

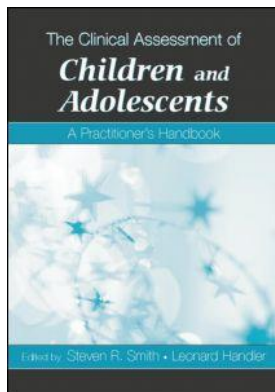
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The Clinical Assessment of Children and Adolescents: A Practitioner's Handbook

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Play Assessment

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PART

II

ASSESSMENT TECHNIQUES

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PLAY ASSESSMENT

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Why is the assessment of pretend play important? Although clinicians understand the importance of play in child development and use play in a variety of ways in psychotherapy, a formal assessment of play has not been a standard part of child psychological assessment.

The purpose of this chapter is to discuss the ways in which play assessment could contribute to treatment planning and evaluation of treatment effectiveness. We review several play assessment measures. In addition, the Affect in Play Scale (APS) is one possible instrument to utilize in a clinical setting. We briefly review the current research status of the APS and present case material to illustrate how the scale could be used. We also describe a new brief rating version of the scale that rates the child's play as it occurs and does not require videotaping.

IMPORTANCE OF PLAY ASSESSMENT

Children's pretend play is important in child development and in psychotherapy (Russ, 2004; Singer & Singer, 1990). Children's play provides a window on both cognitive and affective processes. Russ (2004, pp. 2–5) categorized different play processes that can be observed and measured in play. They are:

Cognitive Processes

- Organization—the ability to tell a story with a logical time sequence and indications of cause and effect
- Divergent thinking—the ability to generate a number of different ideas, story themes, and symbols
- Symbolism—the ability to transform objects (blocks, Legos) into representations of other objects (e.g., a block becomes a telephone)
- Fantasy/make-believe—the ability to engage in “as if” play behavior; to pretend to be in a different time and space

Affective Processes

- Expression of emotion—the ability to express positive and negative affect states and actual emotions in a pretend play situation
- Expression of affect themes—the ability to express affect content and images in play
A doll becomes a monster, which is aggressive or scary content, even if no emotion accompanies it
- Comfort and enjoyment in the play experience—the ability to be involved in play
- Emotion regulation and modulation of the affect in the play—the ability to contain the emotion within a narrative

Interpersonal Processes

- Empathy—The ability to express concern for others and to take the role of the other
- Communication—the ability to express ideas and emotions to others
- Interpersonal schema—capacity for self-other differentiation and trust in others

Play processes relate to important areas of adaptive functioning in children. For example, play has been found to relate to creative problem solving (Dansky, 1980; Russ & Grossman-Mckee, 1990); perspective-taking (Fisher, 1992), and coping (Christiano & Russ, 1996).

In child therapy, play is often used as a form of communication with the therapist. In addition, children use play for expression of thoughts and feelings, and for working through and processing emotional material. Assessment of play skills can help determine whether and how a child can use play in therapy.

MEASURES OF CHILDREN'S PLAY

There are play measures that have been developed that could be used for assessment for therapy. We review a few of these measures here, but for a comprehensive review, see Gitlin-Weiner, Sangrund, and Schaefer (2000).

Play Therapy Observation Instrument

The Play Therapy Observation Instrument (PTOI) was originally developed by Howe and Silvern (1981) and adapted by Perry (Perry & Landreth, 1991) to assess children's play behavior in a way that would meaningfully inform diagnosis, treatment planning, and outcome measurement. Three areas of functioning are assessed with 13 items: (a) social inadequacy, (b) emotional discomfort, and (c) use of fantasy. Six items do not fall onto the three domains. The first item on the social inadequacy subscale refers to incoherent or bizarre content. This refers to disjointed, psychosis-like trains of thought or statistically infrequent play behavior. Other items on the social inadequacy scale include the exclusion of the therapist from the child's activities, responding to the therapist's interventions with hostility or withdrawal, and the degree of body stiffness that the child exhibits in gross and fine movements. One aspect of the emotional discomfort subscale includes the quality and intensity of affect that the child expresses; this refers to the child's mood, not the affect-theme within the play. Other areas of the emotional discomfort scale include aggression toward the therapist, con-

flicted play, and anxiety as expressed by talk about concerns or by disruption of the play. The use of the fantasy subscale includes items such as the amount of time spent in fantasy versus reality, time spent concentrating on characters rather than things, number of different fantasy stories, and number of different roles enacted.

The PTOI was designed to be used in rating 12-minute segments of a videotaped play therapy session. For each subscale item, the rater chooses a descriptive number that best represents the frequency and/or intensity of the child's play behavior as it occurred over the 12 minutes. In the original development study (Howe & Silvern, 1981) two undergraduate students who were not therapists were reliably trained on the PTOI after 20 hours by use of a training manual and by observation of videotaped sessions of play therapy and live play therapy sessions.

The PTOI has been found to discriminate adjusted from maladjusted children most strongly on the emotional discomfort subscale (Perry & Landreth, 1991). Rosen, Faust, and Burns (1994) used the PTOI with children participating in either psychodynamic or client-centered play therapy and found no significant differences between children's play in the two approaches. This may have been due to the study's small n ($n = 6$). Changes were found, however, in the fantasy play and quality of interaction subscale scores from the first therapy session to the eighth session. This suggests that the PTOI may be a useful instrument for detecting changes in a child's functioning during treatment, as it identifies changes in both process and content.

There are some limitations to the PTOI. As Perry and Landreth (1991) note, there are only two published studies of the PTOI. There is a need for developmental norms and a standardized administration (Perry & Landreth, 1991). They suggest that future research examine the use of the PTOI in direct observation of a session, rather than through the use of a videotape. This step may be particularly important for therapists who wish to assess play behaviors, but who have limited space or funds for video equipment.

NOVA Assessment of Psychotherapy

The NOVA Assessment of Psychotherapy (NAP) was also designed to assess the play therapy process and outcome by capturing components of the child's and therapist's behavior during play (Faust & Burns, 1991). This scale was intended for use in both clinical and research settings. As such, there is a longer, more comprehensive scale intended for research use and a shorter, more convenient version intended for clinical use. In the long version, 17 child behaviors and 12 therapist behaviors are coded in 7-second intervals. Raters tally the presence of any of the scale codes during each 7-second segment. These behaviors fall into four categories: (a) child verbal, (b) child nonverbal, (c) therapist facilitating, and (d) therapist channeling. "Therapist facilitating" refers to behaviors such as reflecting, interpreting, modeling, or imitating. "Therapist channeling" refers to questioning, suggesting, responding, confronting, setting limits, or demanding. Some of the relevant aspects of the child's play that are coded include valence of affect expressed (i.e., positive or negative), cooperative behavior, and aggressive behavior. The scale can be scored during live interaction or from videotape. Initial single case studies of the validity and reliability of the scale suggest that, like the PTOI, the NAP may be useful for assessing affective and behavioral changes during the treatment process (Faust & Burns, 1991).

Faust and Burns' (1991) description of preliminary data from pilot studies indicates that the NAP shows promise, like the PTOI, for assessing affective and behavioral changes during the treatment process. There are several limitations to the NAP at this time, however.

To our knowledge, there are no published studies describing the psychometric characteristics of the instrument and no normative data for the different scales. The authors report that there is psychometric information available in the manual (Burns & Faust, 1989). Although there is a manual that can be used for training and the authors report interrater reliability for a single case study (Faust & Burns, 1991), it is not clear how long training of clinicians in the field would take and how easily adequate agreement would be obtained.

Children's Play Therapy Instrument

Like the other two play therapy instruments described thus far, the Children's Play Therapy Instrument (CPTI; Kernberg, Chazan, & Normandin, 1998) was designed to measure change and outcome in child treatment. In addition, it is intended to be used as an aid in diagnosis. The CPTI assesses play comprehensively; the domains within it contain a number of psychodynamic constructs. The CPTI comprises three levels: 1) Segmentation of Child's Activity, 2) Dimensional Analysis of the Play Activity, and 3) Pattern of Child Activity over Time.

In the first level, *Segmentation*, the therapist/observer identifies segments of the therapy session as either Non-Play (in which the child is engaged in an activity other than play), Pre-Play (in which toys are arranged and the child prepares for play), Play, or Interruption (in which the play stops because of a distraction). The second level of the CPTI, the *Dimensional Analysis* of the play, has three domains, each with its own subcomponents. One of the dimensional aspects of the CPTI is the *Descriptive Analysis*. In this domain, the category of play is described (e.g., gross motor, fantasy, game play, etc.), the script is described (this assesses the child's autonomy and reciprocity and the therapeutic alliance), and the sphere of play is described (where the play takes place). The next domain under the Dimensional Analysis of the play is the *Structural Analysis*. When the structure of the play is analyzed, affective components (types of affect and modulation), cognitive components (how objects and people are depicted), narrative components (topic and theme of play and use of language), and developmental components (estimated developmental level, gender identity, and social level) are all assessed. The final domain included in the Dimensional Analysis of the play is the *Functional Analysis*. In the Functional Analysis, the therapist assesses coping and defensive strategies, as well as a rating of the degree of the child's subjective awareness of herself as a player. The third level of the CPTI assesses *Patterns over Time* (e.g., the sequence and length of the different segments of Pre-Play, Play, Non-Play, and Interruption).

In the initial reliability study (Kernberg et al., 1998), three raters were trained for 15 hours to use the CPTI to assess 8 videotaped play therapy vignettes. On the majority of the domains the raters reached agreement ranging from acceptable to excellent. There were a few subscales, however, in which adequate agreement was not obtained. The authors concluded from this that further development of some of the scales was needed. The CPTI has been used to assess changes in play over the course of 7 months in a single case study of a 2-year, 5-month-old child with autistic features (Chazan, 2000). Chazan (2000) noted an increase in time spent in play and a decrease in non-play and pre-play activities. Changes were also observed in the child's affect expression, cognitions, use of language, developmental ratings, and adaptive functioning

The CPTI appears to be a clearly conceptualized, theory-based measure that shows promise for comprehensive assessment of a child's play activities in therapy. The CPTI is still in the preliminary stages of development. Although preliminary interrater reliability has been established for the measure, further work must be done to establish its reliability definitively. In addition, construct validation has to occur. Kernberg et al. (1998) state that they plan to

validate the CPTI as a diagnostic tool that distinguishes among diagnostic categories and is sensitive to changes occurring over time.

Affect in Play Scale

The Affect in Play Scale is a measure of pretend play that assesses both cognitive and affective play processes with a standardized play task, instructions, and coding system (Russ, 1987, 2004). The APS is appropriate for children from 6 to 10 years of age. The task consists of puppets and blocks, and the child is asked to play with them any way he wants to for 5 minutes. The play is videotaped and then coded on variables of organization of play, imagination, comfort, amount of affect, and variety of affect content categories. There are 6 negative affect categories (i.e., aggression, sadness) and 5 positive affect categories (i.e., happiness, nurturance). Each unit of affect expression is scored. A detailed coding manual has been developed (Russ, 2004). The APS attempts to measure the cognitive and affective play processes described earlier in this chapter.

A large number of validity studies have been carried out with the APS (see Russ, Niec, & Kaugars, 2000, for a review). The APS has been related to theoretically relevant criteria such as creativity, coping, and emotional understanding. In a recent study by Russ and Schafer (in press) the amount of affect in play related to the amount of affect in descriptions of memories in first and second graders. This finding has implications for therapy in that the expression of emotion in play is related to the ability to think about and describe emotional events in memory.

Although the APS has engendered a significant amount of research in the field of children's play, the fact that the play sessions must be videotaped for later scoring and that the raters must be well trained in scoring the APS limits its utility in the world of managed care. It would be beneficial to both clinicians and the field of play research if there were an instrument that could be used to more easily assess children's play. An easier measure would serve the dual purposes of breaking the ice and making the child comfortable, as well as allowing the clinician to gain immediate information about the affective and cognitive dimensions of the child's play. It could also be used as a measure of change in the treatment process and as an outcome measure.

In the development of this more efficient, brief rating scale version of the APS (Affect in Play Scale–Brief Rating; APS-BR), the main consideration was to produce a version of the APS that could be substituted for the APS and scored quickly during observation, while maintaining the integrity of the original scale. A new version in the familiar form of a behavioral rating scale would allow clinicians to easily add a measure of play to an assessment. Because of the ease with which this assessment could be carried out, it could encourage the use of play in more child-directed research. Unlike the original APS, the brief behavioral rating version does not require the use of videotape of the play. This will make the assessment more manageable and will increase parental consent for studies in which it is used, as no videotaped record will be kept of the children. Furthermore, because a brief rating scale version would not require videotaping the child, it would be considerably less cumbersome and easier to use during therapy.

Like the APS, the APS-BR scores the child's pretend play on both cognitive and affective dimensions. The cognitive scores include Organization, Imagination, and Comfort. The affective scores include Frequency of Affect Expression and Tone of Affect Expression. Though the APS-BR is very similar in format to the original APS, there are some notable differences. A major difference between the original APS and the new APS-BR is the way in

which the frequency of affect expression is scored. On the original APS, the rater scores the total frequency of units of affective expression and classifies the content of the affect according to the 11 categories. While feasible for the videotaped version of the APS, classifying the content of affect in terms of 11 categories during a live 5-minute observation is not practical. Therefore, on the APS-BR, the rater is instructed to "attempt to tally each unit of affect expression. The tally should be an estimation, so as not to detract from the other rating." Instead of a total frequency count, the rater is instead asked to rate the total frequency on a 1–4 scale from low to high. In addition, the APS-BR asks the observer to rate the "overall tone of affect in the story, based on the average amount of positive or negative affect expression in the affect units in the child's play." The manual provides the rater with brief descriptions of each of the 4 points on the scale, along with clear examples of each point. Because the focus is on rating the relative positive/negative tone of the affect expression, and not on the specific affect categories, the APS-BR does not produce a variety of affect categories score.

Apart from these changes, the other notable change from the APS to the APS-BR is the Likert scale scoring. On the original APS, scoring for Organization, Imagination, and Comfort was done on 1–5 Likert scales. On the APS-BR, these scales were adapted into 1–4 Likert scales. The Likert scale was simplified because the rater would not have the luxury of pausing and rewinding videotaped observations when using the APS-BR.

The changes made for the APS-BR do not result in a significant deviation from the format of the original APS. The rater is still scoring the child on the total amount of affect expressed during the 5 minutes, as well as the tone of the affect expressed, and the quality of the fantasy in the play. In addition, the same play task, toys, and instructions are used.

A current study (Sacha, Russ, & Short, 2005) began the process of validating this new measure. In this study, the validity of the APS-BR was assessed by a comparison of scores of play sessions using the original APS and the new APS-BR in a sample of first-grade and second-grade children; examination of associations between scores on the APS-BR and scores on theoretically relevant criterion measures of divergent thinking and emotional memories; and comparison of the pattern of correlations between the APS-BR and criterion measures and the APS and the same criterion measures.

This new study, which used existing videotapes of play observations from a previous study of the APS (Russ & Schafer, in press), produced encouraging results. First, interrater reliability, using a stringent absolute agreement intraclass correlation coefficient, was very high. The average scores for the intraclass coefficients were .86 for Organization, .93 for Imagination, .87 for Comfort, .96 for Frequency of Affect Expression, and .89 for Tone of Affect Expression.

Pearson bivariate correlations were used to test the main hypotheses. As hypothesized, the APS-BR scores were very highly correlated with their respective scores on the APS. Organization ($r = .80$), Imagination ($r = .81$), Comfort ($r = .77$), Frequency of Affect Expression ($r = .79$), and Tone of Affect Expression ($r = .75$) were all significantly correlated at the $p < .001$ level. These correlations all meet Cohen's criteria for a large effect size (1995).

Also as hypothesized, significant correlations were found between the APS-BR and the criterion measures of divergent thinking and emotional memories. In addition, the patterns of correlations between the APS-BR and both criterion measures were similar in strength and direction to the patterns of correlations between the APS and these same measures.

The strength of correlations between the APS and the APS-BR, as well as the similarity of the pattern of correlations between the APS and the APS-BR with criterion measures, suggests that the APS-BR functions in a manner similar to that of the original APS. Therefore,

the APS-BR might be used in instances where the APS might be cumbersome or incapable of being used. For example, the APS-BR could be used by a clinician wanting a brief rating of a child's play as part of a more comprehensive assessment. In addition, clinicians outside the field of play and unaware of the APS could use the APS-BR without extensive training or knowledge of its background. Because it does not require videotaping or extensive training to score, the APS-BR could be more readily used than the APS as a part of assessment batteries in research. In this way, the study of play could be advanced by the inclusion of the APS-BR into more child research projects.

Future studies will use the APS-BR with a live sample of children, and new criteria measures, including both convergent and discriminant validity, will be incorporated. Another step in this research is to have clinicians unfamiliar with the APS and outside the field of play research use the APS-BR with children, to determine its feasibility with this sample of practitioners. It is hoped that this quicker, easier version of the APS will encourage more clinicians and researchers to incorporate play into their general assessment of children and to measure change in psychotherapy.

PLAY IN CHILD THERAPY

Research from a variety of sources suggests that play helps reduce anxiety in children. For example, play prior to surgery reduced anxiety in children (Rae, Worchel, Upchurch, Sunner, & Dainiel, 1989). Play also reduced separation anxiety in preschoolers (Milos & Reiss, 1982). Research also suggests that children who already have good fantasy and play skills are better able to use play to reduce anxiety. Implications of the research findings are that play should be considered for therapy if the child is experiencing anxiety around internal conflicts or external trauma and when the child has adequate play skills (see Russ, 2004, for a review). Play assessment can determine whether the child has play skills that are adequate for use in order to use play to process emotional material in therapy.

Case Example

What follows is a case example of a child struggling with separation anxiety. This case has been discussed in Russ (2004). However, what we do in this chapter is score the play dialogue in the therapy according to the APS scoring criteria. Although there is no video recording that permits scoring of nonverbal expressions, this scoring attempt is an illustration of how the APS could be used for treatment planning and assessment of change in therapy.

John was a 6-year-old boy who was having trouble staying in school. The conceptualization of the case was that there were internal conflicts that were underlying the separation anxiety. It was also possible that John's past illness or that of his mother had been traumatic for him. Russ did an informal play assessment at the time of intake. John built an Olympic Village from Legos and had people figures talking and interacting in the play. Organization of narrative and imagination would receive a 3 and 4, respectively (on a 5-point Likert scale), suggesting that he should be able to use fantasy and pretend play in therapy. However, there was no expression of affect in the play. Most 6-year-old boys express emotion in the 5-minute play narrative, especially aggressive content. John was constricted in his affect expression, and one goal of therapy was to help him increase his affect expression in the play. We have chosen samples of play dialogue from Russ (2004, pp. 51–54) and have now scored it.

Session 3:

Content:	Affect Category
Therapist (T): What is that you are making?	
Child (C): An alligator. (Turned it into something else).	Aggression
T: Now what is it?	
C: A swordfish	Aggression
T: Oh, a swordfish. Now what?	
C: A turtle.	
T: And now?	
C: A hippopotamus.	

John then tried to make a horse with Legos but could not get it built to his satisfaction. I kept repeating that what he had done was OK and he could use it to play, but he was critical. He then went back to the clay and made something else.

T: What is that?	
C: A dinosaur. (He showed it falling off a cliff.)	Aggression Sickness/Hurt
Now it is an angel. (He made a halo for it.) (He then made something else)	
This is a person who eats too much.	Oral
He is so fat he keeps falling over, because he is so heavy.	Sickness/Hurt
T: He's so heavy and ate so much food, that he keeps falling.	

Then John drew a picture.

T: What's happening there?	
C: This is a giant. He is stomping on the city. Everything is on fire.	Aggression Aggression Aggression
T: The giant is stomping on everything. Maybe he is mad about something.	

John didn't comment on that. I told him I would see him next week and he seemed happy about coming.

In this play sample, John received a total affect score of 9. There are 6 expressions of aggression, first in the form of aggressive animals (alligator, swordfish, dinosaur). Finally, a giant is stomping on a city. I had tried to give permission for John to express aggression in this session and in previous sessions. His organization of the story in this session was scored a 3 and imagination a 4.

Session 5:

Content	Affect Category
John went right to the clay and made forms and smashed them. I commented on his smashing them: "You really smashed that one."	Aggression
Then one clay figure would start to smash another.	Aggression
He would play monster and start to attack and then stop.	Aggression
He would abruptly pull back. This happened repeatedly.	

I tried to support his aggressive play and say things like, "He is going to attack," or "He is really angry," or "He is going to smash him." John then took some puppets and said he would put on a puppet show.

The alligator and hippopotamus puppet were trying to eat the man.

Oral Aggression

The man escaped. I commented that they were trying to eat him, but the man escaped. Then John asked me to play with him. I put on a puppet, but followed his lead.

He was the boy puppet.

C: His nose is growing, because he told a lie (this occurred in a previous session).

T: Sometimes it's hard not to lie. Kids lie sometimes. John immediately stopped playing.

In the initial series of aggressive attacks, first in the clay forms and then in the monster, John was expressing much aggression. Although he received 3 aggressive units here, because a long series of non-verbal aggressive attacks occurred, he would have received a higher frequency of aggressive units, if the play had been videotaped. Then the alligator and hippo tried to eat the man, receiving an oral aggression score.

Session 6:

Content

Affect Category

John began by making clay figures.

First he made a flower, which he smashed.

Aggression

Then he made a ring, which he put on his finger.

Then he made a play set with slides and caves and had clay figures go down the slide.

They were having fun.

Happiness/Pleasure

John then moved to the puppets and put on a puppet show.

There was a father puppet and a boy puppet. First, the boy got shocked by an electric wire and fell on the ground.

Sickness/Hurt

Then a frog came along and said, "I'll cook you for supper."

Oral Aggression

Then a snake came and started to eat his hand.

Oral Aggression

Then the father puppet came and chased the creatures away.

Aggression

He took the boy to the hospital.

Nurturance

Father talked to the doctors and asked what they would do.

Nurturance

The doctors operated on the boy.

Sickness/Hurt

The boy got better.

Nurturance

Father took him home.

Nurturance

Then father and the boy went on a trip.

Nurturance

They climbed a mountain and got to the top.

They jumped up and down and cheered.

Happiness/Pleasure

T: The dad took care of the boy. He took him to the hospital and talked to the doctors. The boy got better. Then they climbed the mountain and were happy and proud.

Then John asked me to put on a puppet show with him.

He made cars out of clay and his puppet and my puppet rode on them.

The cars went fast and the puppets were having a good time.

Happiness/Pleasure

There was a total of 14 affect units in this play sample. There was a wide range of affect (aggression, happiness, nurturance/affection, sadness/hurt). What was new in this session was the expression of positive affect in the play (happiness, nurturance/affection). We also scored organization and imagination, and both received a 5. There was good organization of the story and much imagination.

In just focusing on the play, John became less constricted in his expression of affect over six sessions. He became freer in expressing aggression in play and even, eventually, expressed positive affect as well. He also used the play to resolve internal conflicts. The expression of aggressive ideation in his play was central to the conflict resolution. He became more comfortable with his aggressive impulses, and anxiety around aggression was lessened. It is hard to know for sure whether anxiety around aggressive impulses was responsible for the separation anxiety or whether early trauma around his hospitalization or that of his mother was responsible. In his story, the father rescues the boy and the boy gets better in the hospital. He might have resolved issues around his father and now sees him as a protector. Anxiety reduction probably occurred in several ways in the therapy.

In this case, John did improve outside of the therapy. When school began in the fall, he was able to stay in school. The therapy ended shortly thereafter, since he was doing well in school. Factors other than the play contributed to improvement as well (firm message from parents that he would have to stay in school), but the changes in the play process could be seen in the play sessions. This is the type of case where repeated measures of play processes before, during, and after therapy could have measured change. In this case, the goal of increased affect expression and a wider range of affect expression would probably have been met if they had been carefully measured.

If a therapist is working with a different type of child, a child who has low organization play skills and high emotional content, but has some imaginative ability, (such as a child with borderline features), then a goal of therapy would be to increase the organization of the narrative. Better organization skills would place the emotional material in a more meaningful context and could help with emotion regulation. The amount of coherence and logic in the narrative could be measured over time.

CONCLUSION

In conclusion, by including an assessment of play in the diagnostic interview or testing process, we can better determine whether and how play should be used in treatment. We can also measure change in play processes throughout the therapy and relate changes in play processes to changes in behavior and other internal processes. Because children frequently play during intake interviews and therapy, it should be relatively easy to include a play assessment. By including play assessment, we can reduce the gap between research and practice and refine our therapy interventions.

REFERENCES

- Burns, W. J., & Faust, J. (1989). *The Nova assessment scale of psychotherapy*. Manuscript in preparation. [AU3]
- Chazan, S. E. (2000). Using the children's play therapy instrument (CPTI) to measure the development of play in simultaneous treatment: A case study. *Infant Mental Health Journal, 21*, 211–221.
- Christiano, B., & Russ, S. (1996). Play as a predictor of coping and distress in children during an invasive dental procedure. *Journal of Clinical Child Psychology, 25*, 130–138.

- Cohen, J. (1995). A power primer. *Psychological Bulletin*, *112*, 155–159.
- Dansky, J. (1980). Make-believe: A mediator of the relationship between play and associative fluency. *Child Development*, *51*, 576–579.
- Faust, J., & Burns, W. J. (1991). Coding therapist and child interaction: Progress and outcome in play therapy. In C. E. Schaefer, K. Gitlin, & S. Sandgrund (Eds.), *Play therapy: Diagnosis and assessment* (pp. 663–689). New York: John Wiley & Sons.
- Fisher, E. (1992). The impact of play on development: A meta-analysis. *Play and Culture*, *5*, 159–181.
- Gitlin-Weiner, B., Sangrund, A., & Schaefer, C. (Eds.). (2000). *Play Diagnosis and Assessment*. New York: Wiley & Sons.
- Howe, P. A., & Silvern, L. E. (1981). Behavioral observation of children during play therapy: Preliminary development of a research instrument. *Journal of Personality Assessment*, *45*, 168–182.
- Kernberg, P. F., Chazan, S. E., & Normandin, L. (1998). The children's play therapy instrument (CPTI): Description, development, and reliability studies. *Journal of Psychotherapy Practice and Research*, *7*, 196–207.
- Milos, M., & Reiss, S. (1982). Effects of three play conditions on separation anxiety in young children. *Journal of Consulting and Clinical Psychology*, *50*, 389–395.
- Perry, L., & Landreth, G. (1991). Diagnostic assessment of children's play therapy behavior. In C. E. Schaefer, K. Gitlin, & S. Sandgrund (Eds.), *Play therapy: Diagnosis and assessment* (pp. 643–660). New York: John Wiley & Sons.
- Rae, W., Worchel, R., Upchurch, J., Sanner, J., & Dainiel, C. (1989). The psychosocial impact of play on hospitalized children. *Journal of Pediatric Psychology*, *14*, 617–627.
- Rosen, C., Faust, J., & Burns, W. J. (1994). The evaluation of process and outcome in individual child psychotherapy. *International Journal of Play Therapy*, *3*, 33–43.
- Russ, S. (1987). Assessment of cognitive affective interaction in children: Creativity, fantasy, and play research. In J. Butcher & C. Spielberger (Eds.), *Advances in personality assessment* (Vol. 6, pp. 141–155). Hillsdale, NJ: Lawrence Erlbaum Associates.
- Russ, S. (2004). *Play in child development and psychotherapy: Toward empirically supported practice*. Mahwah, NJ: Lawrence Erlbaum Associates.
- Russ, S., & Grossman-McKee, A. (1990). Affective expression in children's fantasy play, primary process thinking on the Rorschach, and divergent thinking. *Journal of Personality Assessment*, *54*, 756–771.
- Russ, S., Niec, L., & Kaugars, A. (2000). Play assessment of affect—The Affect in Play Scale. In K. Gitlin-Weiner, A. Sangrund, & C. Schaefer (Eds.), *Play diagnosis and assessment* (pp. 722–749). New York: Wiley.
- Russ, S., & Schafer, E. (in press). Affect in Play, emotion in memories, and divergent thinking. *Creativity Research Journal*.
- Sacha, T. J., Russ, S. W., & Short, E. J. (2005). *Development and validation of the Affect in Play Scale—Brief Rating Version (APS-BR)*. Manuscript submitted for publication.
- Singer, D. G., & Singer, J. L. (1990). *The house of make-believe: Children's play and the developing imagination*. Cambridge, MA: Harvard University Press.

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