Assessment and Its Role in the Play Therapy Process

by Lynda Schmaljohn, MA, LPC, NCC, RPT-S, CPT-S

"The urge to simplify is extremely powerful. Human beings seem to be able to tolerate complexity for only brief periods of time."[1] I must admit that in periods of my history as a psychotherapist with families and children, I have emphasized the simpler and briefer side of assessment. Striving to survive demands of paper work, court dates, client crises, and schedules, the time to develop an assessment protocol only led to the crisis center verging on a Niagara Falls tumble. If you find yourself in a similar boat, I hope this article will bring some helpful tidbits and encouragement to look at our assessment structures more closely.

I am among those who would be called a "traditionalist" in the area of child and family psychotherapy assessment; those who believe that treatment should only be undertaken with as clear an understanding of the issues as is possible. An assessment protocol and development of treatment recommendations at the beginning of the treatment process are critical to the therapist's clarity and to engaging caregivers in the intense process into which treatment is most likely going to plunge the client and family. Only when we share with parents and caregivers the most informed picture possible, can they truly consent to assist in the therapeutic process. A lack of comprehensive assessment very well could lead to missing unique family and child strengths or cause damage to clients that could result in unsuccessful or incomplete treatment. Rather than to give into the urge to respond to the pain immediately, I believe that the clinician needs to take the time to assess carefully. This will, in the long run, lead to a deeper amelioration of the client's pain and symptoms.

The intake and assessment process is a decision tree each step of the way. A well planned intake leads to a clinician's choice of proceeding further up the assessment tree or stopping because the information obtained is sufficient. We as clinicians have an ethical obligation to use assessment instruments judiciously and only for the furtherance of our clients's well-being.

I would offer the following structure as food for thought to begin to develop and use your own assessment protocol.

(Assessment Protocol pull-out appears on page 3)

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Assessment Protocol

I. Develop an intake process to assess and understand the following:

A. Historical and current influence of the parents and caregivers of the child. Include the grandparents and extended family.

1) Parental perspective of the history of the child's presenting problem.
2) Has anyone in the family or extended family ever had a similar problem?
3) What is the current family constellation? Have there been changes in the child's lifetime?
4) How is alcohol used in the home? Other drugs, including prescription drugs?
5) Parental description of all of the children in the family emphasizing strengths.
6) List of all caregivers.

B. Health History

1) Of child, including pregnancy, birth, and post-birth.
2) Mother's health history, including time period in number 1.)
3) Of any significant family members.
4) Accidents/hospitalizations of child, either parent, or any siblings.

C. Developmental history interview questions (for one example see Lukas, p. 85)

D. The impact of societal forces such as poverty or wealth, etc.

E. The cultural experiences or beliefs the child has been exposed to or is currently a participant. (Not to judge, but to understand.)

F. Child's behavior and functioning from multi-settings.

1) School observations and reports to parents, collateral reports from schools and day cares.
2) Extended family observations of child in multiple settings: home, extended family homes, church, camping, etc.
3) In extracurricular settings: after school activities, music/art lessons, animal care and activities, etc.
4) Collateral assessment

   a) Child Behavior Checklist (CBCL)
   b) Parent Stress Inventory (PSI) – works well in conjunction with play therapy process.

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c) Denver Developmental Screening Test (ages 2 mos.-6 yrs.); Yale Revised Developmental Test (4 wks.-6 yrs., assessing gross and fine motor, adaptive, personal, social and language skills).

d) Assessing current attachment pattern, adapted from Carson and Goodfield (1988, pp. 118-119) found in Pearce, Pezzot-Pearce, pp. 134.

G. Information from the child's perspective

1) Name, preferred nickname, age, address, school/daycare.
2) Information about best friend and other friends.
3) What child knows or has been told about coming to therapy, about seeing you.
4) Child's perception of the problem.
5) Child's perception of the problem and/or child in relationship to the family, child's perception of family members.
6) Any other information gathering tools a clinician already uses.

II. Formal diagnostic instruments. These instruments would assist the clinician in assessing symptoms, syndromes, and cognitive functioning in order to decide in what direction to proceed next.

A. Cognitive testing

1) Wechsler Intelligence Scale for Children-R (WISC-R) – Helpful in identifying style of thinking, "strengths and weaknesses that might inhibit or potentiate treatment progress."[2] One can also compare a child's cognitive functioning to others in the same age range.
2) Southern California Ordinal Scales of Development (SCOSD) – Test six subscales: cognition, communication, social-affective, practical, gross motor, and fine motor. These scales are hierarchically arranged so items not completed can become intervention and treatment goals. Results from this scale provide a wide range of performance information. This instrument is based on Piagetian theory and paraprofessionals can be trained to use the instrument effectively.

These are only two of many possible assessment tools.

B. Interview/Rating Instruments

1) Diagnostic Interview Schedule for Children (IDISC) – appropriate for children 6-17 years old.
2) Interview Schedule for Children (ISC) – appropriate for children 8-17 years old.
3) Family Relations Test Children's Version (FRT) – appropriate for children 7-17 years old.
4) Developmental Therapy Objective Rating Form (DTORF) – appropriate for ages birth to 16.

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C. Clinical Observations

1) Note the following: Describe the child's general size and appearance, coordination, general intellectual functioning, capacity for relationships, mood of child, congruency of affect and play or interactions, use of and reaction to the environment, perception, speech, judgement, etc.

2) Mental Status Checklist-Children – appropriate for ages 5-12 (draws in observations of child, parent, and caregivers).

D. Interpretive Information

1) Draw-a-person
2) House-tree-person
3) Kinetic Family Drawing
4) Projective Storytelling: CAT (Children's Apperception Test) ages 3-10 years, or the RATC (Roberts Apperception Test for Children), which has more contemporary pictures.

III. Play Observations – Children communicate to others important issues such as psychological events or experiences, internal beliefs, or nonverbal experiences that are manifested through play behavior that is observable.

A. Your own list of observations to note: attitudes and responses to toys; responses to play room or office, therapist, family members; use of toys or materials (i.e. art supplies); age appropriateness, observations/unusual themes or unique choices of toys.

B. Structured play observations of child and/or family.
Puppet Assessment –Irwin; Gil
Build-a-House Technique – Sharp
Family Art Evaluation, Scribble Family Picture, and the Family Play Genogram – Gil

The therapist makes clinical decisions concerning which assessment instruments and which process to use with each child and the family in proceeding through the above outline. It is the responsibility of the therapist to be aware of a variety of modalities and instruments that could be used once the basic assessment is completed and to choose further assessments based on the information from these initial interviews, knowledge from reporting agencies, and the uniqueness of the child and family as the clinician's awareness has evolved.

Once the clinician has completed some form of the above initial interview and assessment protocol, more specific instruments can be chosen if a pattern of symptoms or a need to differentiate seems to be evolving. For example, if symptoms in an initial assessment seem to indicate potential depressive,

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traumatic or other symptom patterns, the clinician could decide to pursue a more specific assessment. In this case, a clinician might choose to assess in more depth an array of traumatic symptoms by choosing to use the Children's Impact of Traumatic Events Scale-Revised (CITES) and the Reynold's Child Depression Scale (RCDS).

Due to the limited space in this newsletter, I have summarized an outline of a potential protocol for an initial assessment. How to create a decision tree for further assessment has been only mentioned. Also, the instruments listed are but a few of many available. This is followed by a list of resources used to write this article. I am compiling information on assessment structures and protocols, favorite instruments and why, and formulations of decisions trees in order to write a journal article of depth on assessment of children entering and proceeding through the play therapy process. Any comments, information, or collaboration interest would be appreciated. Send to: Lynda Schmaljohn, 1045 Robertson Street, Ft. Collins, CO 80525, (970) 495-4738.

[1] Pearce, p. 66.
[2] O'Connor, p. 148.

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Assessment Resources

Psychological Assessment Resources, Inc.; P.O. Box 998, Odessa, FL 33556, 1-800-331-TEST, www.parnic.com

Western Psychological Services; 1-626-793-1148, www.wcps.com