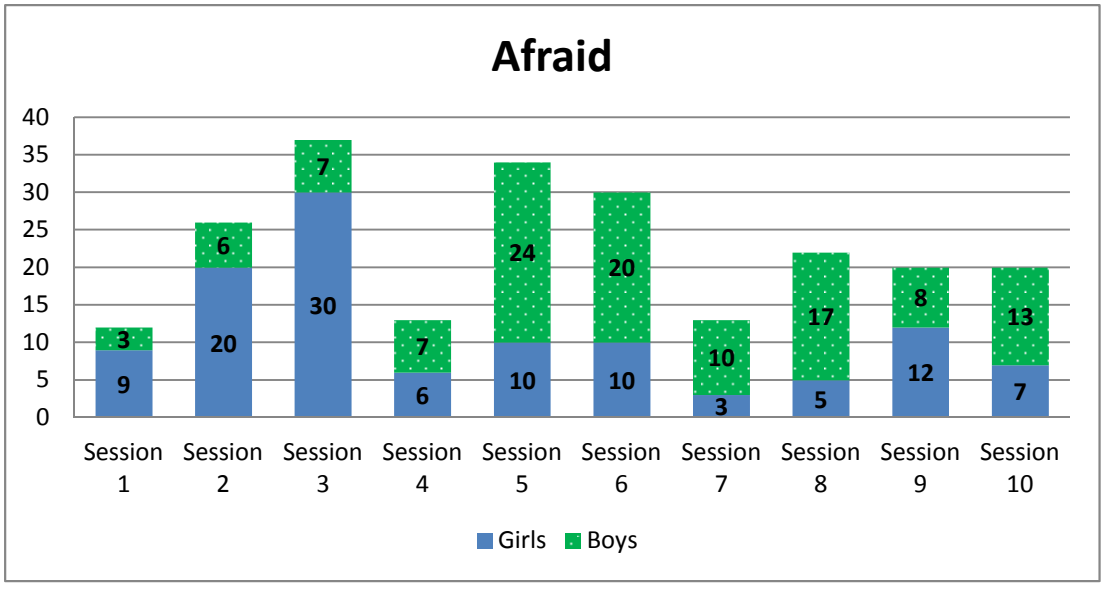


Afraid

While fear was not directly discussed in the research on grieving children, anxiety, which is often caused by fear, was noted in the literature (Kaplan & Joslin,

1993). In the current research, much of the worry expressed was related to consequences both inside and outside of the playroom. “Will I get in trouble if I do?” asked Corinne as she walked towards the researcher’s face with a paintbrush. “My mom’s gonna be so angry at me,” stated Carlin after getting paint on her hands. Worry was also communicated in the form of concern for others. For instance, when John got hurt, Tyler expressed his concern by asking, “Are you okay?” Last, fear was expressed about objects or experiences in the room. After climbing to the top of the shelves, Kai stated, “I’m scared up here.” Like many of the other emotions, afraid was coded the least in the first session but was consistently coded throughout all of the sessions in the playroom, peaking in session five. Overall, there were almost equal numbers of coded expressions when comparing boys and girls (see Figure 11).

Figure 11. Number of coded expressions of afraid- boys compared to girls

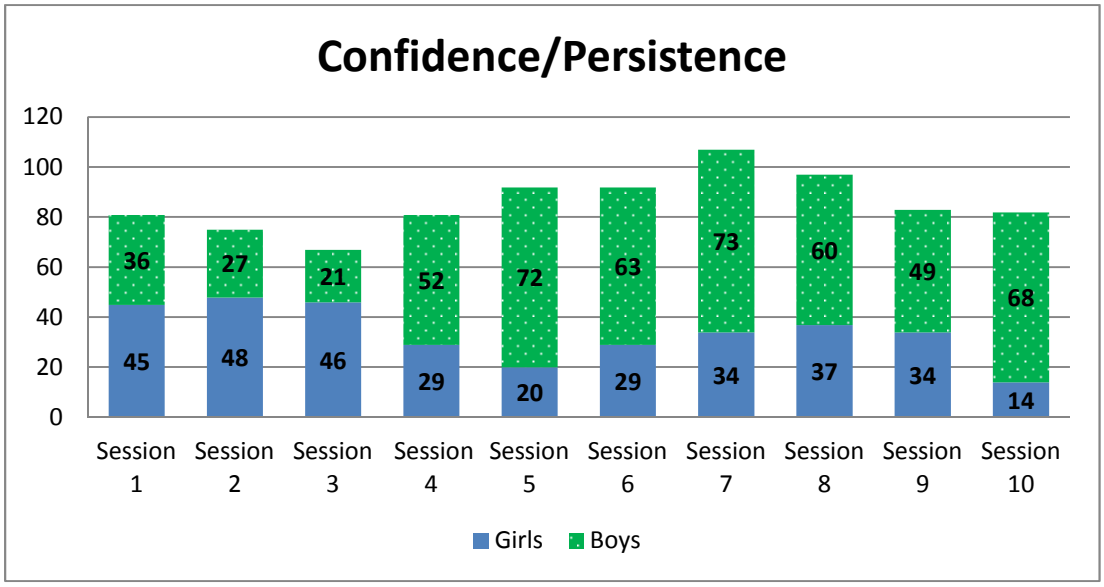


Confidence/Persistence

Confidence was not a concept that was discussed in previous research on play therapy with grieving children. Previous studies did not focus on the process of play but

instead on the symptoms reported before and after the intervention. In the present study, confident/persistent was the third most coded emotion. It was expressed both through statements about self, Corinne: “No I'm really super good at it,” and through actions of persistence, Researcher: “You keep falling but you keep getting back up. You are determined Kai.” Both Kai and Tyler’s confidence increased across the intervention, and while the remaining participants saw a decrease in confidence, when looking at all of the participants together, the number of coded expressions of confidence increased overall and peaked in session eight. Moreover, boys expressed more confidence and persistence than girls (see Figure 12).

Figure 12. Number of coded expressions of confidence-boys compared to girls



Hesitant

Like confidence, hesitation was not talked about in prior research with grieving children. However, the concept of ambivalence was addressed in process research. Moustakas (1955a) identified ambivalent feelings in the second stage of play therapy with disturbed children. Also, Rogers (1969) described children as being hesitant and

ambivalent as they tentatively tried out toys during their first phase in the play process. In addition, Kaplan and Joslin (1993) noted confusion as one of the symptoms expressed in their case study on a six-year-old male following the death of his sister. In the current study, hesitation was the highest in session one and decreased across time. It was exhibited by children verbalizing or acting out confused, timid or undecided behavior.

Researcher: "You found something else. You opened it right up." (Gluestick).

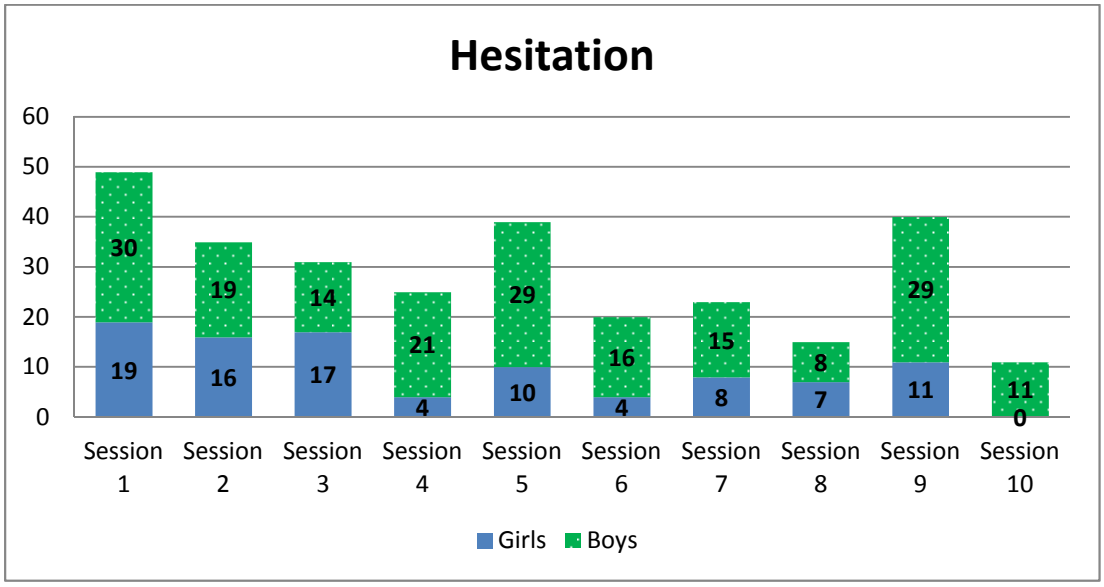
"You're trying to figure out what it is." (Put it on lips like chapstick).

Kai: "I don't know what it is."

Researcher: "You're not sure."

John expressed the most amount of hesitation overall. It peaked in session one but decreased across time. Cara had the least amount of coded expressions of hesitation. Furthermore, boys expressed more hesitation than girls during the study (see Figure 13).

Figure 13. Number of coded expressions of hesitation-boys compared to girls



Play Themes

Another objective of this study was to identify the themes that manifested during

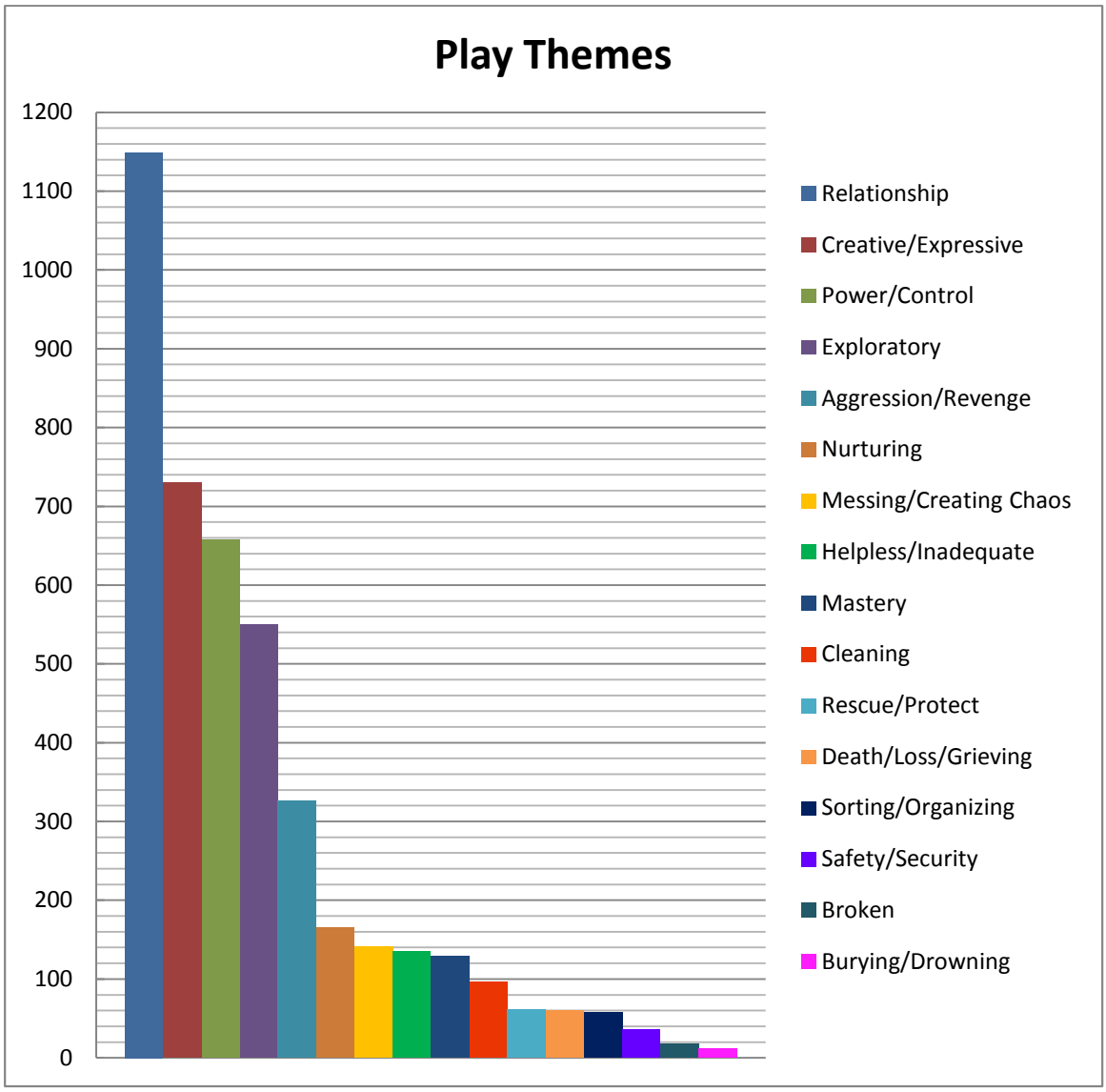
the play therapy process with grieving children and again track changes across the course of treatment. In prior research on grieving children, the primary behavior that was noted was aggression (Glazer & Clark, 1990; Masur, 1999; Oaklander, 2000; Webb, 2007). In the current research, aggression/revenge was a prominent play theme particularly at the beginning of the treatment for male participants. Furthermore, process research on child-centered therapy has not been done with grieving children. There has, however, been research comparing adjusted and maladjusted children. Perry (1988) found that maladjusted children expressed more distressed feelings, conflict, and negative statements than the adjusted group. Moustakas (1955b) asserted that the maladjusted group expressed a significantly greater number of negative attitudes. Similarly, Oe (1989) examined the initial session behaviors of these two populations, looking at 13 different themes. Three of these themes included "self-accepting," "non-acceptance" and "dramatic or role behaviors." She found that maladjusted children displayed more self-accepting and non-acceptance of environment and more extreme dramatic or role behaviors.

Although this study did not examine these specific categories, the evidence seems to correlate with the findings of these authors. When looking at themes that might be considered "negative", two stand out: aggression and power/control. As previously stated, aggression was a popular theme for male participants but decreased across time. In addition, across all participants, power/control was a dominate theme. With the exception of John and Corinne, it decreased across the course of treatment. These "negative" themes parallel the concepts described in prior process research.

Since there is no prior process research on grieving children, the current study

adds valuable data to the play themes that children used to process through the symptoms of grief. Sixteen play themes were identified (see Figure 14). Prominent play themes will be discussed along with other areas that the researcher deemed noteworthy. Because of the number of play themes, more inconspicuous ones will be generally discussed.

Figure 14. Total number of times each play theme was coded (see Appendix I).

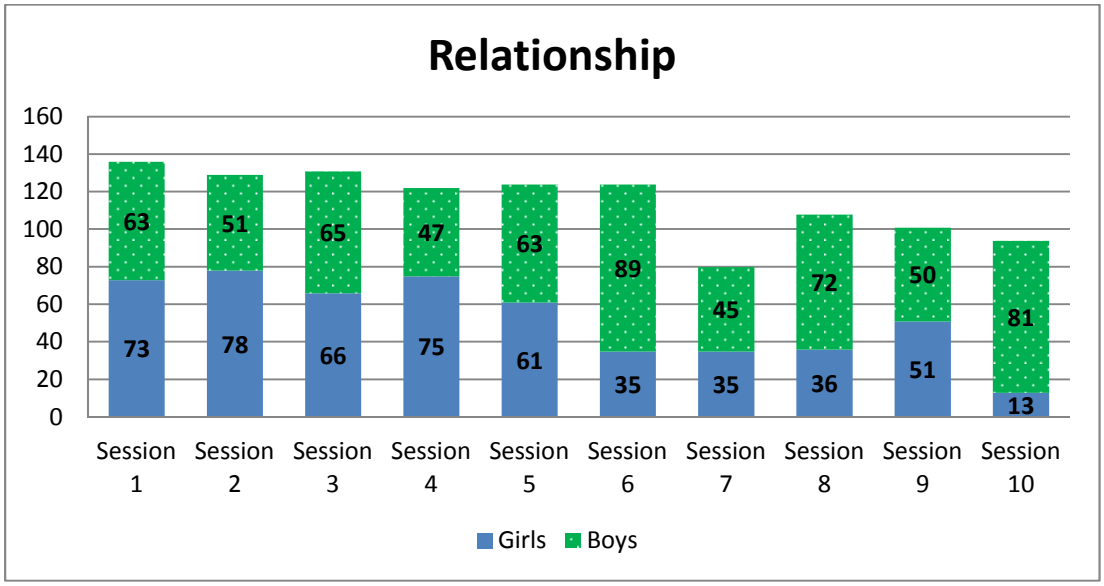


Relationship

In this study, relationship was the most coded play theme when looking at all

participants. It was the most coded for each child except Kai. Previous research in the area of grief did not talk about this theme. However, work in process research explored this concept. Moustakas (1955a) described relationship as a key piece of the process in play therapy as it was the means that children used to express and explore the different levels of emotional developments that occurred during the progression of the play therapy sessions. In addition, Hendricks (1971) asserted that relational play increased during sessions nine to 12 in the playroom. The current study indicated that, when looking at all participants, relational play began in session one and peaked in session five. When breaking things up by gender, relational play decreased across time for girls but increased for boys. Thus, this indicates that relationship was an important part of the play therapy process for grieving children. It was used as a means to act out roles, support one another, interact with the researcher, and join together in the play process. Its predominance in the play of all six children in this study provides evidence that it is an integral part of the play therapy process for this population.

Figure 15. A comparison boys and girls in the expression of relationship



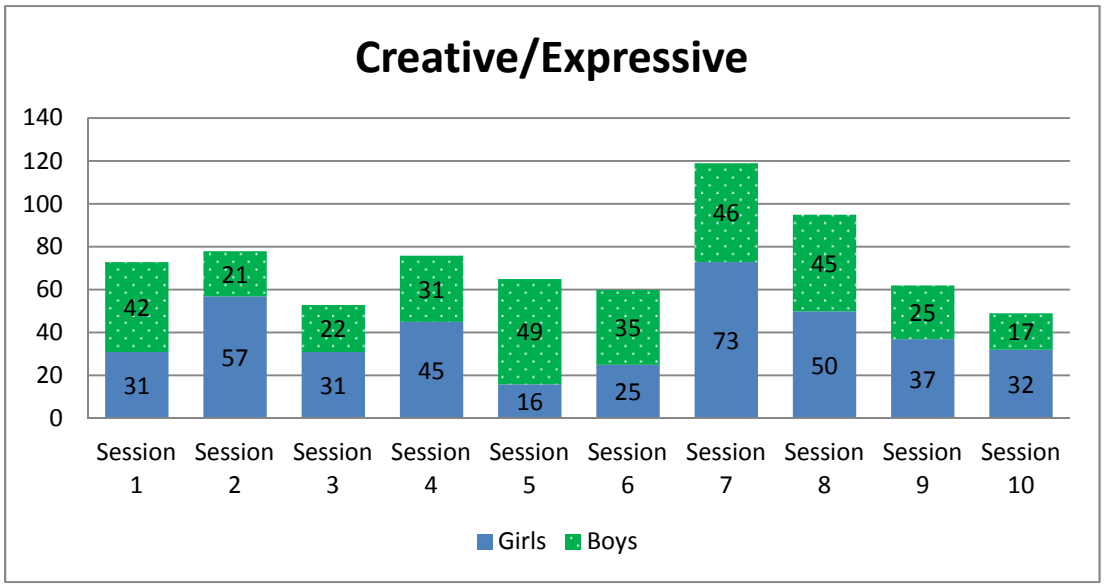
Creative/Expressive

As previously stated, Hendricks (1971) identified creative play as a theme that was present in the process of play therapy. She stated that it started in sessions one to four and continued in through session 16. Furthermore, Withee (1975) asserted that creative play peaked in sessions 10-12. The results of the current study were similar to the findings of Hendricks. Creative play began in session one and continued through all ten sessions. Girls participated in slightly more creative play then boys. When looking at the overall data, coded expressions of creativity peaked in session eight.

For all participants except John and Tyler, creative play increased in general across time. John and Tyler expressed the least amount of creativity throughout the sessions. Instead, much of their play was focused in relationship, power/control, aggression, and exploration. By contrast, for the girls, creative play was second only to relationship when looking at play themes. Still, when looking at play themes overall, creative/expressive was the second most coded play theme indicating that it was an

essential piece of the therapeutic process. The children used creative play as a way to act out and express emotions through the use of role play, puppets, dolls, animals, and art. Utilizing the different means in the room, they were able to express emotions and act out themes.

Figure 16. A comparison boys and girls in the expression of creativity



Power/Control

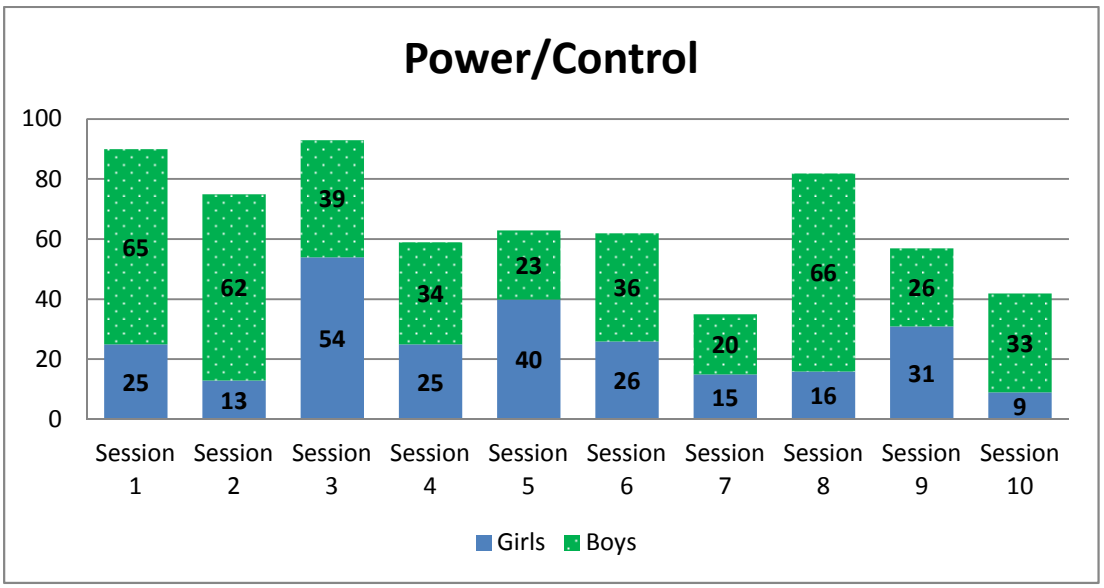
Again, this was not a concept discussed in prior research on grieving children. It was, however, noted in the research on gender differences in play therapy themes. In it, researchers found that girls exhibited more controlling behaviors than boys (Holmberg, Benedict, & Hynan, 1998). This was not true in the current study. Both boys and girls exhibited power and control throughout the intervention with boys having more coded expressions of power/control than girls.

With the exception of Corinne and John, expressions of power and control decreased across time. Corinne's expression of power and control peaked in her final session in the playroom. During this session, Corinne spent time trying to engage her

siblings in a game, telling them what to do, and demanding that the researcher answer her questions. Being aware that it was her final session, she expressed concern that this was her last chance to do the things that she wanted to do in the playroom. As for John, his expression of control peaked in session eight. Throughout his interactions with Tyler, there was a persistent power struggle. In his initial session with Tyler, John struggled to assert himself. This gradually changed over time with John becoming more confident and willing to stand up for himself while Tyler slowly began acquiesce more.

For the majority of their upbringing, children are told what to do by adults. Furthermore, experiencing the death of a loved one is not something that anyone can control. Thus, it makes sense that in the playroom the participants in this study spent time attempting to control others and their environment. It gave them the opportunity to express their desires and to feel like they had a choice in their life. As evidenced by the number of times this theme was coded, it is clear that it was an important part of the recovery process for grieving children.

Figure 17. A comparison of boys and girls in expressions of power/control



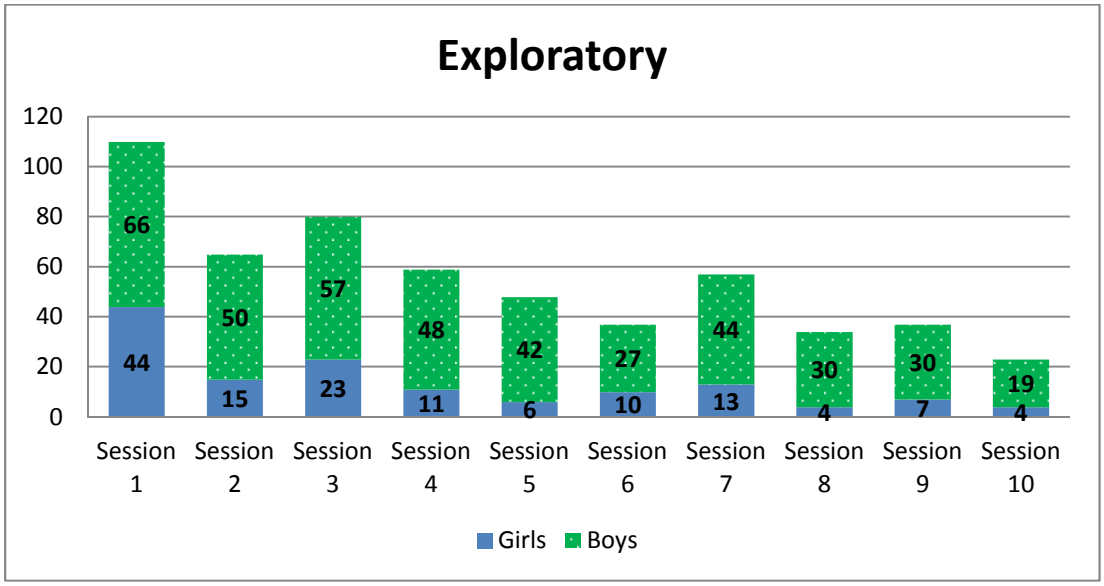
Exploratory

Based on her personal observations of children, Rogers (1969) stated that the first stage of the play therapy process was the exploratory stage. In Hendrick's (1971) process research, she found that children in sessions one to four engaged in exploratory play. This continued through session eight but began to decrease in sessions nine to twelve. In the current research, when looking at the total number of coded expressions across time, the numbers decreased from 110 in the first session to 24 in the final session.

When looking at individual participants, Kai had the most number of coded expressions. They peaked in session three but were prominent through session eight before decreasing considerably. Tyler had the second most coded expressions. His coded expressions decreased after session one but had some small spikes in sessions three, eight, and nine. The remaining four participants saw a gradual decrease across time with the exception of John who had a slight increase in session five before decreasing. In session five, he expressed his exploration by turning the lights on and off and climbing on top of shelves in the room. Overall, this research seems to indicate that in general exploratory play is more predominant in the first five sessions in the playroom. Furthermore, the boys expressed more exploratory themes than girls.

Exploration was a way for the participants to acquaint themselves with the playroom. It is likely that it would be exhibited in virtually all play sessions with individuals from a variety of populations and thus is not specific to grieving children. Still, it was a part of their process allowing them to test limits, examine toys, and gain an understanding of the boundaries of play that were a part of the process making it a fundamental part of the therapeutic process.

Figure 18. A comparison of boys and girls in the expression of exploration



Aggression/Revenge

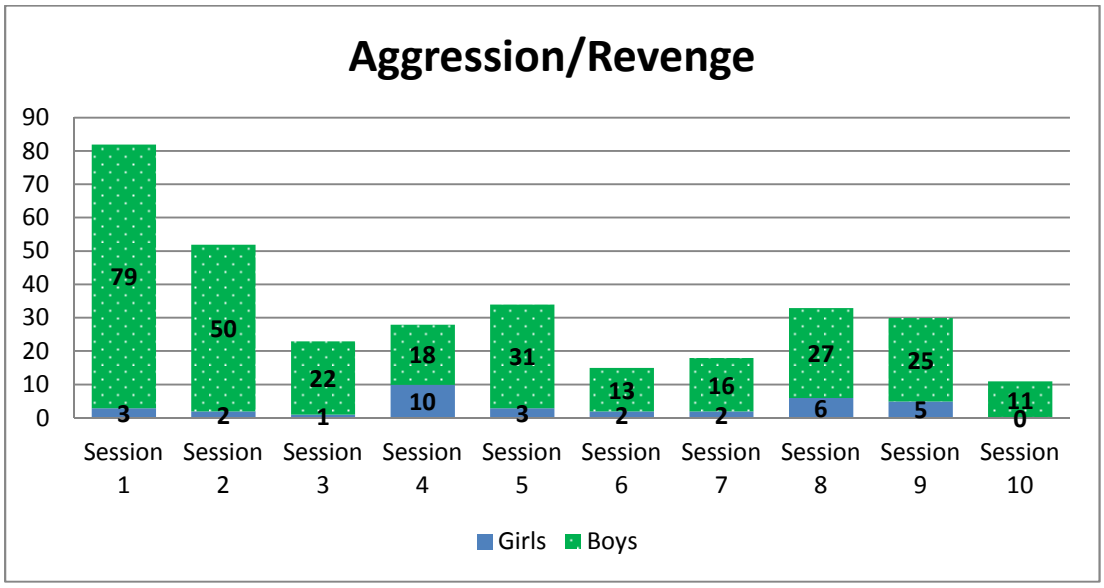
A previous study on gender differences in children's play themes found that boys exhibited a higher percentage of aggressive themes then girls (Holmberg, Benedict, & Hynan, 1998). The current research confirmed this assertion. Girls had 34 total coded expressions while boys had 292. In addition, Perry (1988) noted that in the first 12 minutes of play for maladapted children there were disruptions in play and themes of conflict. Hendricks (1971) stated that aggressive play materialized in sessions five-eight and decreased starting in session nine.

This study indicated that aggressive themes were more prominent in the initial sessions in the playroom and then decreased across time. Kai's aggression started to decrease after session five. For John, it was after his first two sessions in the playroom but it increased in sessions eight and nine before decreasing again in the final session. Tyler's decreased after his first session and had a small surge in sessions five and six.

As previously discussed, anger was one of the primary emotions that was noted in

the literature on grieving children. Aggression is a common manifestation of anger, and thus it is not surprising that it was the fifth most common play theme in this study. The participants in this study were able to express it primarily through the use of the bop-bag. It gave them a safe, non-judgmental arena for playing out a behavior that is frequently displayed following death.

Figure 19. A comparison of boys and girls in the expression of aggression/revenge

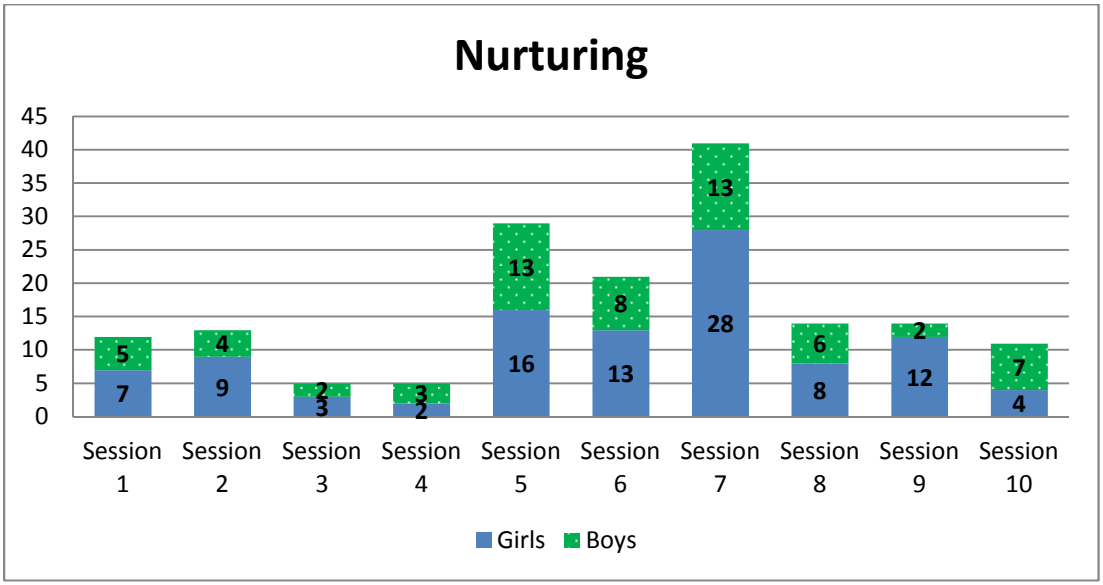


Nurturing

As with the previous themes, nurturing has not been discussed in prior research with grieving children. However, it was explored in research on gender differences in play therapy themes in which girls had significantly higher proportions of sessions with the themes of positive nurturance (Holmberg, Benedict, & Hynan, 1998). The current study confirmed this finding with girls expressing nurturance more frequently than boys. Corinne had the most expressions of the code and conveyed it primarily through caretaking behaviors toward her sisters. It was her fourth most coded theme overall. In addition, Kai had the second highest rate of this theme and communicated it by taking

care of toys in the room along with animals. When looking at all participants, coded expressions of nurturance peaked in session seven. Last, it was the sixth most coded theme in the study.

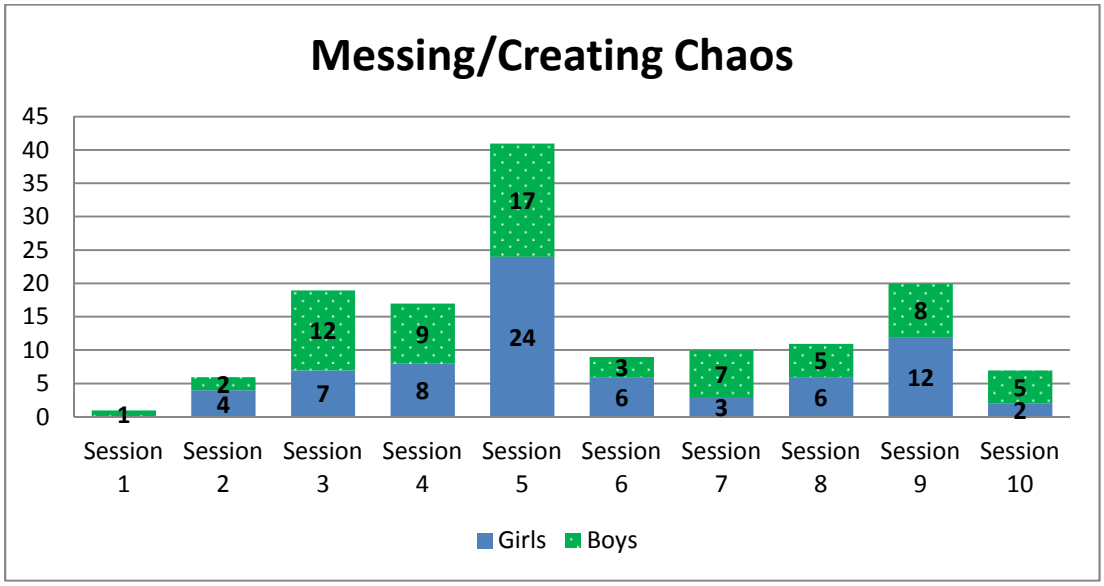
Figure 20. A comparison of boys and girls in the expression of nurturing



Messing/Creating Chaos

Again, like the majority of the previous themes, this code was not discussed in previous research on grieving children. It was used in the study on gender differences but it was not found to be a significant theme (Holmberg, Benedict, & Hynan, 1998). This code stood out in the current study because of the way that it was expressed. All six participants, at one point or another, participated in clearing the toys off the shelves into the center of the room. Session five saw the most coded expressions of this theme for both boys and girls (see Figure 21). This is theme stood out to the researcher because in her experience with play therapy this is not a common theme. It could be surmised that the messing/creating chaos was a manifestation of turmoil that each participant experienced in their lives.

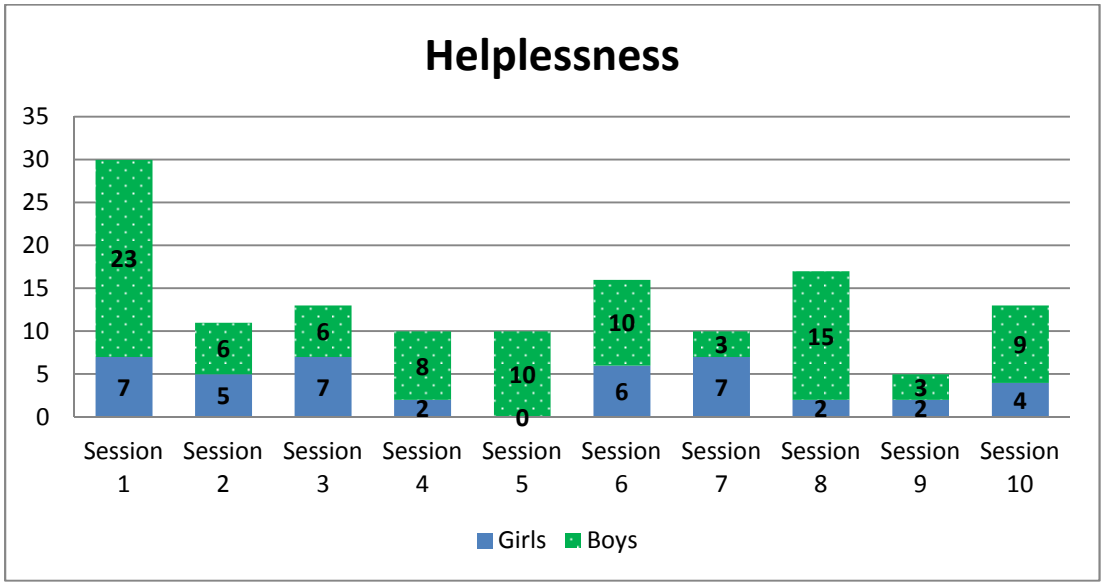
Figure 21. A comparison of boys and girls in the expression of messing/creating chaos



Helpless/Inadequate

Helplessness and inadequacy were not concepts that were discussed in the grief or process research. Thus, this theme expanded the current research in this area. The number of coded expressions of helplessness decreased across time in this study. It was coded the most frequently for Kai but was John's sixth most coded theme overall. Also, boys expressed more helplessness than girls throughout the study (see Figure 22). It was often communicated by children asking for help which was frequently done by Kai and Cara but also when they were submissive, as was the case for John during several sessions. Last, the younger three participants expressed more helplessness than the older three overall.

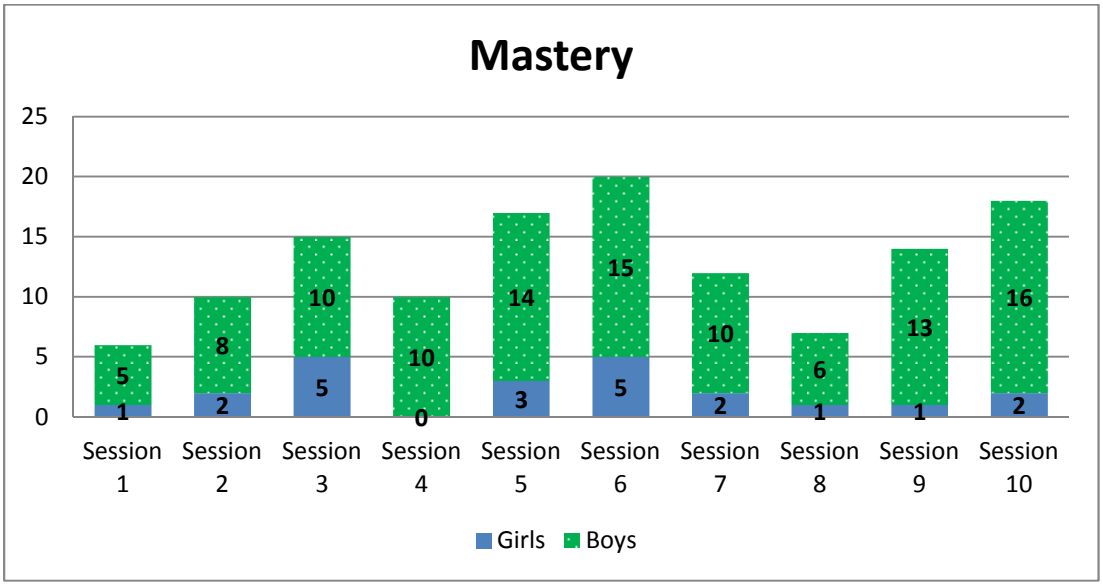
Figure 22. A comparison of boys and girls in the expression of helplessness



Mastery

As with many of the themes in this study, mastery was not discussed in prior research on grieving children but was included in a study on gender differences in children's play therapy themes. This study found that boys performed a higher number of mastery themes than girls did across sessions (Holmberg, Benedict, & Hynan, 1998). The current study confirmed these finding with boys expressing more mastery than girls. In addition, Kai had the most coded expressions and it was his fifth most coded theme overall. He had the most coded expressions during sessions five and six where he spent time climbing on the shelves and celebrated when he reached the top stating, "I did it." Last, mastery increased across time when looking at all of the participants (see Figure 23).

Figure 23. A comparison of boys and girls in the expression of mastery

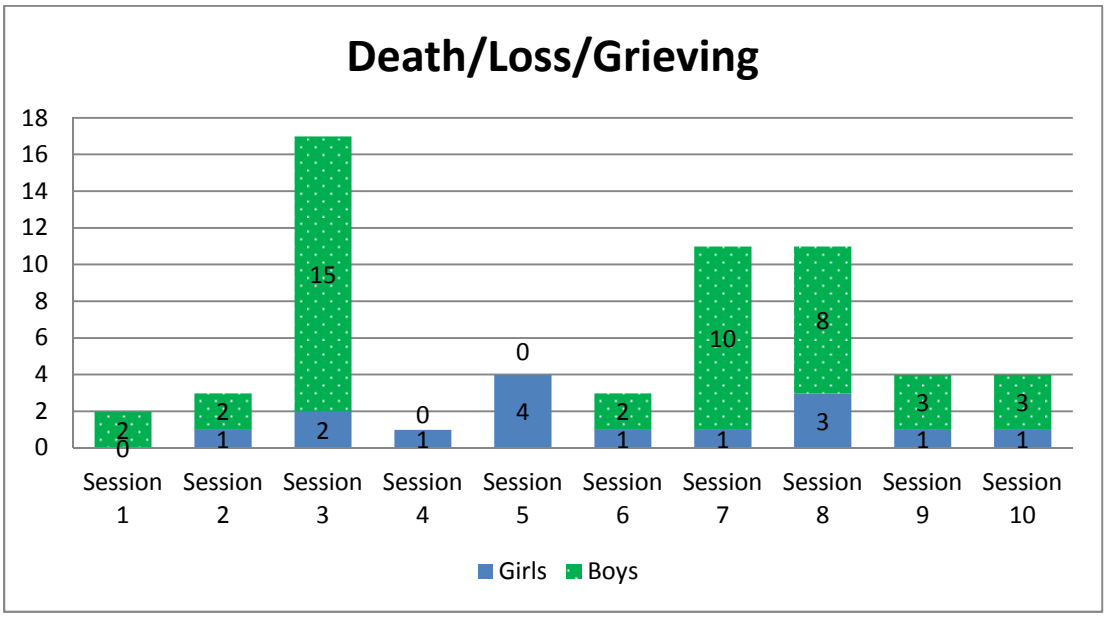


Death/Loss/Grieving

As this is a study on grieving children, it is important to discuss the theme death/loss/grieving. All of the participants mentioned death at least once during the ten sessions. Tyler made the most references to death out of all the participants. This may have been because he had experienced death more recently than the other children. When playing with the soldiers he talked about them dying and yelled “die” when punching the bop-bag dressed as a person. Furthermore, Cara and Kai talked about death the least. This may have been because of their developmental level. As previously discussed, research has indicated that children’s understanding of death increases with age (Swain, 1979). Still, children as young as three seem to have some idea of death with full understanding happening between ages nine and twelve (Kane, 1979; Melear, 1973; Nagy, 1948). Carlin exhibited that she was processing the concept when she asked the researcher, “Is your dad dead?” Moreover, John seemed to be moving to another level of understanding

when he talked about going to heaven after death. In general, expression of this code increased slightly with boys expressing it three times more than girls (see Figure 24).

Figure 24. A comparison of boys and girls in the expression of death/loss/grief



Other themes

The remaining six play themes that were coded less than 100 times each and included broken, burying/drowning, cleaning, rescue/protect, sorting/organizing, and safety/security. None of the remaining codes were addressed in grief research. However, some were touched on in Holmberg, Benedict, and Hynan's (1998) study on gender differences. They found that girls had a higher proportion of sessions with the theme of fixing which was similar to the theme rescue/protect in the current study. Furthermore, the themes safety and broken were included in this study but the results were not significant when looking at gender. In the current study, all of the remaining themes were coded more often in boys than in girls with the exception of cleaning which was slightly higher in girls. This data suggests that, in general, boys' play themes were more varied

than girls' overall.

For three out of these six themes, Kai had the most coded expressions: broken, burying/drowning, and safety/security. The theme broken was focused around toys breaking in the room. Kai: "That one, that one break apart." His expression of burying/drowning consisted of him burying things in the sandbox and putting soldiers in the bucket of water. Last, Kai's expression of safety/security included hiding in the room, Kai: "It's very safe in there" and putting toys in a "safe spot." Kai exhibited empathy through the broken and safety themes, expressing concern for the toys.

When looking at the remaining three themes, Cara had the most coded expressions of cleaning and Tyler had the most for rescue/protect and sorting/organizing. Cleaning was Cara's sixth most coded theme overall. She spent time cleaning the toys and the room. At one point she sang, "Sweep and I dust, sweep, sweep, sweep, and da-da-da." In addition she stated that she had to "do everything." Cleaning was a way for her to express a caretaking role in the playroom. Tyler spent time protecting the bop-bag in the room but also protected the researcher by giving her a shield. Through these actions he expressed empathy and concern for others. Last, he sorted and organized the toys before doing certain activities such as play store. This code seemed to be way for children to have a sense of control in the playroom.

Wong-Baker

A unique piece of this study was the use of the Wong-Baker to gain insight into the emotional state of the child before and after each session. Changes in the Wong-Baker scores occurred primarily in the three younger children. Prior to session eight, Kai's before and after scores had all been tens. In session eight, his before score was a

four and his after score a zero. His after scores remained zeros in the final two sessions, indicating that as he expressed and processed through his emotions, his level of pain decreased. Thus, session eight appeared to be a changing point for Kai.

Cara and Carlin's scores and the Wong-Baker were more variable. Cara's before scores were always zeros but her after scores spiked to a ten in sessions two and five and an eight in session three. In addition, Carlin's before scores were zero except in the first session in which it was a two and the fifth session where it started out as a ten. In sessions, one, two, three, five, six, nine and ten her after scores were higher than her before scores. The variability in their after scores seems to indicate that sessions were bringing up thoughts and feelings that increased these two participants pain but also that they were processing through them.

For the three older participants, Corinne, John, and Tyler, they picked zeros before and after each session with two exceptions. In his last session in the playroom, John picked a two before and a zero after, and in Tyler's second session he picked a two before and a zero after. This could have been because the older children did not want to communicate their emotions in a concrete way and instead acted as if things were okay which was contrary to their behavior in the playroom and their results on the Child Behavioral Checklist and Parenting Stress Index.

Grief Symptoms

The first goal of this study was to examine how the process of play impacted the symptoms of grief. These symptoms were measured using the Child Behavioral Checklist (CBCL) and the Parenting Stress Index (PSI). On the CBCL, the majority of the participants did not have scores in the clinical range with the exception of Carlin. Still,

scores were tracked across time for all participants. Four out of the six participants had a decrease in internalizing scores. As previously stated, Corinne's posttest scores were not obtained but on her midpoint assessment her internalizing scores had remained the same. In addition, Cara's internalizing scores increased from pretest to posttest by 12 points.

When looking at the two participants age five and under, Cara had an increase in all scores with the exception of withdrawn which decreased and attention, sleep and ADHD which all stayed the same. Kai only had an increase in two areas, attention problems and oppositional defiant problems. In addition, he had a decrease in sleep, affective, and anxiety problems as well as internalizing behaviors as previously mentioned. Furthermore, Kai had a decrease in his personal stress score and total stress score, whereas Cara experienced an increase on both of these scores. Thus, these two children exhibited different responses to grief and the process of play therapy with Kai seeing more improvement than Cara. This may have been because Cara's family was experiencing additional stressors towards the end of the study including moving and changing schools.

Among participants age six to ten, all had a decrease in conduct problems, although Tyler's was only a one point decrease. Corinne's score had been in the borderline clinical range but decreased by three points at her midpoint moving it to the normal range. In addition, all four showed a decrease in attention problems on the syndromes scale again with Corinne's score being taken at the midpoint. Three out of the four had a decrease for rule-breaking behaviors when looking at pretest and posttest scores with Corinne having a two point increase (again for her mid-point score). There were no similar trends in the remainder of the scores. When looking at the pre- and

posttest scores on the PSI for this group, Carlin, John and Tyler all had a decrease in their stress score while Corinne's increased (again at the midpoint).

Grief as a process

The results of the CBCL and the PSI, demonstrated the differences in the symptoms that children exhibit while grieving. Furthermore, the variety of emotions expressed and play themes displayed during the intervention support prior assertions that, for bereaved children, grief appears to be an individualized process (Andrews & Marotta, 2005; Christian, 1997). This was seen clearly when looking at Cara, Carlin, and Corinne. Each of them had experienced the same loss at the same time but were at different developmental levels and manifested different behaviors. In addition, Carlin seemed to be struggling more than her siblings when looking at her CBCL scores. This supports previous research that suggested that some children may be able to cope with death over time, while for others it may interfere with their social, emotional, or physical development (Webb, 2002).

In addition, many scores increased for the participants which supports that play is a way for children to process through their emotions. Kai seemed to have the most apparent change in all areas including the CBCL, PSI, and Wong-Baker. This may suggest that play therapy is beneficial for younger children who have difficultly verbalizing their emotions. Furthermore, the variety of differences for each child on all measures indicates that grief may be an individualized process particularly for children. Thus, providing them with an environment without expectations or a curriculum in which they can express themselves through a variety of means is valuable for this population.

Academic Difficulties

Although it was not a focus of this study, previous research has suggested that grieving children often experience difficulties in school (Balk, 1993, 1996; Bluestone, 1991; Osterweis, Solomon, & Green, 1984; Silverman & Worden, 1993; Tait & Depta, 1993.) In the current study, two of the participants had experienced problems in school. Carlin's mom reported that two months into her previous year of school, she didn't want to go into class. She cried and convinced her counselor to keep her in the office. She stayed in the office during class time for over two weeks before her mom found out. In addition, she struggled with "socialization skills." At the midpoint assessment, Tyler's mom reported that during the past couple of weeks he had being having trouble focusing at school and was rushing through his work. These two examples provide further support that grief impacts children in a variety of ways.

Limitations of the Study

One of the primary limitations of this study was sample size. The researcher spent over a year attempting to recruit participants for this study but was not able to get the number that was expected. Because of the low number of participants and the number that dropped out, a control group was not used which is another limitation. It would have been useful to have a control group consisting of children that had not experienced a recent death of a significant individual in their lives. Having a baseline of the emotions and play themes expressed by non-bereaved children would have allowed the researcher to better delineate which emotions and themes were common in the play therapy process compared to bereaved children. This would have addressed another limitation of the

study which was that it was assumed that the behaviors that manifested in this study were directly related to grief.

The participant selection was limited to individuals that attended peer support groups in a single city in the United States which decreases generalizability. However, the results would not have been generalizable even if a wider sample was used because it was a case study design. In addition, three of the participants were a sibling group which meant that they had a prior relationship which was also a limitation. However, it also provided the researcher the opportunity to observe the differences in their behaviors and reactions to the same loss which provided an alternative perspective on the process for individuals.

An additional limitation of this study was that the groups were not consistent because of dropouts and missed sessions. This meant that Kai only had four of his session with another participant. The remaining six sessions were individual play therapy. Also, both John and Tyler had sessions alone in the playroom when one of them could not attend. Last, Cara and Carlin had a session in which Corinne was absent. Therefore, the process was not all group play therapy and the dynamics changed for all of the participants because of these changes in configurations.

Finally, this study did not account for other variables such as income, level of support, or other losses. It is likely that income decreased because of the death which may have increased stress. Also, additional losses such as having to sell a home, moving, or other changes as a result of the death may have further exacerbated the symptoms. In addition, level of family or community support may have mitigated some of the symptoms and stressors if it was higher but may have intensified them if it was lacking.

Implications for Further Study

The results of this study sparked numerous ideas for further research. First, if this research were replicated, each session should be videotaped so that multiple evaluators can be used when coding the transcripts of the play therapy sessions. This would create more reliable results and would help fine tune the definitions of emotion and play theme codes. Next, conducting this research using a control group with children who have not experienced a death would provide a better understanding of how the emotions and play themes of grieving children are different than non-bereaved children. In addition, extending the length of the study to 12 or 14 sessions would show if there is a difference in the results on the three instruments used.

The results of this study also generated thoughts about how to expand the research. First, it would be simple to broaden the research to include other types of loss such as the death of a pet, divorce, moving, financial loss and children in foster care. Moreover, research comparing child-parent-relationship therapy to play therapy to see if one is more effective than the other and comparing individual and group play therapy to see if there is a difference in the process might be considered. Last, longitudinal work to see how symptoms change across time and to identify the lasting effects of the play therapy intervention would be valuable.

Conclusion

Even though each of these children experienced the same loss, the death of their father, how they responded to it varied greatly. In this study, all the participants parents with the exception of Tyler, expressed concern that the process would somehow bring up feelings that the children had already dealt with or moved past. However, because of the

nature of play therapy, there was no agenda and the topic of death was not introduced by the researcher. Instead, the children were provided with a safe space and the means to express themselves in the manner of their choosing.

The results of the children's experience in the playroom indicate several things. First, grief appears to be a unique process. This is supported by the variety of emotions that were expressed, play themes that were utilized, behaviors that were identified on the CBCL, the stress scores on the PSI, and the results of the Wong-Baker. Second, there seems to be differences in the process when looking at gender. There were certain themes and emotions that were frequently manifested more in one group over the other. Finally, the impact of death on children is multifaceted and thus not easily resolved. This means that even though children may not be openly talking about their loss it does not mean that they have finished grieving their loss.

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Appendix A

DEMOGRAPHIC DATA

The following information is about the child participant:

Age of participant: _____ Male or Female (circle one)

Number of siblings in the home: _____

Please list age and sex of each sibling: _____
(i.e. female, age 8)

_____

_____

Approximate number of Peer-Support groups your child has attended: _____

Other treatment/support child has received: _____

(i.e. individual or family counseling, counseling through school, support from church, etc.)

If child received other treatment/support how long did your child attend?_____

(i.e. number of days, weeks, months, or years)

The following information is about the deceased:

Age of deceased:_____ Male or Female (circle one)

Child's Relationship with the Deceased: _____

(i.e. mother, father, grandmother, cousin, friend, etc.)

Amount of Time since death has occurred: _____ (i.e.

number of weeks, months, or years

How did the deceased die? _____ (i.e.

heart attack, stroke, cancer, car accident, etc.)

How much time did child have to prepare for the death? _____

(i.e. number of weeks, months, or years)

Appendix B

Date/Session #_____/____ Code #_____

GROUP PLAY THERAPY SESSION SUMMARY

Page 1 of 3

Signature on bottom of each page required

Counselor_____ Theory_____

Specific Interventions Utilized_____

Children/Age A._____ C._____

B._____ D._____

I. SUBJECTIVE: (Feelings Expressed): *Place letter above all that apply (including capitalized words). Indicate predominate feeling(s) by circling letter*

HAPPY: relieved, satisfied, pleased, delighted, excited, surprised, silly

SAD: disappointed, hopeless, pessimistic, discouraged, lonely

ANGRY: impatient, annoyed, frustrated, mad, mean, jealous

AFRAID: vulnerable, helpless, distrustful, anxious, fearful, scared, terrified

CONFIDENT: proud, strong, powerful, determined, free

HESITANT: timid, confused, nervous, embarrassed, ashamed

CURIOUS: interested, focused

FLAT: restricted, contained, ambiguous

II. OBJECTIVE:

A. TOYS/PLAY BEHAVIOR *Place letter above all that apply, give brief description of play. In the blank, indicate meaningful/sustained play with a "*", indicate first time happenings with "1st", indicate discontinued play as "DP", Indicate play disruption as "PD", and indicate any therapist initiated activity as "TH".*

A. ___ B. ___C. ___ D. ___ hammer/log/woodworking

A. ___ B. ___C. ___ D. ___ sandbox/water/sink

A. ___ B. ___C. ___ D. ___ puppets/theater

A. ___ B. ___C. ___ D. ___ kitchen/cooking/food

A. ___ B. ___C. ___ D. ___ easel/paint/chalkboard

A. ___ B. ___C. ___ D. ___ riding car

A. ___ B. ___C. ___ D. ___ bop bag/bean bag

A. ___ B. ___C. ___ D. ___ dress up/jewelry/hats/masks/wand

A. ___ B. ___C. ___ D. ___ crafts table/clay/markers/paints/etc.

A. ___ B. ___C. ___ D. ___ doll house/doll family/bottle/ pacifier

A. ___ B. ___C. ___ D. ___ cash register/money/telephone/camera/flashlight

A. ___ B. ___C. ___ D. ___ medical kit/bandages

A. ___ B. ___C. ___ D. ___ musical instruments

A. ___ B. ___C. ___ D. ___ games/bowling/ring toss/balls/etc.

A. ___ B. ___ C. ___ D. ___constructive toys (tinkertoys, etc.)

A. ___ B. ___ C. ___ D. ___vehicles/planes

A. ___ B. ___ C. ___ D. ___animals: domestic/zoo/alligator/dinosaurs/shark/snake

A. ___ B. ___ C; ___ D. ___soldier/guns/knife/sword/handcuffs/rope

A. ___ B. ___ C. ___ D. ___blocks/barricade

A. ___ B. ___ C. ___ D. ___sandtray/miniatures

_____

Counselor's signature with credentials

D:Sue's Zip/Group Therapy/Group PT Session Summary.doc 07/18/2002

B. **SIGNIFICANT VERBALIZATION**: *CH= Child initiated (indicate which child by A, B, etc) TH= Therapist initiated*
Note significant interaction between children (ex: A to B.....)

C. **LIMITS SET**: *Write limit set beside the category & indicate child's letter and # of times limit set. If ultimate limit was set, describe process.*

PROTECT CHILD (HEALTH/SAFETY):

PROTECT THERAPIST/PROMOTE THERAPIST ACCEPTANCE:

PROTECT ROOM/TOYS:

STRUCTURING:

REALITY TESTING:

SOCIALLY UNACCEPTABLE BEHAVIOR:

III. ASSESSMENT: General Impressions/Clinical Understanding

A. **DYNAMICS OF SESSION**: *Rate 0=low, 10=high): Child's play/activity level: A.___ B.____ C.____ D.____*
Intensity of play: A.___ B.____ C.____ D.____ Inclusion of therapist/level of contact A.___ B.____ C.____ D.____
Put child's letter beside appropriate level (#). Circle level # and Child's letter. (1 abc)

Destructive	1	2	3	4	5	6	7	8	9	10	Constructive
Messy	1	2	3	4	5	6	7	8	9	10	Neat

B. **PLAY THEMES:** place letter above all that apply (including capitalized words). Indicate predominate theme by circling letter.

EXPLORATORY: (not a true play theme – rather the way child gets comfortable & familiar with playroom)

RELATIONSHIP: connecting/approval seeking/manipulative/competitive/collaborative/testing limits

POWER/CONROL:

HELPLESS/INADEQUATE:

AGGRESSION/REVENGE:

SAFETY/SECURITY:

MASTERY: constructive/competency/integration/resolution

NURTURING: self-care/reparative/healing

DEATH/LOSS/GREIVING:

SEXUALIZED:

OTHER;

Counselor's signature with credentials

C. **OVERALL, CHILD'S BEHAVIOR/AFFECT WAS:** (refer to explanation of how to code child's behavior/affect)

Sad/depressed/angry	1	2	3	4	5	6	7	8	9	10	Content/satisfied
Anxious/insecure	1	2	3	4	5	6	7	8	9	10	Confident/secure
Low frustration tolerance	1	2	3	4	5	6	7	8	9	10	High frustration tolerance
Dependent	1	2	3	4	5	6	7	8	9	10	Autonomous/Independent
Immature/regressed/hypermature	1	2	3	4	5	6	7	8	9	10	Age appropriate
External locus of control	1	2	3	4	5	6	7	8	9	10	Internal locus of control (self-control)
Impulsive/easily distracted	1	2	3	4	5	6	7	8	9	10	Purposeful/focused
Inhibited/Constricted	1	2	3	4	5	6	7	8	9	10	Creative/Expressive/Spontaneous/Free
Isolated/Detached	1	2	3	4	5	6	7	8	9	10	Connected/Sense of Belonging

D. **OVERALL, CHILD'S PLAY WAS:**	**OVERALL, GROUP'S PLAY WAS:** *Collaborative, Connection facilitated, Partners in crime, Ego strengthening, Problem solving,, Other*
A.	
B.	
C.	
D.	

E. **GROUP INTERACTION**: (% of play time spent)

IP = Individual Play_____ PP= Parallel Play_____ CP = Cooperative Play_____ CF = Conflict_____ *Note which child initiated conflict*

F. **CONCEPTUALIZATION OF CLIENT AND CLIENT'S PROGRESS BASED ON THEORETICAL ORIENTATION:**

A.

B.

C.

D.

IV. GROUP PLANS/RECOMMENDATIONS: (include talking with parent(s)/school—requesting records, etc.)

A.

B.

C.

D.

Counselor's signature with credentials

Appendix C

List of Toys

Bop-bag (punching bag)
Animal figures (domestic, zoo, dinosaurs, shark, snake, etc.)
Human figures
Musical instruments
Basketball hoop
Foam balls
Doll house/doll family
Baby doll/baby carrier/bottle/pacifier
Plastic food/dishes
Wooden broom and mop set
Plastic cell phone
Play dough
Sandbox
Dress-up clothes (shield, Viking hat, dresses, crowns, etc.)
Soldiers
Plastic and foam sword
Handcuffs
Large blocks for building barriers
Puppets
Bubbles
Craft table (markers, crayons, yarn, feathers, ribbon, paint)
Paper
Glue
Tools
Medical kit
Vehicles/planes
Cash register/money
Constructive toys (building materials)

Appendix D

UNIVERSITY OF NEVADA, RENO SOCIAL BEHAVIORAL INSTITUTIONAL REVIEW BOARD
PARENTAL PERMISSION AND CONSENT TO PARTICIPATE IN A RESEARCH STUDY

TITLE OF STUDY: The Impact of Group Play and Group Activity Therapy on Symptoms of Grief in Bereaved Children.
INVESTIGATOR(S): Melinda N. Johnson (360)-903-1662; Jill Packman, Ph.D. (775) 682-5502
PROTOCOL #: SA09/10-149

PURPOSE

You and your child are being asked to take part in a research study. The purpose of this study is to understand the impact of group play therapy and group activity therapy on the symptoms of grief in children after the death of an important individual in their life.

PARTICIPANTS

Your child is being asked to participate because your child:

1) has experienced the death of an important individual in their life;
2) is between the ages of 2 and 17;
3) is fluent in written and spoken English.

You are being asked to participate in the study because you:

1) have a child that meets the requirements to participate in the study
2) are fluent in written and spoken English

It is expected that 20-80 children and 20-80 parents will participate in this study locally.

PROCEDURES

Group play and group activity therapy are two standard treatments that are used to help children and adolescents cope with and express emotions. Children 10 and under will receive group play therapy with a total of 3 children per group and those over age 10 will receive group activity therapy with a total of 5 children per group.

There will be two groups of participants: those who receive the treatment right away and those who will be invited to receive the same treatment at the end of the study. For both waitlist control and treatment groups, parents and participants will be asked to complete questionnaires. The questionnaires that are being used in this study are not a part of standard practice and are being used solely for the purpose of research. They also increase the time requirements for this study. The questionnaires used in this study will ask questions about you and your behaviors, your child and his/her behaviors and your relationship with your child.

If you agree to participate and allow your child to participate in this research study:

- You and your child will be placed in a treatment or waitlist control group
- You will be asked to meet and complete a demographic form along with two questionnaires.
- The questionnaires will be given at three points during the study: beginning, at the 5-week mark, and at the end of the study.
- The questionnaires will include questions about you, your child, and your relationship with your child

- Each time you fill out the questionnaires will take an hour and a half..
- Your child, if between the ages of 11 and 17, will also be asked to complete a questionnaire about him- or herself before the study, at the 5-week mark, and following the end of the study.
- If you and your child are in the waitlist group, when the study is over (after 10 weeks) your child and other teenagers will be invited to participate in the same activities that the treatment group did.

In addition to the above requirements, if you and your child are assigned to the treatment group:

- You will agree to transport your child to and from group sessions that will take place once a week for an hour and a half for 10-weeks;
- Your child will be asked to complete a short assessment before and after each session that will measure your child's level of emotional pain.
- Each group session will be audio taped and later transcribed to ensure that data is correctly recorded in written form. These tapes will be destroyed at the end of the study.

For the treatment group, all group sessions will take place at the Downing Counseling Clinic on the University of Nevada, Reno campus. For both the treatment and non-treatment groups, parents and children age 11 and over may complete paperwork, questionnaires, and tests at the Downing Counseling Clinic or the Solace Tree.

TIME COMMITMENT

Waitlist control group: Parent participants and child participants age 11 and over in the control group will be required to participate 4.50 hours.

Treatment group: Parent participants will be required to participate for a total of 4.50 hours; child participants 10 and under will be required to participate 15 hrs and those 11 and over 19.50 hours.

ALTERNATIVES

Alternative treatments for coping with symptoms of grief may include individual therapy, family therapy, group talk therapy, and peer-support groups.

If you are currently participating in peer support groups at the Solace Tree you may continue to participate in these groups. This study will in no way impact your participation in these groups at the Solace Tree nor will it affect any other services you or your child may be receiving.

DISCOMFORTS, INCONVENIENCES, AND/OR RISKS

The risk posed by this research is no more than minimal. However, for child participants in the treatment group, this study has the potential to elicit feelings that may make you or your child feel uncomfortable.

If you or your child are in need of additional support you will be given a referral for additional services. Parent participants and child participants age 11 and over in both the treatment and non-treatment groups will be required to make three separate appointments for an hour and a half in

order to complete assessments and questionnaires. In addition, child participants in the treatment group will be required to meet once a week for an hour and a half which has the potential to create a time inconvenience. Additionally, there may be risks that are unforeseen by the researcher.

BENEFITS

For the treatment group, the potential benefit of this study is that children and adolescent's symptoms of grief may decrease more rapidly. Also, their ability to cope and express feelings may increase. If this research indicates that group play and group activity therapy are effective in impacting grief symptoms this data may work toward establishing a standardized therapeutic intervention for children and adolescents that are coping with symptoms of grief.

For parent participants in the treatment group, it is anticipated that there may be a reduction in the level of stress experienced in the parent-child relationship. There are no expected benefits for participants in the waitlist control group unless your child participates in the therapy that will be offered after the study; in this case, the potential benefits are the same as above.

CONFIDENTIALITY

You and your child's identities will be protected to the extent allowed by law. You will not be personally identified in any reports or publications that may result from this study. Confidentiality will be broken if you or your child report wanting to hurt yourself or others. In addition, it will be broken if your child reports being abused or if you report abusing your child.

The Department of Health and Human Service (DHHS), other federal agencies as necessary, the University of Nevada, Reno Social Behavioral Institutional Review Board may inspect your study records.

Records will be stored in a locked filing cabinet in the principal investigators office. Each parent/child team will be given an identification number for the study. This number will correspond with your name and your child's name on a master list. This list will be kept separate from the data in order to protect privacy. The only identifying marks that will be on the assessments and questionnaires will be your identification number. Records will be kept for up to but no longer than 5 years at which point they will be destroyed.

COSTS/COMPENSATION

There will be no cost to you nor will you be compensated for participating in this research study. You will receive a pass for free parking for the duration of the study.

RIGHT TO REFUSE OR WITHDRAW

You may refuse to participate or withdraw from the study at any time and still receive the care you would normally receive if you were not in the study. This includes peer support groups at the Solace Tree. If the study design or use of the data is to be changed, you will be so informed and your consent re-obtained. You will be told of any significant new findings developed during the course of this study, which may relate to your willingness to continue participation.

TITLE OF STUDY: The Impact of Group Play Therapy on Reducing Symptoms of Grief in Bereaved Children.
INVESTIGATOR(S): Melinda N. Johnson (360)-903-1662; Jill Packman, Ph.D. (775) 682-5502
PROTOCOL #: SA09/10-149

QUESTIONS

If you have questions about this study or wish to report a research-related injury, please contact Melinda N. Johnson at (360) 903-1662.

You may ask about your rights and your child's as a research subjects or you may report (anonymously if you so choose) any comments, concerns, or complaints to the University of Nevada, Reno Social Behavioral Institutional Review Board, telephone number (775) 327-2368, or by addressing a letter to the Chair of the Board, c/o UNR Office of Human Research Protection, 205 Ross Hall / 331, University of Nevada, Reno, Reno, Nevada, 89557.

CLOSING STATEMENT

I have read ( ) this consent form or have had it read to me ( ). [Check one.]

Melinda Johnson has explained the study to me and all of my questions have been answered. I have been told of the risks or discomforts and possible benefits of the study.
If I do not take part in this study, my refusal to participate will involve no penalty or loss of rights to which I am entitled. I may withdraw from this study at any time without penalty.

I have been told my rights and my child's rights as a research subjects, and I voluntarily consent to participate in and give permission to allow my child participate in this study. I have been told what the study is about and how and why it is being done. All my questions have been answered.

I will receive a signed and dated copy of this consent form.

Signature of Participant Date

Signature of Person Obtaining Consent Date

Signature of Investigator Date

Appendix E

UNIVERSITY OF NEVADA, RENO SOCIAL BEHAVIORAL INSTITUTIONAL REVIEW BOARD
VERBAL ASSENT TO PARTICIPATE IN RESEARCH AGES 7-10, TREATMENT GROUP

TITLE OF STUDY: The Impact of Group Play and Group Activity Therapy on Symptoms of Grief in Bereaved Children.
INVESTIGATOR(S): Jill Packman, Ph.D. (775) 682-5502;
Melinda N. Johnson (360)-903-1662
PROTOCOL #: SA09/10-149

My name is Melinda Johnson.

I am asking you to take part in a research study. A research study is a way to learn more about something. I am trying to learn more about how to help kids deal with the feelings that happen after someone close to them dies.

If you agree to be in this study:

- You will also be asked to come to a group and play with other kids for one hour and answer some questions for 30 mins. Your mom or dad will bring you to the group once a week for 10-weeks. This will take 15 hours total.
- You will be playing in a group with kids about your own age that have also lost someone to death. There will be one or two other kids in the group with you.
- While everyone is playing, a tape recorder will be running so later I can listen to the tapes to help me remember what you and the other children said while in the group.
- Before we meet each time I will ask you to show me how you feel by picking a picture on a page and then after our playtime is over I will ask you to show me how you feel again.
- When you are playing with the other kids you might feel some feelings that you do not like.
- Playing with other kids might make you feel better and help you tell others how you are feeling.
- Your mom or dad will be answering some questions about you and how you act three different times during the 10 weeks you are in the group.

If you want, you can talk to your mom or dad right now before you choose to be in this study. I will also ask your parents if it is all right with them for you to be in this study. If your parents say that you can be in the study you can still say no.

You can ask me any questions that you have about this study and I will try to answer them for you.

Taking part in this study is up to you. No one will be upset if you don't want to be in this study. If you decide you don't want to do it you can also change your mind and stop any time you want.

Appendix F

Emotions Codes

Emotion Name	Basic Meaning
Confident/Persistent	Belief in one's self which is characterized by feeling proud, strong, powerful, determined, free and persistent.
Happy	A positive emotion connected with a sense of wellbeing that is indicative of pleasure. Feeling relieved, satisfied, pleased, delighted, excited, surprised, silly and content.
Sad	Feeling disappointed, hopeless, pessimistic, discouraged, and lonely.
Afraid	Feeling vulnerable, helpless, distrustful, anxious, fearful, scared, terrified, worried, apprehensive, or regret.
Hesitant	Feeling timid, confused, nervous, embarrassed, ashamed, undecided, and doubtful.
Angry	Feeling impatient, annoyed, frustrated, mad, mean and jealous.
Curious	Eager to learn or know. Feeling interested, focused, or watching others play.

Appendix G

Play Themes

Theme Name	Basic Meaning
Rescue/Protect	Characters in danger are rescued; toys/things are repaired or protected.
Broken	Characters being broken, sick, or hurt and needing repair.
Sorting/Organizing	Lining up toys, organizing sorting toys or objects into categories.
Messing/Creating Chaos	Characters or the child being messy or dumping things out.
Cleaning	Spontaneous cleaning or cleaning play.
Burying/Drowning	Characters/toys being buried or drowning.
Creative/Expressive Art	Painting, drawing, playing with musical instruments, dress-up, bubbles, building or creating something new, acting things out, and digging in the sandbox.
Safety/Security	Building cages and containers for characters, objects or self; keeping things clearly in or out of spaces; protecting, keeping characters or things safe; needing to be kept safe; invincibility; hiding to be safe; protecting self from things or people.
Mastery	Constructive, competency, integration, and resolution; superiority or victory; expert skill; ego building activities; achievement and accomplishment; showing off abilities and strengths.

Nurturing	Self-care, reparative, healing, and making amends following conflict. Protect, support and encourage; caregiving activities.
Aggression/Revenge	Hostile play: hitting, kicking toys or other children; throwing toys; pushing or shoving other children.
Helpless/Inadequate	Weak, dependent, submissive.
Power/Control	Command over others; dominate; manipulating others.
Relationship	Connecting, approval seeking, manipulative, competitive, collaborative, testing limits, sharing; seeking assistance; expressing care or empathy towards another person/toy.
Exploratory	The way a child gets comfortable and familiar with the playroom; climbing up on shelves, examining different toys; observing and trying to gain information about the room; asking questions about the room; asking questions about what materials are available or how objects work.
Death/Loss/Grieving	Death during play; death of an object; talking about death, loss, grieving.

Appendix H

Total Emotions

Numbers indicate the number of time that emotion was coded for each session

Emotions	Session 1	Session 2	Session 3	Session 4	Session 5	Session 6	Session 7	Session 8	Session 9	Session 10	**Total**
Afraid	12	26	37	13	34	30	13	22	20	20*	**227**
Anger	68	72	77	59	57	88	74	59	61	61*	**676**
Confident	81	75	67	81	92	92	107	97	83	82*	**857**
Curious	213	126	137	134	159	137	174	104	172	78*	**1434**
Happy	134	86	116	83	131	82	127	106	129	139*	**1133**
Hesitant	49	35	31	25	39	20	23	15	40	11*	**288**
Sad	19	20	27	29	19	36	17	7	9	12*	**195**

*Data missing from session 10 for participant Corinne.

Appendix I

Total Play Themes

Numbers indicate the number of time that play theme was coded for each session

Play Themes	Session 1	Session 2	Session 3	Session 4	Session 5	Session 6	Session 7	Session 8	Session 9	Session 10	**Total**
Aggression/ Revenge	82	52	23	28	34	15	18	33	30	11*	**326**
Broken	3	0	0	2	2	2	3	5	0	1*	**18**
Burying/ Drowning	0	4	2	2	0	0	0	2	0	2*	**12**
Cleaning	3	23	15	11	14	14	9	2	3	3*	**97**
Creative/ Expressive	73	78	53	76	65	60	119	95	62	49*	**730**
Death/Loss/ Grieving	2	3	17	1	5	3	10	12	3	4*	**60**
Exploratory	110	65	80	59	48	37	57	34	37	23*	**550**
Helpless/ Inadequate	30	11	13	10	10	16	10	17	5	13*	**135**
Mastery	6	10	15	10	17	20	12	7	14	18*	**129**
Messing/ Creating Chaos	1	6	19	17	41	9	10	11	20	7*	**141**
Nurturing	12	13	5	5	29	21	41	14	14	11*	**165**
Power/ Control	90	75	93	59	63	62	35	82	57	42*	**658**
Relationship	136	129	131	122	124	124	80	108	101	94*	**1149**
Rescue/ Protect	5	4	5	2	13	13	5	5	4	5*	**61**
Safety/ Security	5	3	7	5	2	2	3	1	1	7*	**37**
Sorting/ Organizing	2	2	14	5	10	13	4	2	3	3*	**58**

*Data missing from session 10 for participant Corinne.