extended play-based developmental assessments  
clinicians guide

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Problem Statement

Abused children are often reticent to volunteer information about traumatic experiences. In addition, young children may find it difficult to perceive events accurately, conceptualize their meaning, and explain them verbally. Self-reporting is further compromised by emotions children may feel (associated with stressful experiences), such as fear, confusion, worry, loyalty, conflicts, and anxiety. Many abused children are also routinely interviewed by multiple professionals (within rigid timeframes), which may further confuse, exhaust, or frighten young children.

Purpose of Extended Play-Based Developmental Assessment

The purpose of the Extended Play-Based Developmental Assessment (EPBDA) is to give children an opportunity to externalize their thoughts and feelings in the context of a less demanding, user-friendly environment that allows and encourages children to express themselves utilizing both verbal and non-verbal communication.

Description

Extended Play-Based Developmental Assessments are designed to determine children’s overall functioning; identify current clinical symptoms; identify trauma impact, if any; assess children’s perceptions of parental support and guidance; and determine children’s perceptions of their internal and external resources. Clinicians who conduct EPBDA observe and address a variety of domains including physical functioning, patterns of relational interactions, thematic material in their play, and externalized concerns. A variety of directive and non-directive techniques are utilized avoiding suggestive language or questioning and allowing children to feel comfortable enough to volunteer relevant information about their world.

Non-directive approaches are based on the relational experience between the clinician and the child. Children are able to control session activities and decision making and change is left with them. Clinicians provide an unconditional acceptance of children rather than a symptom-focused assessment. In addition, clinicians provide non-judgment and reflection, as well as respect and empathy to children. There are many benefits to children through the use of a non-directive approach, such as allowing them to externalize their internal worlds, placing few demands or expectations on them, and allowing them to engage at their own pace. In addition, EPBDA tend to be less threatening to most children and views them as individuals with unique interests and needs.

When conducting EPBDA, clinicians observe and interpret the child’s play in order to understand their internal experience. Equally important is the recognition that play has many curative benefits and children can utilize it in a reparative way. These assessments are conducted in play therapy offices that have a range of therapeutic toys. In Play Therapy: The Art of the Relationship, Landreth (2002) provides a list containing a wide range of items therapists should incorporate into a play therapy room (See Appendix D).

Sweeny (2003) and Sweeney & Homeyer (1999) suggest that play materials in general should:
- Facilitate a wide range of creative expression
- Facilitate a wide range of emotional expression
- Engage children’s interests
- Facilitate expressive and exploratory play
- Allow exploration and expression without verbalization
- Allow success without prescribed structure
- Allow for non-committal play
- Have sturdy construction for active use

Schaefer (1993) proposes eight curative aspects of play that are important to the needs of children which provide the following opportunities:

- Developmental growth and learning
- Mastery and control
- Decrease of anxiety through affective discharge
- Release of endorphins and promotion of well-being
- Release of pent up conditions
- Communication and externalization of inner world
- Symbolic (conscious or unconscious) working through
- Helping children assimilate stressful experiences “shrinks” the problem
1. **Children’s natural medium is play.** As stated earlier, children’s natural mode of communication is not necessarily verbal language. More often than not, children express themselves through a range of behaviors, non-verbal communication, and symbolic language (stories, art, play movement, etc). It is important for clinicians to broaden their repertoire to include an interest and comfort with more ample interactions with children.

2. **Children may have had multiple interviews.** Children who have been sexually abused may have already been interviewed by various professionals such as Child Protective Services workers, police officers, attorneys, or parents. Parental interviews can often be problematic in that parents who have concerns about their children’s safety may ask questions in a way that frighten or worry children. Professional interviews may be problematic in that professionals may feel uncertain or uncomfortable interviewing very young children and thus the interviews may feel stressful to both interviewer and interviewee.

3. **Children in crisis may be anxious, confused, distrustful, and fearful.** When children have been hurt in any way they may already be scared or disoriented. It is more difficult for children to meet new people and answer personal questions when they already feel unsafe or unsettled.

4. **Often children who are referred for assessments may have been placed in foster care.** They may have talked to different helpers, and may feel uncertain about the stability of professionals in their lives. This can cause situations of mistrust and fear.

5. **Children deserve time to gain comfort.** Children who are referred for assessments deserve the opportunity to become comfortable in new settings, including therapy offices. Too often child assessments (or evaluations) are done very quickly and children are not given the time they need to develop a sense of security. When clinicians become trustworthy to children, chances are that children will relax and allow themselves to share important information in a variety of ways. As they share information (through what they say or do), clinicians can make better determinations about their overall functioning.
1. Assess child’s overall functioning.

2. Identify observed or reported clinical symptoms.

3. Identify trauma impact, if any.

4. Assess children’s perceptions of parental support and guidance.

5. Assess children’s perceptions of internal and external resources.

6. Assess child’s developmental level(s) (For example, using Greenspan and Greenspan, 2003, dimensions).

7. Identify vulnerabilities and strengths without pathologizing.

8. Assess the child contextually (or systemically).

9. Provide diagnosis based on the latest version of the Diagnostic and Statistical Manual of Mental Disorders.

10. Assist parents or caretakers in providing appropriate responses to child’s behaviors, questions, or statements (e.g., watch for over-under responding).

To achieve these goals, it is useful to initiate a blind process followed by a review or collateral information. This is further discussed in the later section “Giving Feedback: Writing Reports” of this manual.
Children do not usually seek out therapy or understand the purpose or context of therapy. They may be brought to therapy post-crisis or for behavioral difficulties or emotional concerns, and might therefore view therapy with trepidation or ambivalence. In order to put them at ease and get to know them, it will be critical to lower demands, invite self-disclosure by withholding questions, and provide a permissive, respectful, and interesting environment. Toward this end, a non-directive approach allows children to show themselves more fully. Axline (1947) established the following principles of non-directive therapy with children:

- Establish a warm, caring relationship
- Give unqualified acceptance
- Create atmosphere of safety and permissiveness
- Be sensitive to child’s feelings (reflecting in such a way that child gains insight)
- Respect child’s capacity to act responsibly

Landreth (2002) has further revised Axline’s basic principles as follows:

1. The therapist is genuinely interested in the child and develops a warm, caring relationship.
2. The therapist experiences unqualified acceptance of the child and does not wish the child were different in some way.
3. The therapist creates a feeling of safety and permissiveness in the relationship, so the child feels free to explore and express himself or herself completely.
4. The therapist is always sensitive to the child’s feelings and gently reflects those feelings in such a manner that the child develops self-understanding.
5. The therapist believes deeply in the child’s capacity to act responsibly, unwaveringly respects the child’s ability to solve personal problems, and allows the child to do so.
6. The therapist trusts the child’s inner direction, allows the child to lead in all areas of the relationship, and resists any urge to direct the child’s play or conversation.
7. The therapist appreciates the gradual nature of the therapeutic process and does not attempt to hurry the process.
8. The therapist establishes only those therapeutic limits necessary to anchor the session to reality and to help the child accept personal and appropriate relationship responsibility.

When clinicians follow these principles, they create the possibility of growth opportunities for children in which they are respected and can be precisely who they are.
Researchers have found that if children have access to a parent, they are more resilient in responses to trauma than children who do not (Beeman, 1999; Chalk & King, 1998). Children who are exposed to trauma may not have access to one or both parents(s) for psychological support and emotional refuge; the abusive parent is unsafe and the other parent may be emotionally unavailable because of his or her on trauma (Groves, 1996). Furthermore, these children might suffer cumulative losses when they must leave their home to seek safety. In addition, children in a family affected by trauma often have complicated, ambivalent and overwhelming feelings toward the parent with violent behavior (Barnett, Miller-Perrin, & Perrin, 2005).

It is important for clinicians to obtain the pertinent developmental, behavioral, and health information of every child. Clinicians should aim to collect this information from parents before or during the first EPBDA, and continue to update this information over the course of the assessments. Crane (2001) suggests that clinicians should meet with parents to:

- Establish rapport
- Obtain background information
- Assess the situation
- Discuss expectations of parent, clinician, and child
- Discuss goals
- Explain the expectation the play therapy process (or in this case, the EPBDA)

It is also helpful for clinicians to encourage parents to give weekly feedback of child’s functioning. Information from parents is gathered not only by talking with them, but also through utilizing parental assessment tools. We have included several parental self-report assessment tools that clinicians can utilize to collect information from parents (See Appendix A).

Because the EPBDA is designed to gather information about children’s perceptions of traumatic experiences, it is important to take a collaborative approach to the assessment process. Collaboration with other mental health professionals who are involved in the case can be very useful. These include, but are not limited to, child art therapists, social workers, family physicians, and school counselors. In order to access collateral information, clinicians must obtain necessary releases for exchange of information, and explain their roles vis a vis in conducting assessments.
There is growing evidence of the impact of traumatic stressors on children’s development on many levels, including their brain (Barnett, Miller-Perrin, & Perrin, 2005). In particular, when children have traumatic experiences, they may develop unfocused responses to subsequent stress. Some traumatized children may be unable to control impulses, display “acting out” behaviors, or have difficulty regulating or expressing their emotions (they may become agitated, have trouble tolerating emotions, or they may shut down). Children may also have difficulty recalling information, have limited memory or attention, or have problems with dissociative responses, such as depersonalization.

During assessments clinicians will be able to observe children’s patterns and styles of communication; use of physical boundaries; interactional patterns; cognitive and physical capacities; impulse control; and strengths and vulnerabilities. Additionally, clinicians document children’s willingness and ability to organize and accomplish tasks; ability to complete a project; their use of symbol language; children’s ability to make emotional connections; level of enjoyment, spontaneity, and curiosity; and level of insight (spontaneous comments that connect play and reality).

Greenspan and Greenspan (2003) work serves as a guidepost for comparing and contrasting expectable and non-normative behaviors, interests, and activities in children (when compared to peers). Greenspan established the following principles of Developmentally Based Therapy (DBT):

1. Build on the child’s natural inclinations and interests to try to harness a number of core developmental processes at same time (self regulation, boundaries, communication, representing internal experience).
2. Meet the child at his/her developmental level.
3. Aim to effect change by helping the child negotiate the developmental level(s) the child has not mastered fully.

Greenspan and Greenspan (2003) list the following critical assessment areas:

- Physical functioning
- Patterns of relationships
- Overall mood and emotional tone
- Affects (range, variety, depth, appropriateness)
- Anxieties and fears
- Thematic expression
- Resiliency

Lastly, clinicians will assess children’s play behaviors assessing both content (the products that children create) and process (the way in which they approach and undertake their activities). Both these domains provide interesting information about children (Greenspan & Greenspan, 2003).
Common Clinical Questions

What if nothing happens, what if the child does not want to play?

It is important to remember that something is always happening when children play or don’t play. Sometimes they work in a slow and deliberate way; other times they may move from one thing to another. If nothing else, clinicians can track the sequence of behavior or notice the range of children’s attention span. Play is inherently pleasurable and it is one of the few activities that can be undertaken without a particular goal. Therefore clinicians can rest assured that children are always reaping some benefits from play, whether it is a sense of well-being, developmental tasks, pretend play, or simple externalizing of internal interests or worries. Some play is designed as self-soothing therefore it’s also possible that children can utilize play activities to grow in confidence with a new therapist. When children fully refuse to play, this may be suggestive of affective or behavioral constrictions or severe distrust in children.

Do I tell the child what I see/observe?

It’s best to simply accept whatever the child does without offering your commentary about the behavior or what it might suggest to you. Remember that when you make interpretations to children, they must then respond to them in some way, shape, or form. Children may need to defend against the interpretation, explain themselves, or comply, sometimes in deference to authority. All these responses may change children’s willingness to play freely from that point on.

It is clinically appropriate, and useful, to develop as many hypotheses as possible, explore them, consider them, and continue to observe children’s play. At times, it’s possible to make behavioral observations to children, noticing something repetitions, yet, without making the interpretation. For example, notice the difference between “It seems that you’re a little nervous,” versus “I notice that you are shaking your feet a lot and moving from spot to spot.”

What if the child invites you to play?

Children will often invite therapists to play. When this happens, clinicians can respond by asking children for directives of what to say or do. This way, clinicians are participating with children in normal interactions but they are still allowing children to use projection in their play. In a purely non-directive approach clinicians may state, “You would like me to play with you.” and remain physically uninvolved in the play. In this case, it will be important to observe how the child deals with lack of immediate gratification of their demands.
What about the parents; how are they involved?

Parents are involved in a number of ways. They provide basic psychosocial and developmental information about their children, including their perception of the presenting problem. In addition, parents bring children to therapy, provide weekly feedback about children’s home behavior, and guide and support their children. Clinicians provide “coaching” to parents so that they are empowered to respond to children’s questions, set limits, or provide a range of supportive behaviors and statements. Parents may have specific questions or they may want to report problem incidents as well as incidents suggestive of children’s improved functioning. In addition, some parents may need their own supportive individual therapy, a parents group, or psychoeducational information. Parents are more often than not invited to participate in parent-child sessions and family therapy sessions. Clinicians will need to help parents become informed and sensitive to children’s traumatic experiences and post-traumatic behavior. Parents may need special help coping with guilt, shame, anxiety, or their own histories of childhood abuse. It’s important to encourage parents to remain alert to children’s resiliency, as well as signs of possible distress.

How much or how little verbal exploration is needed following play activities?

As long as “processing” stays within the metaphor provided by children, therapeutic dialogues can occur. For example, if a child sets up a play scenario of a mother, father bear, and baby bear and then has the mother bear feed the baby but states that there is “not enough food,” clinicians can ask: “What’s it like for the baby bear when there is not enough food?” If the mom bear did give the baby bear enough food, how would the baby bear feel?” or “What’s it like for the daddy bear to see that there is not enough food for the baby bear?”
Extended Play-Based Developmental Assessments involve:

- 10 to 12 sessions on a weekly or biweekly basis
- 50 minute sessions
  - Sessions 1 to 3
    - “Free” Play
  - Sessions 4-8, children participate in:
    - Individual Play Genogram
    - Sand Therapy (“Make a world in the sand”)
    - Color Your Feelings
    - Self Portraits
    - Kinetic Family Drawings
  - Sessions 9-12
    - Closure and feedback to child/family
sessions 1 - 3

“free” activities

**Goal:** To obtain information about the child’s general functioning; identify presence of any clinically significant symptoms and identify how these symptoms impact functioning; and assess child’s support system.

**Objective**
1. Create a safe and predictable environment with clear limits.
2. Build feelings of trust and safety.
3. Provide unconditional acceptance to child.

**Purpose**
Sessions 1 through 3 utilize non-directive play strategies to establish a therapeutic relationship with the child. The therapist provides unqualified acceptance and creates an atmosphere of safety and permissiveness. The child gains insight into his or her feelings and is able to lead play and conversation. The child is able to gain a sense of mastery through responsibility for his or her own actions, while limit setting is clear and appropriate.

**Time**
50 minutes per session

**Supplies**
- See Appendix D for a summary of basic play therapy materials
- Digital Camera (if possible, for taking a picture of the product)

**Basic Art Materials**
- White paper of different sizes
- Construction paper, color
- Graphite Pencils w/erasers
- Colored Pencils; Colored chalks
- Felt markers (both thin and think); Colored
- Scissors
- Easel Paper; Flip Chart
- Paints
**Data Collection Process**

- Play Assessment Observation Form, Appendix B

**Note**

1. Explain to children the limits of confidentiality:
   
   “Mostly everything that happens in our meetings is private. However, I will need to talk to someone else if I think you are being hurt by anyone, when I think you are trying to hurt yourself, and when I think you are hurting anyone else. In these cases, I will need to talk to your parents or to social workers. I won’t talk to others without telling you first.”

2. Clinician should maintain the role of an engaged yet silent observer.

**Activity A (or):**

*“Free* Play - Free play allows the child to be creative and engage in cooperative play. Free play also empowers the child to have insight into his or her personal choices, and reinforces individual expression through play.

**Directive**

“This is the play therapy room. Let me show you around. Feel free to look around and decide how you’d like to spend your time today. This is a place you can play or talk as much or as little as you want.”

**Activity B:**

*“Free* Drawing – The child draws a picture spontaneously and of their own choice. Free drawings allow children to be creative and engage in cooperative play. Free drawings also empower children to have insight into their personal choices, and utilize their individual expression.

**Directive**

“You can draw or paint whatever comes to mind.”

*The following is a therapeutic question clinicians can pose after child is finished with activity:*

“Tell me about your picture.”

**Remember:**

- Avoid yes/no questions
- Ask expansive questions
- Stay in the metaphor
**Process Possibilities**

1. We encourage “Free Play” for the first few sessions because performance tasks can seem intimidating to some children. Some children may want to draw as they see paper and art materials.

2. Stay at the periphery of this activity without initiating idle chatter that distracts from or diffuses engagement with the activity.

3. Remain engaged, yet silent.

4. Respond to brief questions, if asked any.

5. Help child if help is requested.

6. Restrain from making evaluative comments.

7. Consult with registered art therapists regarding children’s drawings and consult with registered play therapists regarding children’s play. You can also become familiar with the vast literature on children’s art and play.

**Article and Book Resources**


Session 4

Individual Play Genogram

**Goal:** To collect information about child’s perception of his or her family and social support system.

**Objective**

1. Expand child’s ability to communicate using symbol language.
2. Allow child to express thoughts/feelings about self and important family members.

**Purpose**

The Play Genogram is a visual and graphic assessment tool that allows clinicians to visualize and organize the family structure and to obtain demographic information along with perceptions of family relationships and roles.

**Time**

50 minutes

**Supplies**

- Easel Paper
- Markers
- A variety of miniatures that represent as many aspects of life as possible (See Appendix E for suggested list of miniatures that are categorized, organized, and visible)
- Clay
- Digital Camera (if possible, for taking a picture of the Genogram)

**Data Collection Process**

- Play Genogram Recording Form, Appendix G
- Play Assessment Observation Form, Appendix B

**Note**

1. Clinician should maintain the role of silent witness.
2. Be sure to leave ample time for viewing.
3. In this activity, you can have the Genogram prepared ahead of time or assist the child with drawing their personalized Genogram during the session.
4. Encourage children to include other important people or things (e.g., grandparents, foster parents, foster siblings, pets, friends, etc.) You can do this by saying “Add anyone or anything else that is important to you.”
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**Genogram creation**

1. Draw a Genogram of the child’s family on large easel paper.
2. Draw birth/foster/adoptive families on the same page, if applicable.
3. Include important others to children (e.g., teachers, friends, grandparents, pets, etc.).

**directive**

“Find a miniature that best shows your thoughts and feelings about everyone in the family, including yourself. Put that miniature(s) on the square or circle of that person.”

Once choices are made, view the completed Genogram with the child. Express interest and listen as they tell you about their Play Genogram. The following are examples of some therapeutic questions to pose after child is finished with activity:

- “Say as much or as little as you want about the Play Genogram.”
- “Tell me about the (miniature)?”
- “What is it like for the (miniature) to _____?”
- “Does (miniature A) and (miniature B) get along?”
- “What would (miniature A) say to (miniature B) if it could?”
- “What is (miniature) thinking/doing/feeling/wanting?”
- “What is (miniature) like when not being _____?”
- “I noticed that (miniature A) is (clinician’s observation, not interpretation): What is this like?”

**Process possibilities**

1. Once completed, the Play Genogram will have one or more miniature/s on each circle or square. Some children will select one miniature per family member; others will ask permission to use additional miniatures or will simply place as many miniatures as they wanted to on the circles or squares. Multiple miniatures that represent one person might reflect the complexity of the relationship or mixed feelings.

2. When asking questions or making observations, don’t make interpretations and stay within the metaphor language of the client. Instead of saying “The figure you used for your dad looks angry,” say “I notice you picked the bear that’s showing his teeth. What’s going on with this bear? What’s s/he thinking or feeling?”

3. If a child feels frustrated by not finding the precise miniature desired, observe how the child tolerates frustration or resolves the problem. A helpful next step is to offer the child a piece of clay so that they can mold whatever they want or to ask them what object they would have used had it been available.
4. Some children might have difficulty verbalizing their thoughts/feelings about the Genogram. Do not ask the child to explain why he or she chose a particular object. Beginning a question with “why” often puts children on the spot and asks them to explain their choices which they may not fully understand. Instead, ask children to tell you more about the miniature, what kind of miniature it is, what the miniature likes and doesn’t like to do, etc.

5. Use an open and expansive dialogue in which the child can volunteer a broad range of information. Don’t ask questions that elicit “yes/no” responses.

6. Ask permission to take a photograph of the individual Play Genogram if you are so inclined. Children often like to take home photographs and clinicians can keep pictures in the client chart/file to help children recreate genograms later, if additional processing is relevant. If children take their photos home, it is worth discussing who they’ll show them to, what responses they expect, and so forth.

7. If clinicians don’t have cameras and prefer to draw simple pictures using words to describe location and type of miniature.

**Article and book resources**


Session 5
building a “world” in the sand

Goal: To collect information about child’s perception of how they see their world.

Objective
1. Expand child’s ability to communicate using symbol language.
2. Provide a vehicle for self-healing.
3. Give child opportunity to externalize his or her inner world of thoughts and feelings.

Purpose
The use of sand therapy in play-based assessments allows for several possible experiences: an externalization of internal worlds; an unconditional acceptance (by clinicians and clients) of internalized material; an emotional and mental assimilation of inter-and-intrapsychic experiences; and opportunities for projection, working-through and development of insight. The sand therapy process has the potential to communicate, touch, and be evocative to self and others. The child is able to make a creation of something whole in a limited space which provides opportunities for processing, assimilation, and integration.

Time
50 minutes

Supplies
- Waist-high, waterproof sand tray, painted blue inside
- Specific dimensions are 19.5 x 28, 3 inches deep
- A variety of miniatures that represent as many aspects of life as possible (See Appendix E for suggested list of miniatures)
- Water and containers/Dixie cups
- White, fine sand
- The box should be filled half way with sand
- Digital Camera (if possible, for taking a picture of the sand tray; Sketches of the sand tray scenarios can also be useful)

Data Collection Process
- Sand Therapy Recording Form, Appendix F
- Play Assessment Observation Form, Appendix B
1. Clinicians maintain the role of silent witness and provide unconditional acceptance, exhibiting interest in the sand tray scenario, modeling that it’s worth “taking in.”

**Process Possibilities**

1. Be sure to leave ample time for viewing. The length of time it takes to build the tray may determine how much time you have to hear children’s comments about the sand scenario.

2. Rules of sand therapy are few:
   a. The sand stays in tray (I, EG, share this rule if children start throwing sand around but not before).

**Directive**

“Using as few or as many miniatures as you would like, build a world in the sand. There is no ‘right’ or ‘wrong’ way to do this” Some clinicians prefer to say, “Using these miniatures, make anything you would like in the sand.” Asking for a “world” may have an organizing effect for children. The broader directive sometimes results in activities such as drawing a happy face in the sand.

*After the child creates the sand scenario, walk around the tray, modeling observation and valuing what’s been created. Tell children that they can say “as much or as little” as they want. Allow for spontaneous communication. If you are so inclined, you may ask about the sand world creation with questions such as the following:*

- “What was it like to make your world?”
- “What reactions do you have when you look at your world?”
- “What is going on in your world?,” (or)
- “Tell me about your world…” (or)
- “Tell me what kind of world this is.”
- Ask about objects, for example “I noticed the first thing you chose to place in the sand was (miniature), tell me a little about (miniature)?”
- “How did it feel to make this part of the world?”
- Ask about groupings/areas, for example “Tell me about the miniatures in the left corner of your world?”
- “What is your favorite part of the world?”
- “What surprised/delighted/intrigued you about the world you built?”
- “What does (miniature) see?”
b. Therapist/clinician does not break the plain of the tray; thus the clinician touches the outside of the tray to ask about an object.

c. Therapist/clinician is present in the room; therapist/clinician does not leave the room.

d. Therapist/clinician does not dismantle the tray in front of the maker.

3. Therapist Posture
   a. Sit opposite the builder.
   b. Stay silent and present throughout the process; do not initiate conversation but answer questions client poses in brief fashion.
   c. Keep miniatures carefully arranged and orderly.
   d. Display undivided attention and interest modeling that this process is valuable.
   e. Avoid invading or abandoning the process.

4. Process of the Tray
   a. Look for signs of resiliency (e.g., resource; water-nurturance; greenery, trees, or plant life-growth); rather than pathology (e.g., resource; water-nurturance; greenery, trees, or plant life-growth).
   b. Pay attention to groups of objects; diagonals (opposite corners of tray); center of tray (might denote the problem); use of sand, marking; bridges (transitions, connection, crossing, etc); or observing ego (object/character that rests above the tray—watching over).

5. After the Tray is Completed
   a. Make decisions about how quickly to respond; Don’t rush to verbal communication unless client wants to speak spontaneously.
   b. Take photographs (permission usually asked in advance) of tray, asking how he or she wishes it to be photographed.
   c. Move around the tray modeling observation.
   d. Await spontaneous communication from builder.

6. Various Possibilities of Trays
   - Journey
   - Developmental
   - Cross-cultural
   - Autobiography
   - Spiritual
   - Affective
   - Real life components
   - Preoccupation or problem

7. When asking questions or making observations to the child, stay within the metaphor language the child uses. For example, ask the owl who is facing a particular direction, what the owl sees or thinks.

8. If a child feels frustrated by not finding the precise miniature desired, observe how the child tolerates frustration or resolves the problem.
9. Use an open dialogue in which the child volunteers a broad range of information.

10. Reframe from over-analyzing/over interpreting the child’s sand scenario. It is recommended that you let your mind wander and allow yourself to take in “the life of the tray.” A range of hypotheses is always desirable to only one.

11. Do not verbalize your interpretations to children because you can cause children to adapt to them or to resist them.

12. If different hypotheses arise in your mind as the child talks about his or her work, simply hold all the possibilities without committing to any one hypothesis in rigid fashion.

13. Ask open-ended questions, being cautious not to impose value-laden words. For example, “I noticed that the bird has a lot of sand on top of it, tell me about that,” is different than “The bird is obviously scared of flying, how come?”

**article and book resources**


Session 6  

Color Your Feelings

**Goal:** To collect information about child’s perceptions of feeling states.

**Objective**

1. Encourage child to identify emotions, thoughts, and perceptions of self and other family or support systems.

**Purpose**

The “Color Your Feelings” activity is designed to assess a child’s experience with diverse affect and expression, particularly as it relates to different settings or relationships with specific people.

**Time**

50 minutes

**Supplies**

- Easel Paper
- Markers
- Crayons
- Digital Camera (if possible, for taking a picture of the product)

**Data Collection Process**

- Play Assessment Observation Form, Appendix B

**Note:**

1. Clinician assists child as needed.
**Process Possibilities**

1. Stay at the periphery of this activity without initiating idle chatter that distracts from or diffuses engagement with the activity.

2. Ask permission to take a photograph of the product.

3. Provide silent involvement, which allows the art process to proceed without interruption.

4. Use an open dialogue in which the child volunteers a broad range of information.

5. Ask open-ended questions, being cautious not to impose value-laden words. Instead of saying, “It looks like you’ve used ‘dark/sad’ colors for the bottom of your body,” say “I noticed that you have blue and grey on the bottom half of your body, tell me about that.”

6. If younger children cannot think of the names of “feelings” you might provide them with some feeling cards so they can see a range of feelings, and to give names/labels to their feelings. They can then select from those for their art work. See Appendix H for Feeling Faces cut-outs.

**Article and Book Resources**

**Session 7**

**Self Portraits**

**Goal:** To identify child’s self-perception.

**Objective**

1. To collect information about how children view themselves.
2. To collect information about children’s emotions and thoughts.

**Purpose**

Self Portraits are used to assess and understand a child’s perception of self.

**Time**

50 minutes

**Supplies**

- Paper, 8 1/2 x 11
- Pencils with erasers
- Markers
- Digital camera (if possible, for taking a picture of the product)

**Data Collection Process**

- Play Assessment Observation Form, Appendix B

**Note**

2. Clinicians should maintain the role of silent observer.
3. For a general guide to help make sense of children’s drawings, see Appendix C.
**directive**

The directive is simple and to the point:

“Draw a picture of you.”

If children look for more direction, tell them whatever they do is fine and that there is no right or wrong way of doing this drawing.

*Clinicians may ask the following questions after the child has finished the activity:*

- “Tell me about your picture?”
- “What is going on in your picture(s)?”
- “What is this little girl/boy thinking in this picture?”
- “How does the little girl/boy feel in the picture?”

---

**process possibilities**

1. If child refuses to make a self portrait, go to another activity, for example, a free drawing. Do not engage in power struggles.

2. Emphasize to children that they can do whatever they want, including an abstract self-portrait (older children like this). The directive for an abstract self-portrait is “Use lines, shapes, colors, or images to make a picture of you.”

3. Stay at the periphery of this activity without initiating idle chatter that distracts from or diffuses engagement with the activity.

4. Provide silent involvement; allow the drawing to proceed without interruption.

5. Notice changes in child's affects as s/he makes the drawing. You might then say, “I noticed that you wrinkled your forehead and moved around in your chair when you were drawing this part of the picture.”

**article and book resources:**


Session 8

Kinetic Family Drawings

**Goal:** To identify child’s perceptions of self, family and/or support system, as well as family dynamics.

**Objective**

1. To collect information from children about how they view themselves, their family, and perceptions of their family relationships.

**Purpose**

Kinetic family drawings are used to assess children's views of themselves and their family relationships.

**Time**

50 minutes

**Supplies**

- Paper 8 1/2 x 11
- Pencils with erasers
- Markers
- Digital camera (if possible, for taking a picture of the product)

**Data Collection Process**

- Play Assessment Observation Form, Appendix B

**Note**

1. Consult with a Registered Art Therapist to better understand children’s Kinetic Family Drawings.
2. Clinicians should maintain a role of silent observer.
**Directives**

“Draw a picture of yourself and your family doing something…some kind of action.”

*Clinicians may ask the following questions after child has finished the activity:*

- “Tell me about your picture or drawing?”
- “What is going on in this picture(s)?”
- “How do the figures in the drawing feel about one another? If they could speak, what would they say to each other?”
- “If the girl could speak, what would she say to…?”
- “I wonder what this person is thinking?; I wonder what s/he is thinking or feeling?”
- “If your family wasn’t doing this activity, what else would they do?”

**Process Possibilities**

1. Stay at the periphery of this activity without initiating idle chatter that distracts from or diffuses engagement with the activity.

2. Provide silent involvement; allow the drawing to proceed without interruption.

3. Use an open dialogue in which the child volunteers a broad range of information.

4. Ask open-ended questions, being cautious not to impose value-laden words. Instead, ask “I noticed that you seem shorter than everyone else in your drawing, tell me more about that?”

**Article and Book Resources**

sessions 9-12

closure

goal: To provide closure for the child; and provide feedback to children and parents (and referring professionals when necessary).

objective

1. To provide referrals as needed.
2. To provide written reports to referring professionals as required.

purpose

Children need to understand a little about their experience during an assessment. It’s important to let them know:

1. You are grateful for their willingness to come to assessment sessions.
2. You have learned a lot about them.
3. You appreciate their being open with their thoughts and feelings.
4. You have some ideas about how to be of help to them and their parents.

time

50 minutes per session

supplies

- See Appendix D for a list of basic play therapy materials
- Digital Camera (if possible, for taking a picture of the product)
**Process Possibilities**

1. You can either tell children your recommendations alone, or you can have a family session so that parents and children hear the same information and suggestions.

2. I (EG) often review with children all the activities they have done, things they may have told you, or ideas you have discussed together. I may bring all the pictures I have collected and review them with the children. I tell children what I will and will not share with their parents and get their feedback about sharing information. I try to preserve their privacy to the best of my ability and I will tell them if I feel I have a reporting responsibility.

**Article and Book Resources**

1. Summarize the process of conducting an EPBDA.
2. Indicate meeting dates and who attended.
3. Comment on spontaneous play activities of child; Specifically, themes, process, content.
4. List thematic material of child’s play and emphasize repetition of themes.
5. State children’s spontaneous comments or responses to specific questions.
6. Offer clinical impressions based on child’s play, verbal communication, and behavioral patterns of interactions.
7. Review and summarize collateral information (e.g., talking with teachers about child’s academic/behavioral functioning in school).
appendixes
Appendix A

Assessment Tools

Goal: To collect information from parents about the family, presenting problems, children’s development, and other relevant information.

Objective

1. Meet with parent(s) or caretakers.
2. Collect the following information:

TALKING WITH PARENTS & CAREGIVERS

Demographic Information
- Marital Status
- Family Composition (Name, age, relationship, school grade, occupation)
- Immigration history (Level of acculturation)
- Race/ethnicity
- Language preferred
- Annual family income

Parent’s Description of Presenting Problem
- When began?
- Who is it a problem for?
- Scaling (Level of 1-10 how serious)?
- Example of last time it happened?
- What have they tried so far?
- What one thing has changed since the problem occurred?

Parent’s Support Networks

Parent’s Environmental Stress (e.g., recent deaths, suicides, use of alcohol)

Parent’s Family of Origin History
- Parent’s occupations
- How anger expressed in home (e.g., use of violence)
- Alcoholism and other drug abuse
- Physical illnesses
- History of hospitalizations
- Anyone currently on medication or under medical supervision?

Family Genogram (not the Family Play Genogram)

Child(ren’s) Developmental History
- Prenatal history
- Birth history
- Developmental milestones and early temperament of child
- Medical and hospitalization history
- Mental health history
- School counseling or school concerns
- Child's signs of
  - Depression
  - Danger to self/suicidality
  - Danger to others (weapons, threats, homicidal thoughts, violent behaviors)
  - "At risk" behaviors (sexual acting out, self-injury, putting self in harm's way, drinking, dangerous peers/friends; killing or torturing pets

School History
- Academic problems
- Behavioral problems
- Special Ed or Learning disabilities

External Systems (e.g., courts, child protective services, probation)

Parent's Description of Child's Personality

Parent's Description of Child's Strengths and Favorite Activities
- Favorite toys, play activities
- Best friends
- Television watching habits
- Favorite show
- Favorite character or hero
- What the parent likes best about child
- Positive comments others make about child
- Concerns

Assessment Tools

Parent Questionnaires
- Child Behavior Check List (CBCL)
- Child Sexual Behavior Inventory (CSBI)

Children's Paper and Pencil Tests
- Trauma Symptom Checklist for Children (TSCC)
Appendix B

Play Assessment Observation Form

Date__________________________Child’s Name_____________________________

Child’s age________________________Gender______________________________

Cultural background________________________________________________________

Does child use play room alone □ or with parent □?

Sessions occur in play therapy room □ adult room with toys □ selected toys taken to other environment □

Physical functioning:____________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Is child’s communication primarily verbal □ non-verbal □ expressive □

Is child’s affect primarily expansive □ or constrictive □

Is child’s affect appropriate □ inappropriate □

Is child capable of affect tolerance □ Affect Modulation □

Is child’s typical attention span limited □ average □

Can child begin and end one project/activity before moving on to another? Yes □ No □

Non-directive work:

Toys selected and sequence of play___________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Themes in play______________________________________________________________

__________________________________________________________________________

__________________________________________________________________________
Stories told

Interaction with therapist during play

Depth and richness of symbolic play

Culture-specific symbolism

Issues suggested by the play

Is child’s play mostly adaptive □ Mostly non-adaptive □

Signs of suicidality □ Homicidal ideation □ Dissociation □ Other dangerous issues (eg., killing and torturing pets, self-injury w/o suicidality) □

How does child appear to clinician before/during/ after play therapy?

How do parents or others report child acts before and after play therapy?
Directive work:

What toys did you select for the child to play with?________________________________
__________________________________________________________________________
__________________________________________________________________________

Why? What were your goals?_________________________________________________
__________________________________________________________________________
__________________________________________________________________________

How did you introduce toys/game to child?_____________________________________
__________________________________________________________________________
__________________________________________________________________________

Did child engage easily with your idea?________________________________________
__________________________________________________________________________
__________________________________________________________________________

Was there any specific resistance to play?_______________________________________
__________________________________________________________________________
__________________________________________________________________________

Did the child initiate interaction with therapist?_________________________________

Did the child respond to:
reflective comments □ Specific questions □ Specific interpretations □

How did the child respond?_________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Did you feel that your interventions were helpful □ harmful □ neutral □

How so?______________________________________________________________
__________________________________________________________________________
What ideas do you have for follow up to selected play interventions?

_______________________________________________________________________

_______________________________________________________________________

Transference and Countertransference responses

_______________________________________________________________________

_______________________________________________________________________

Other Comments:

_______________________________________________________________________

_______________________________________________________________________

Did you meet your goals for this session? Yes □ No □

Plan for next session

Issues for supervision/consultation

_______________________________________________________________________

_______________________________________________________________________
Appendix C

Making Sense of the Drawing and the Drawing Process

The following observations are offered to clinicians to help organize and review the child’s responses to the session (Malchiodi, 1998, p.55):

**Process-related observations**

- Does the child wait for directions or instruction, or is s/he impulsive about materials and beginning the drawing activity?
- Does the child seem calm and focused or restless and agitated? Active or withdrawn? Is the child able to concentrate, or does she or he appear distracted?
- Does this change during the session, with the art activity, or with any particular intervention or interaction?
- Is the child able to follow instructions, or she or he easily frustrated or unable to follow simple instructions?
- Does the child seem confident in drawing or is s/he overly concerned about mistakes?
- Does the child seem to work independently or does s/he seem overly dependent on the therapist?
- To what degree does the child require structure or assistance in drawing?
- Can the child share materials and maintain appropriate boundaries?
- Does the child have difficulty leaving the session? How does the child respond to leaving his or her work if requested? Does the child seem excited to take the work with her or with him? Does the child specifically want the therapist to keep the drawing?

**Product-related observations**

- Is the child proud of the finished product, or does s/he devalue the drawing?
- Does the drawing contain unique expressive imagery, or does it contain stereotypic images?
- How does the child respond to questions about the drawing?
- Does the child associate image in the drawing with her- or himself, or does she or he not seem to self-associate with the drawing?
- Can the child discuss the drawing metaphorically or in relationship to the self, or is discussion or describing the drawing difficult?
- Is the drawing developmentally appropriate for the child's age?
Landreth (2002, p.126) recommends the following list of play therapy materials for clinicians to incorporate into their therapeutic work with children:

- wood doll furniture
- bendable doll family
- bendable Gumby dolls
- doll bed, clothes, etc.
- pacifier
- plastic nursing bottle
- purse and jewelry
- chalkboard and chalk
- colored chalk and eraser
- wood refrigerator
- wood stove
- plastic or tin dishes
- pans and silverware
- pitcher
- dishpan
- plastic food
- empty fruit and vegetable cans
- egg cartons
- sponge and towel
- broom and dust pan
- soap, brush, and comb
- crayons, pencils, and paper
- transparent tape and paste
- toy watch
- building blocks (different shapes and sizes)
- paints, easel, newsprint, and brushes
- Play-Doh or clay
- pipe cleaners
- tongs
- popsicle sticks
- truck, car, airplane, tractor, and boat
- toy bus
- toy bench and hammer
- xylophone
- cymbals
- drum
- toy soldiers and army equipment
- hats
- toy pine log, hammer, nails
  - sandbox, large spoon, funnel, sieve, and pail
- zoo animals and farm animals
- rubber snake, alligator
- Bobo (bop bag)
- suction throwing darts
- target board
- rubber knife
- handcuffs
- dart gun
- toy machine gun
- balls, various sizes
- telephone
- blunt scissors
- construction paper, various colors
- toy medical kit
- play money and cash register
- rags or old towels
- hand puppets
- rope
- tissues
Gil (2000, p.35) recommends the following categories of miniatures for play Genograms and sand therapy:

<table>
<thead>
<tr>
<th>Categories</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>People</strong></td>
<td></td>
</tr>
<tr>
<td>Family sets</td>
<td>different ethnicity, ages, sizes</td>
</tr>
<tr>
<td>Children</td>
<td></td>
</tr>
<tr>
<td>nude and dressed</td>
<td></td>
</tr>
<tr>
<td>infants through adolescents</td>
<td></td>
</tr>
<tr>
<td>Older grandparent figures, and Brides and grooms (separate or together), ethnically diverse</td>
<td></td>
</tr>
<tr>
<td>Professionals</td>
<td></td>
</tr>
<tr>
<td>police, judge, physician, nurse, firemen, sports figures</td>
<td></td>
</tr>
<tr>
<td>Armed forces</td>
<td></td>
</tr>
<tr>
<td>tanks and equipment, soldiers, wounded with stretchers, and military branches</td>
<td></td>
</tr>
<tr>
<td>Historical</td>
<td></td>
</tr>
<tr>
<td>cave people and aborigines, knights and royal figures, cowboys, Indians, settlers, modern figures</td>
<td></td>
</tr>
<tr>
<td>Animals</td>
<td></td>
</tr>
<tr>
<td>zoo animals, farm animals, dinosaurs, domestic and wild animals, insects and butterflies, water</td>
<td></td>
</tr>
<tr>
<td>Nature</td>
<td></td>
</tr>
<tr>
<td>trees, bushes, rocks, water (wells, lakes), volcano, cave, sea shells, twigs</td>
<td></td>
</tr>
<tr>
<td>Vehicles</td>
<td></td>
</tr>
<tr>
<td>Cars, trucks, airplanes, boats, motorcycles, ambulance, school bus, police car</td>
<td></td>
</tr>
<tr>
<td>Boundaries</td>
<td></td>
</tr>
<tr>
<td>fences, popsicle sticks, cardboard and foam board</td>
<td></td>
</tr>
<tr>
<td>Structures</td>
<td></td>
</tr>
<tr>
<td>buildings, churches, schools, bridges, wells, caves</td>
<td></td>
</tr>
<tr>
<td>Minerals</td>
<td></td>
</tr>
<tr>
<td>copper, sand shells, eye of the tiger, crystals, dinosaur tears</td>
<td></td>
</tr>
<tr>
<td>Fantasy</td>
<td></td>
</tr>
<tr>
<td>wizard, castle, fairy godmother, dragons, angels, fairies, space aliens</td>
<td></td>
</tr>
<tr>
<td>Religious/Spiritual</td>
<td></td>
</tr>
<tr>
<td>minister, priest, rabbi, nun, bible, crosses, devil, Buddha, wise meditating men and women</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>weird or scary characters, cross-cultural items, social/cultural symbols (pager, flags, hi-tech), art materials, and containers</td>
<td></td>
</tr>
</tbody>
</table>
### Sand Therapy Recording Form

<table>
<thead>
<tr>
<th>Symbols/Associations</th>
<th>“Energy” Sports/Theums</th>
<th>Verbal Statements</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Process/Affect</th>
<th>Hypotheses</th>
<th>Queries/Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Client Name __________________________________   Date ___________________

Sandtray # ____________________

Carry-over themes/objects ________________________________________________

Dynamic movements/sings or resiliency ______________________________________

Adopted from Gil’s (2000) *Family play therapy: Rational and techniques*
## Appendix G

**Play Genogram Recording Form**

<table>
<thead>
<tr>
<th>MOTHER/STEP M</th>
<th>SELF</th>
<th>SPOUSE</th>
<th>CHILD 1</th>
<th>CHILD 2</th>
<th>CHILD 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>FATHER/SELF</td>
<td>SELF</td>
<td>SPOUSE</td>
<td>CHILD 1</td>
<td>CHILD 2</td>
<td>CHILD 3</td>
</tr>
<tr>
<td>CHILD 1</td>
<td>SELF</td>
<td>MOTHER</td>
<td>FATHER</td>
<td>CHILD 2</td>
<td>CHILD 3</td>
</tr>
<tr>
<td>CHILD 2</td>
<td>SELF</td>
<td>MOTHER</td>
<td>FATHER</td>
<td>CHILD 1</td>
<td>CHILD 3</td>
</tr>
<tr>
<td>CHILD 3</td>
<td>SELF</td>
<td>MOTHER</td>
<td>FATHER</td>
<td>CHILD 1</td>
<td>CHILD 2</td>
</tr>
<tr>
<td>PATERNAL GM</td>
<td>MOTHER</td>
<td>FATHER</td>
<td>CHILD 1</td>
<td>CHILD 2</td>
<td>CHILD 3</td>
</tr>
<tr>
<td>PATERNAL GF</td>
<td>MOTHER</td>
<td>FATHER</td>
<td>CHILD 1</td>
<td>CHILD 2</td>
<td>CHILD 3</td>
</tr>
<tr>
<td>MATERNAL GM</td>
<td>MOTHER</td>
<td>FATHER</td>
<td>CHILD 1</td>
<td>CHILD 2</td>
<td>CHILD 3</td>
</tr>
<tr>
<td>MATERNAL GF</td>
<td>MOTHER</td>
<td>FATHER</td>
<td>CHILD 1</td>
<td>CHILD 2</td>
<td>CHILD 3</td>
</tr>
</tbody>
</table>

Adopted from Gil’s (2000) *Family play therapy: Rational and techniques*
Appendix H

Feeling Faces

- Happy
- Mad
- Sad
- Frustrated
- Nervous
- Proud
- Embarrassed
- Loved
- Scared

Adopted from Bernard (2002) You Can Do It! Emotional Resilience Program
Appendix J

Therapist Feedback Evaluation Form

1. Is this your first EPBDA? Yes □ No □
   If not, how many others have you done? ________________________________

2. Are you a registered Play Therapist? Yes □ No □

3. Have you received any training in play therapy? Yes □ No □

4. Were the directives in the EPBDA clear enough for you to use? Yes □ No □
   If not, what was unclear? ___________________________________________

5. Did most activities go smoothly? Yes □ No □
   If not, which did not go smoothly? ____________________________________

6. Did you have sufficient guidelines for processing activities when completed? Yes □ No □
   If not, which particular activities did not include sufficient guidelines for how to proceed? _____________________________________________

7. Was the reference material useful? Yes □ No □

8. Did you use the reference material? Yes □ No □

9. Did you find the EPBDA process useful in gathering sufficient information to render opinions? Yes □ No □
   If not, what additional information do you think should be included? ____________________________

10. Did you feel you had enough guidance to draw conclusions and formulate recommendations based on the EPBDA? Yes □ No □

11. Where did you encounter difficulty drawing conclusions or formulation recommendations? __________

12. Would you recommend the EPBDA to another colleague to use with a young child? Yes □ No □

13. Would you accept a referral to conduct another EPBDA? Yes □ No □

Your general feedback is welcomed:

THANK YOU

We are in the process of improving this assessment manual so that play therapists and other professionals will feel comfortable conducting the EPBDA.
References


