DEVELOPMENTALLY APPROPRIATE PLAY THERAPY WITH ASIAN
AMERICAN CHILDREN

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DEVELOPMENTALLY APPROPRIATE PLAY THERAPY WITH ASIAN AMERICAN CHILDREN

A Project

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Abstract

DEVELOPMENTALLY APPROPRIATE PLAY THERAPY WITH ASIAN AMERICAN CHILDREN

by

Thanh Nuong - Kathy Thi Nguyen

Few community organizations exist for serving the mental health and wellness needs of Asian Americans. One such organization, the Transcultural Wellness Center (TWC), located in Sacramento, California, provides a breadth of services to Asian and Pacific Islander populations and their communities, but lacks programming that focuses on young children. The purpose of this project was to construct an in-service training on developmentally appropriate and culturally sensitive play therapy with Asian American children. A two-hour pilot training was conducted at the TWC on Tuesday, November 10, 2009. In attendance were 20 persons, including four supervisors, nine clinicians and five counselor specialists. Feedback from a TWC evaluation tool and a constructed questionnaire indicated that the participants felt the training was helpful and would like to continue learning about play therapy with the Asian and Pacific Islander population.

Marya C. Endriga, Ph.D.

Date
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Chapter 1

INTRODUCTION

Statement of the Problem and Purpose

Current data from the U.S. Bureau of the Census (2004) indicate Asian Americans currently constitute approximately 5% of the United States population with 13.5 million individuals. By 2050, this group is estimated to make up 10% of the U.S. population (U.S. Bureau of the Census, 2004). Asian-American children continue to face stressors including socioemotional adjustment difficulties and communication challenges stemming from socioeconomic status, immigration history including enculturation and acculturation (Kim & Omizo, 2005; Li & Kim, 2004) and cultural differences (Gil & Drewes, 2005) which may eventually result in them being referred for therapy.

Although few in number, community organizations exist for serving the mental health and wellness needs of Asian Americans, such as the Transcultural Wellness Center (TWC). The TWC is a full service partnership administered by Asian Pacific Community Counseling, Inc. (APCC) and developed in collaboration with the Sacramento County Department of Mental Health. APCC is located in Sacramento, California and is a community-based, nonprofit, tax-exempt agency, with a mission to promote the well-being of individuals and families through culturally and linguistically relevant relationship-based counseling, outreach, prevention, and education with an emphasis on serving Asian and Pacific Islander communities (Cameron, Ton, Yang, Endriga, Lan, & Koike, 2008). Despite this breadth of services, programming that focuses on young
children is lacking, such as developmentally appropriate and culturally sensitive play therapy.

With this program gap in mind, this project reviewed recent literature on working with Asian Americans in therapy and child development as it relates to play therapy. This information was then synthesized in order to develop an in-service training on play therapy with Asian American children. Specific objectives for the in-service training were:

1. To provide a background on play therapy and its importance,
2. To review child development and its relationship to play therapy,
3. To provide recommendations for what should be included in a play therapy environment
4. To introduce general play therapy techniques with Asian American children, and
5. To give examples of age appropriate toys and materials for paraprofessionals and/or therapists/counselors to utilize with Asian-American children that simultaneously support their development.

The project Introduction section presents a literature review of the following areas: a brief description of play therapy, play therapy with Asian Americans, current theories of play therapy, and play therapy and child development. The Methods section covers the steps included in the planning of the in-service training, constructing the training, and gathering of recommendations for equipping a play therapy environment. The Results section describes evaluation and data gathered from those in attendance at a
piloting of the in-service training and the Discussion section summarizes the project and suggests directions for future work in this area.

Play Therapy

Play therapy has been shown to be an effective method of treating children’s mental health in the following areas: self-concept, behavioral change, cognitive ability, social skills, and anxiety (Bratton & Ray, 2000). It has been used as a treatment of choice for young children since the early 1900s (Ray, 2006). Anna Freud (1928) and Melanie Klein (1932) are generally acknowledged as the originators of play therapy, using play to substitute for verbalized free association in their work with children. Virginia Axline’s (1947) application of nondirective therapeutic principles in her work with children was influenced primarily by Carl Roger’s (1942) person-centered theory. Later, Axline’s (1947) nondirective play therapy with children came to be called Child-Centered Play Therapy/CCPT (Frost, Wortham, & Reifel, 2008; Guerney, 2001; Russ, 2004; Schaefer, 2003). Axline (1949) was among the first to attempt to study the effects of play therapy and extend credibility to the intervention. Although Axline’s (1949) research does not address the rigor of research needed in the psychotherapy field to demonstrate efficacy of an intervention, she set the course for developing protocol and measuring effects of the play therapy approach.

Decades later in 1982, the Association for Play Therapy (APT) was founded and formed to develop and promote play therapy as a separate and distinct psychotherapy modality of treatment for children (Ray, 2006). APT currently serves more than 5,000
members identified as play therapy professionals (Frost et al., 2008). APT defines play therapy as "the systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development (Association of Play Therapy, Inc)" (¶ 2). Through play therapy, children learn to communicate with others, express feelings, modify behavior, develop problem-solving skills and learn a variety of ways of relating to others. Play provides a safe psychological distance from their problems and allows expression of thoughts and feelings appropriate to their development (Association of Play Therapy, Inc., 2009; Barnes, 2006; Kaufman, 1994). Play is currently recognized as a distinct and valid treatment modality that facilitates adaptive functioning in a variety of areas, such as social, emotional, cognitive, and personal development. Because play is a central experience for children as well as a natural form of communication for them, play provides a unique opportunity to step into their world, as well as to have a positive and direct influence on their adaptive functioning (Gitlin-Weiner, 2006; Russ, 1998; Russ, 2004; Russ, 2005). Overall, the results of research of play therapy are positive, demonstrating the efficacy and power of play for therapy and healing (Frost et al., 2008).

Yet, even though the research supports the treatment intervention of play therapy with children, there remains an abundance of issues when it comes to utilizing play therapy. First, in order to conduct play therapy, there needs to be a therapeutic setting for it. There has been some research on what should be included in a play therapy room and
how to structure the therapeutic environment (Frost et al., 2008), and some research on what should be included in a therapeutic setting that applies to multicultural and diverse clients (Gil & Drewes, 2005). Second, a vast amount of literature covers child development and how it relates to play therapy. It is shown that when children are at certain ages, they are only developmentally capable of certain activities and skills in the areas of physical, cognitive, language, social, and emotional developmental domains. Being equipped with the knowledge of what play activities and developmental tasks are age appropriate with a child in therapy is of great importance in terms of conducting effective interventions. Moreover, given that our society now includes children from diverse backgrounds, there remains the question of “how do we best provide treatment to children in a culturally sensitive way and still be responsive and effective to treating their specific needs?” Gil and Drewes (2005) use cultural knowledge, history, values, and traditions in order to provide a variety of approaches and insights for the purpose of play therapists to attend to the therapeutic needs of children, adolescents, and families from diverse cultures and backgrounds in a sensitive, yet respectful way. Included in their investigations and citations of recent research, play in the Asian American culture was one of them.
Chapter 2

REVIEW OF THE LITERATURE

Play Therapy with Asian American Clients

Asians are a very large and diverse group composed of at least 53 different ethnic groups (Gil & Drewes, 2005), within which four large general ethnic groupings within the Asian community have been identified: Pacific Islanders includes those from Hawaii, Samoa, and Guam; Southeast Asians includes those from Vietnam, Thailand, Cambodia, Laos, and Myanmar (formerly Burma), but also people from the Philippines, Singapore, Malaysia, and Indonesia; East Asians includes those from China, Japan, and Korea; and South Asians include those from India, Pakistan, and Sri Lanka (Gil & Drewes, 2005). It has been documented that the Asian-American population underutilizes mental health services as compared to European Americans (Kim, Ng, & Ahn, 2005; Root, 1985; Shea & Yeh, 2008; Sue & Sue, 2003), not necessarily out of lack of need but because of cultural, social, and service barriers (Kim, Atkinson, & Yang, 1999; Root, 1985; Sue & Sue, 2003). Numerous theorists have described the importance of recognizing and understanding the role of Asian American values in mental health theory, practice, and research. Asian cultural values have been associated with many psychological processes including therapeutic intervention and case conceptualization, academic achievement, career interests, coping, counselor cultural sensitivity, counseling attitudes, and counselor preferences (Yeh, Carter, & Pieterse, 2004). Numerous writers have also pointed out that the degree to which Asian American clients have retained the norms of their indigenous
cultures and have adapted to the norms of the European American culture plays a significant role in mental health outcomes (Kim et al., 2005). Values conflicts arising from cultural differences between Asian American clients and non-Asian counselors are frequently cited as a reason why many Asian Americans avoid seeking mental health services and why they often terminate therapy prematurely (Kim et al., 1999).

The common cultural threads running through Asian cultures are often very strong and are maintained for generations after people move to another country. In simple terms, “culture” consists of all those things that people have learned in their history to do, believe, value, and enjoy. It is the totality of ideals, beliefs, skills, tools, customs, and institutions into which each member of society is born (Sue & Sue, 2003). These beliefs, values, and behaviors of a culture provide its members with some degree of personal and social meaning for human existence, learned through tradition and transmitted from generation to generation (Ramsey, 2006). Therefore, culture, serves two functions: the Integrative, which are the beliefs and values that provide individuals a sense of identity and the Functional, which is comprised of the rules for behavior that enable the group to survive physically, to provide for its welfare, and to support an individual’s sense of self-worth and belonging (Kagawa-Singer & Chung, 1994). Play therapists must have cultural knowledge, yet also be careful to not over-generalize this knowledge; but rather, determine the implications for counseling on an individual basis. Knowledge of cultural values can help play therapists generate hypotheses about the way an Asian American might view a disorder and his or her expectations of treatment. Cultural differences, such
as degree of assimilation, socioeconomic background, family experiences, and educational level are all factors that impact an individual in a unique way. Therefore, a therapist’s task is to assist the client in identifying or developing different ways to deal with problems within cultural constraints and to develop or strengthen skills necessary to negotiate cultural differences with the larger society (Gil & Drewes, 2005; Sue & Sue, 2003).

Some of the Asian cultural values that may have implications for therapy include collectivism, conformity to norms, hierarchical relationships/family structure as well as deference to authority figures, filial piety, humility, maintenance of interpersonal harmony, avoidance of shame and saving face, emotional restraint, and academic and occupational achievement (Gil & Drewes, 2005; Kim, Hill, Gelso, Goates, Asay, & Harbin, 2003; Kim, Li, & Liang, 2002; Kim, Ng, & Ahn, 2005; Kim & Omizo, 2005; Li, O’Brien, & Kim, 2007; Shea & Yeh, 2008; Sue & Sue, 2003; Yeh, Carter, & Pieterse, 2004). Asians are often characterized as relational, interdependent, or collectivistic; characterizations that contribute to a strong cultural emphasis on obedience, duty, personalized relationships, and in-group and social harmony (Shea & Yeh, 2008; Yeh et al., 2004). Instead of promoting individual needs and personal identity, Asian families typically have a group or family orientation. That is, the needs of the individual and autonomous behaviors are not encouraged (Sue & Sue, 2003). Instead, children are expected to strive for family goals and not engage in behaviors that would cause the family shame. The limited focus on individuation and identity is consistent with
traditional Asian cultural values that diminish the importance of the individual in comparison to the family or the collective. The individual-centeredness of American society is in sharp contrast to the group-centered, extended family unit of Asian cultures (Huang, 1994). In a society that emphasizes individualism and encourages self-directed behavior and autonomy, potential problems may arise.

In therapy, it is important that the therapist ask the client whether or not to include the family in the decision making process and determine if it is vital for them to be involved in dealing with the problem. Another question the therapist can ask is how the treatment goals will affect the client, the family, friends, and the social community in order to address any possible problems or concerns that could potentially be due to having a collectivistic orientation (Gil & Drewes, 2005; Sue & Sue, 2003; Yeh et al., 2004).

Traditional Asian American families tend to have a family structure that is both hierarchical and patriarchal, with older individuals and males occupying a higher status. Children are expected to show deference to adults and sons are also expected to carry on the family name and tradition. Even after they are married, their primary allegiance is to the parents. In family therapy, it is important to analyze the family structure and communication patterns. It is suggested that the father be initially addressed, followed by the mother. Moreover, if English is a problem, an interpreter can be utilized, since using a child to interpret would contradict the hierarchical structure (Sue & Sue, 2003).
Another value held by Asian families is having emotional restraint and face-saving. Demonstrating emotional restraint is a sign of maturity, whereas strong emotional displays indicate a lack of control and immaturity. This can be challenging in therapy since showing emotions can make the client and family members feel ashamed. Shame has a predominant influence in traditional Asian cultures where people learn to act very cautiously because an individual’s misbehavior reflects poorly upon the status of the family and community. In a play session, for instance, a child may be cautious and may not play or talk spontaneously. It then becomes important for the play therapist to not automatically assume that this behavior is resistance (Gil & Drewes, 2005). For example, as cited in Hinman (2003) and O’Conner (2005), Japanese American families seeking play therapy for their child may have a sense of shame for not being able to effectively deal with their child’s difficulties. To effectively engage them, ensuring confidentiality is a start (Hinman, 2003; O’Conner, 2005). Furthermore, other misunderstandings can arise from nonverbal communication in play therapy. Nonverbal behaviors such as smiling, head nodding, and verbal assent on the part of an Asian American client can be interpreted as agreement by a Western therapist, when it could just simply represent friendliness and interest. In this case, therapists should be cautious when interpreting such behaviors (Gil & Drewes, 2005; Sue & Sue, 2003).

Perhaps, one of the most salient reasons that Asian American children come to therapy is the pressure for academic achievement. Asian cultural values and practices promote academic excellence (Asakawa, 2001). Based largely on anecdotal and
observational evidence, investigators have identified the following values or practices in Asian families that promote educational achievement: demands and expectations for achievement and upward mobility, induction of guilt about parental sacrifices and the need to fulfill obligations, respect for education, social comparisons with other Asian-American families in terms of education success, and obedience to elders such as teachers (Sue & Okazaki, 1990). There is great pressure for children to succeed academically and have a successful career since both would be indicative of a good family upbringing – high achievement brings honor and prestige to the family, whereas failure brings shame. Such pressure may lead to problems for children, including constant self-criticism and lowered self-esteem despite attaining relatively high levels of success, and shame and alienation if they fail to achieve as expected. In addition, parents of children who are struggling may also suffer, as they interpret their children’s school failures as their own parenting failure (Gil & Drewes, 2005; Sue & Sue, 2003). Nonetheless, such academic issues need to be discussed in an open manner in the therapy process so that underlying family issues can be understood and addressed (Gil & Drewes, 2005).

Types and Theories of Play Therapy

Psychodynamic Play Therapy (Harvey, 1994; Russ, 2004; Schaefer, 2003)

Psychodynamic play therapy goals include helping the child to suffer less; overcome trauma; adjust to life events such as divorce; cope with illness; comply with treatment; master phobias; be better able to attend, learn, and work in school; manage personal anger and aggression; and come to terms with a learning disability or physical
handicap (Harvey, 1994). The therapy intends to go beyond the immediate pain or difficulty and remove obstacles to healthy development that has been stalled or detoured by external trauma or untenable internal conflict. Therefore, the goals of psychoanalytic play therapy tend to be ambitious and aspire to change not just a behavior or symptom, but broader, deeper, and more essential aspects of the child and his/her ways of dealing with life and its ordeals (Russ, 2005). Empirical support for psychoanalytic play therapy is sparse and weak as much of this research is based on case studies that provide in-depth, subjective analysis of a single child’s treatment. Although much of the case study research on psychoanalytic play therapy is detailed in the observations and insights, it lacks the standardization and measurement that experimental and controlled studies can provide (Schaefer, 2003).

*Child-Centered Play Therapy/CCPT* (Guerney, 2001; Russ, 2004; Schaefer, 2003)

Originally called non-directive play therapy by Virginia Axline (1947, 1949), the rationale for CCPT is derived from Carl Rogers (1951) who developed the philosophy of personality development and client-centered/nondirective therapy. The basic assumption is play therapy can be most effective when the child takes the lead in the play therapy without direction from the therapist (Guerney, 2001). The role of the therapist is to facilitate the child’s growth and to provide a safe place in which the child can grow (McCalla, 1994). Thus, the child-centered approach embraces the belief that children can grow and heal when their environment facilitates that growth free from an agenda or


CBPT incorporates behavioral and cognitive interventions into a play therapy paradigm and integrates these in a developmentally sensitive way. There is a strong emphasis on the child’s involvement and active participation in treatment. CBPT is brief, time-limited, structured, directive, and problem-oriented. It depends on a sound therapeutic relationship in which one role of therapy is educational. CBPT is a collaborative process, one in which the child is a participant and the parent is involved. Methods of CBPT include modeling, role-playing, and behavioral contingencies (Knell, 1994; Schaefer, 2003). Behavioral techniques of CBPT include systematic desensitization, contingency management (positive reinforcement, shaping, stimulus fading, extinction and differential reinforcement of other behavior), self-monitoring, activity scheduling (Knell, 1994). Cognitive techniques of CBPT include recording dysfunctional thoughts, cognitive change strategies, coping self-statements, bibliotherapy (Knell, 1994; Schaefer, 2003).

CBPT treatment stages include assessment using parent report inventories such as The Child Behavior Checklist by Achenbach and Edelbrock (1983), clinical interview, play assessment measure, cognitive/developmental tests, or projective tests such as Thematic Apperception Test, Children’s Apperception Test, and Roberts’s Apperception
test for Children. CBPT stages also include introduction/orientation to therapy, middle stages, and termination (Knell, 1994).

Because cognitive therapy with young children can prove to be challenging, Knell (1994) argued that it could be modified with young children in the way it was presented. For instance, puppets, stuffed animals, books, and other toys could be used to model cognitive strategies. With a coping model approach, for example, the model (e.g. puppet) might verbalize problem-solving skills or solutions to problem that parallel the child’s own difficulties (Schaefer, 2003).

CBPT is a developmentally based, integrated model of psychotherapy that incorporates empirically-supported techniques such as modeling and systematic desensitization. Although cognitive techniques have been well established and empirically supported with adults with various presenting diagnoses, CBPT is still in the early stages of empirical validation (Schaefer, 2003).

Adlerian Play Therapy (Kottman, 1994; Kottman, 2001; Schaefer, 2003)

In Adlerian therapy, play therapists utilize the concepts of Alfred Adler’s Individual Psychology to conceptualize the child’s: a) belief about self, others, and the world, b) methods for attaining a sense of belonging in the family, and c) behaviors that stem from the child acting as if his or her beliefs are true (Kottman, 2001). The goals and techniques of Adlerian play therapy can best be understood in the context of each of the four stages of the therapeutic process.
The primary goal of the first stage of Adlerian play therapy is building an egalitarian relationship with the child. Tracking is a technique used in this phase by reflecting and telling the child what the child is doing. By tracking, the therapist is letting the child know what s/he is doing is important. During the second stage, play therapists use a variety of strategies including art, questioning, observation of play patterns, and solicitation of early recollections in order to gain a clear understanding of the child’s interpersonal and intrapersonal dynamics. The third phase of the therapy process includes the goal of helping the child gain insight into his or her lifestyle. Techniques used in this phase include metacommunication, delivering metaphors, “spitting in the soup” (spoiling the game of the client), and drawing techniques to convey essential information about lifestyles, mistaken beliefs, goals of misbehavior, and assets to the child. The final stage, the reorientation/reeducation phase, is designed to help the child learn and practice more positive attitudes, perceptions, beliefs, feelings, and behaviors. This phase includes many directive techniques in order to facilitate learning in a variety of areas including problem-solving skills, social skills, negotiation skills, and other skills that are lacking in his or her behavioral repertoire.

Adlerian play therapy appears to work well with children who have acting out behavior, getting into power struggles with others or children who are highly anxious or perfectionistic. Although there is little empirical support for Adlerian play therapy, anecdotal information and case studies in the professional literature provide some support for the efficacy of this approach (Schaefer, 2003).
Time-Limited Play Therapy (Sloves & Peterlin, 1994)

Time limited play therapy is a dynamically oriented, closed-ended, individual psychotherapy with a duration lasting no more than 12 sessions and with a termination date agreed upon before the therapy begins. Time limited play therapy has some unique characteristics, which separate it from traditional long-term therapies. First, this treatment demands the selection of a single dynamic focus or central theme that underlies the child’s challenges in order to determine the main goal of therapy. Second, therapy is theme driven; for example, the central theme is the child’s feelings of separation and loss. The chosen theme represents, at any moment, the child’s cognitive, psychodynamic, and interpersonal struggle to gain mastery over the environment. Third, the brief nature of the treatment requires that the therapist is actively involved and serves to nurture and sustain a positive transference throughout the treatment process. Fourth, the play therapy is structured in order to avoid regression, dependency, and a sense of helplessness on the part of the child. Lastly, time, which is written in the initial contract, is used in a unique way to maintain the momentum of the therapy process and the child to appreciate the passage of time (Sloves & Peterlin, 1994).

Gestalt Play Therapy (Oaklander, 1994; Oaklander, 2001; Schaefer, 2003)

Gestalt therapy is a dynamic, present-centered, humanistic, process-oriented mode of therapy that focuses attention on the healthy integrated functioning of the total organism, including the senses, the body, the emotions, and the intellect (Oaklander, 2001). The therapist respects the uniqueness and individual process of each child, while
at the same time providing activities and experiences to help the child renew and strengthen those aspects of the self that have been suppressed, restricted, and, perhaps, lost. The therapist never intrudes or pushes but gently creates a safe environment in which the child can engage in a fuller experience of himself or herself.

Numerous expressive, creative, and projective techniques are utilized in Gestalt therapy, such as graphic art forms, clay, sand play, music, storytelling, puppets, fantasy and imagery, sensory experiences, and body movement experiences. These techniques in combination with the Gestalt therapy approach have been used with great success in various populations from senior adults to children of all ages. This approach has crossed many cultural boundaries as evidenced by the fact that Windows to Our Children: A Gestalt Therapy Approach to Children and Adolescents (Oaklander, 1988) has been translated into 11 languages, including Chinese and Korean (Schaefer, 2003).

Ecosystemic Play Therapy/EPT (O’Conner, 1994; O’Conner, 2001; Schaefer, 2003)

Ecosystemic Play Therapy (EPT) is an integrative model of play therapy that requires the therapist to always consider the child, his/her problems, and the therapy process within the context of the child’s entire ecosystem. EPT is theory dependent versus technique dependent (O’Conner, 2001), meaning that it is based on other theories, but does not provide specific techniques. Ecosystemic play therapy is a relatively new model, developed in the 1980s, that integrates elements of many psychological, social work, and systems theories. The goal in creating this theory was to encourage play
therapists to take a very broadly systemic perspective in developing their case conceptualizations and treatment plans.

Ecosystemic Play Therapy is a theory grounded in phenomenology, a philosophy based on the notion that there are no absolute right and wrong answers: instead, all knowledge and its value are relative. In this model, personality is defined as the “sum of intra-and interpersonal characteristics, attributes, cognitions, beliefs, values, and so forth that make a person unique” (Schaefer, 2003, p. 245). The basic motive driving personality is thought to be the desire to maximize the rewards obtained in daily life while avoiding negative consequences. Early attachments and developmental factors are important factors that influence personality. Consistent with this model of personality, pathology is defined as occurring in children who are “unable to get their needs met in ways that do not substantially interfere with the ability of others to get their needs met” (Schaefer, 2003, p. 248). That is, the child has been thwarted in his/her attempts to satisfy their basic drives (Schaefer, 2003).

Ecosystemic play therapy is particularly adaptable for two reasons. First, because the model focuses on child development in conceptualizing and treating children’s challenges, it is therefore flexible enough that it can be used with infants as easily as it can be used with adolescents. Secondly, the developmental focus of this theory allows the therapist to vary the intervention style to match the client without having to vary the underlying theoretical model. So, the developmentally younger the child, the more the therapist will take responsibility for the content and structure of the sessions, and play
will dominate. The developmentally older the child, the more the therapist will facilitate the child in doing his or her own problem solving and balancing play and verbal activity in the session (Schaefer, 2003).

The theoretical models mentioned above have not been researched in terms of their specific applicability to the Asian American population. However, Gil and Drewes (2005) have outlined suggestions for modifying play therapy techniques as it applies to working specifically with Asian children.

Modifying Play Therapy Theory and Techniques for Asian American Children

*Adjusting the Frequency of Tracking Behavior*

Play therapists usually use the technique of tracking when initially meeting with a child in therapy in order to establish rapport with the child. Consideration ought to be given to “collectivism” in Asian cultures and a child may be more comfortable being a part of a group and not singled out. Constant tracking of behavior by the therapist may be perceived by the child as receiving too much attention and cause self-doubt. Therefore, adjusting the frequency of tracking behavior may help the child feel more at ease in the therapeutic setting.

*Clarifying the Nature of Limit Setting*

Limit setting is important for any therapeutic relationship and is one of the main principles in psychotherapy. However, for some Asian children, limit setting can be perceived as criticism and may cause them to feel that they have done something wrong or shameful. In order to be sensitive to the child, limit setting that is clear and directed to
a behavior and not the child, will be helpful in dealing with the possible sensitivity to criticism. Stating to the child that a limit setting is a rule may also prevent the child from taking it too personally.

**Being Attentive and Sensitive to Nonverbal Cues**

Asian children are often seen as polite, quiet, cooperative, and hardworking. Therefore, language and cultural differences can present barriers in communication and also limit a child’s expression since self expression and voicing personal opinions in the Asian culture is not considered desirable. Therefore, the therapist may need to focus attention on nonverbal cues and behaviors in order to get a better assessment and understanding of the child’s play.

**Being Careful about Reflection of Feelings**

Asians are generally more reserved than Westerners about openly expressing feelings. Older children are expected to be able to contain and regulate feelings and emotions since openly displaying feelings is a sign of immaturity. This may contradict the therapy process, which involves open exploration of thoughts and feelings. The therapist should be careful in choosing words to reflect a specific feeling and avoid strong feeling words that may cause the child to feel awkward.

**Being Cautious in Interpreting Play Behavior**

Interpreting a child’s play behavior can vary depending on the therapist’s cultural perspective. It is advised that therapists keep an open mind and use observations to
generate hypotheses and make interpretations. Moreover, a therapist should also leave room for a child to correct an interpretation and not view it as resistance in therapy.

*Taking a More Directive Approach*

Although many nondirective play therapists can work effectively with Asian children, many Asian children are more familiar with adults being authority figures and taking an educational role. A child may need to be prepared by the therapist and given clear expectations of what to receive from play therapy. Hence, a more directive approach may be useful in guiding the child through the therapy process.

*Using More Self-Esteem-Building Skills*

Encouragement is a very helpful strategy in building a positive relationship with a child. Because a therapist is viewed similar to a teacher (an authority figure from a Chinese point of view), children feel a sense of accomplishment when being praised or recognized by an authority figure.

*Communicating Genuineness and Trust through Nonverbal Skills*

Communication between people can go beyond words to include facial expressions and gestures and tone of voice, among other things. Thus, it is suggested that the therapist and child accept that cultural limitations exist and acknowledge efforts made in communication. The child can sense the therapist’s efforts and can change and grow in response to the therapist’s genuineness.
Play Therapy and Child Development

Research on developmentally appropriate tasks and activities for children of different ages support the categorization of play in the infant and toddler years, play in the pre-school age years, and play in the school-age child. Gitlin-Weiner (2006) asserts that play skills are similar to social and cognitive skills, in that they follow a fairly specific normative pattern of development that moves along a continuum ranging from basic to very complex actions. At each stage, play is essential to the acquisition and mastery of multiple developmental tasks. Clinically, this information is especially important when working with emotionally challenged individuals. Therapists must have a solid understanding of typical age-appropriate play behaviors in order to identify delays, deviations, fixations, or precocities, as well as to plan and implement effective treatment interventions. Therapists’ understanding of how play competencies are achieved permits them to establish realistic expectations for the content of play, choice of play activities, types of toys, continuity of play, ability to differentiate reality and fantasy, and degree of interaction with the therapist. The use of play in treatment is most effective when the type of challenge the therapist presents matches the individual’s skills and developmental level of functioning (Gitlin-Weiner, 2006).

*Play from Birth to Two Years*

In the first two years of life, the infant/toddler is rapidly developing in two major areas: physical development and motor development. By the end of the first year, the infant has tripled its weight and increased its length by seventy-five percent. An
important characteristic of physical development is the growth of the brain. At birth, the brain has achieved a fourth of its adult weight and will develop to three fourths of its adult weight by age two. Other physical growth development includes increase in skill growth in relation to increase in brain size. Physically, teeth also start to grow at an average age of six months. Perhaps the most significant changes in the first two years, however, are in the area of motor development. The newborn infant’s motor abilities are described as reflexes. The toddler is able to climb stairs and run outdoors and is said to have achieved full mobility by the age of two.

Physical development in the infant and toddler results in development of gross and fine-motor skills and abilities (Frost et al., 2008). Gross motor skills involve large body movements. Frankenburg, Frandel, Sciarillo, and Burgess (1981) suggest that gross-motor achievements during the first two years follow this predictable sequence: lifts head and holds erect and steady, rolls over, sits propped up, sits without support, stands holding on, walks holding on, stands momentarily, stands alone well, walks well, walks backward, walks up steps with help, jumps in place, kicks a ball. Fine motor skills, on the other hand, require coordination of emerging abilities. These include control of the arms and hands. The first skill developed is the ability to grasp an object, which requires coordination of the eyes and hands. This skill is mastered at about six months, followed by exploration and practice in grasping objects in the environment (Fromberg & Bergen, 2006; Frost et al., 2008).
In addition to physical and motor development during the infant and toddler years, cognitive development also proceeds at a fast rate. Known as the sensorimotor period, Piaget (1952) believed that intelligence in infancy depends on the senses and physical abilities. Infants are able to see, hear, taste, and smell from birth. They use their senses to perceive the environment around them and that perception supports cognitive development. Piaget elaborated the sensorimotor period with six substages where intelligence becomes more advanced through each substage. Between the ages of 8-12 months, the infant is in Piaget’s stage called coordination of secondary circular reactions. The infant is able to walk and can coordinate several different behaviors, such as playing with more than one object. Most importantly, however, memory is developed as evident by the emergence of object permanence. With the development of memory, symbolic or pretend play begins (Frost et al., 2008).

Moreover, like cognitive development, the acquisition of language during the first two years is a very impressive achievement and also occurs in a sequence. Between birth and two years, infants and toddlers learn enough about their language to speak and develop a vocabulary ranging from fifty to two hundred words. Language is used in play with the child and can teach the child the game of taking turns (Frost et al., 2008).

The first two years of life are important for development and play. Emerging senses are used to engage in pleasurable play activities. This engagement in activities combined with new abilities in physical, cognitive, and social development widen possibilities for play. Gross and fine motor skills enable the infant and toddler to achieve
mobility and to grasp and explore objects. As these skills are mastered, play becomes more sophisticated. As infants are able to move about and manipulate objects, play with body parts expands to play with toys (Frost et al., 2008).

Play in the Preschool Years

According to Vygotsky (1976), play is the leading source of development in the ages between two and six. Critical transformations occur in children’s relationships to their social and physical world between the ages of four and eight (Johnson, 2006). Whereas toddlers are gaining control over basic movement skills and mobility, preschoolers refine mobility skills through a range of motor activities involving the entire body. Gross-motor development includes locomotor dexterity, which requires balance and movement and upper-body and arm skills. Preschool children gain more precision in fine-motor development between ages of three and five. This allows them to become proficient in using small materials that require grasping and control such as stringing beads, cutting with scissors, pasting, tracing, drawing, coloring, and using a computer keyboard.

Combining the use of the senses and motor skills, the child increases its ability to interact with the environment, also known as perceptual-motor skills. Perceptual motor-skills include body awareness (capacity to understand body parts and what it can do to be more efficient), spatial awareness (knowledge of how much space the body occupies), directional awareness (understanding of location and direction of the body in space), and
temporal awareness (development of awareness of the relationship between movement and time) (Frost et al., 2008; Johnson, 2006).

The preschool children make gigantic strides in their cognitive and social development during this time. Play is said to promote cognitive development. For example, sociodramatic play promotes intellectual development to include imagination and creativity. Children between the ages of two and seven are in Piaget’s (1952) preoperational stage of development, in which children are able to represent objects and events mentally, therefore, allowing use of more complex symbolism. Preoperational children are described as egocentric – concerned with their own thoughts and ideas and unable to consider the point of view of others. Children move through stages of play that have been described in various ways by various theorists, including Piaget (1952), Vygotsky (1976), and Smilansky (1968, 1990). The stages reflect the child’s cognitive progress and ability to use cognitive advances in play (Dougherty & Ray, 2007; Frost et al., 2008).

Language development and literacy permit school-age children to communicate with others. During the years between three and six, children acquire the major components of their language and their vocabulary increases dramatically. Most children during this time also possess an impressive array of social and physical concepts and rudimentary and preoperational thinking skills. They have acquired sufficient levels of social competence and abilities to regulate attention, affect and activity to sustain peer interactions, nurture budding friendships and engage in prolonged play episodes alone or
with others. Through varied experiences including books, stories and writing activities, young children learn about written language and take initial steps in acquiring literacy as reflected in their play, particularly sociodramatic play.

Sociodramatic play includes pretend play and role play. Fantasy and fantasy play are key elements in healthy child development, and as such, it is an important resource for play therapy. Moreover, using superheroes in storytelling and therapeutic play can be useful for a variety of problems in young clients: improving social and conflict resolution skills, helping them to understand what it means to be a member of a team, helping to heal from physical/sexual abuse, family trauma, the challenges of living with a disability, acculturation difficulties, grief and loss, as well as anger (Frost et al., 2008; Johnson, 2006; Rubin & Livesay, 2006; Smilansky, 1968).

Play and the School-Age Child

Children in this age range continue to develop physically in the area of gross and fine motor skills. They also continue to develop cognitively in their language and literacy abilities, as well as socially and emotionally. Improved gross motor skills are reflected in flexibility, balance and agility. For instance, there is more flexibility in swinging a bat and improved balanced and agility in sports such as soccer or hopscotch. Whereas six and seven year old children may still be inaccurate in batting and more successful at T-ball, older school-age children can throw and kick a ball with greater force. Hence, older school-age children are able to participate in games such as handball, tennis, basketball and football. Fine-motor skills are improved as evident in school-age children’s
handwriting and drawing abilities. First-grade children are typically able to write their names, letters of the alphabet and numbers. As they get older, they are able to form letters more accurately. By third grade, fine motor skills are strengthened and children start to write in cursive.

Cognitively, children enter the concrete operational period, which enables them to use logical and organized thinking. Games with rules begin about the age of seven, when children enter into a concrete form of intelligence according to Piaget (1952). During concrete operations, play shifts from an egocentric to a socialized form, and symbols are replaced by rules (Dougherty & Ray, 2007; Elkind, 2007). These advances in cognition can help explain school-age children’s interests in games and sports with rules. Children are able to follow rules for a game as well as make up their own games with their own rules. Nonetheless, while games with rules increases in popularity during this age, pretend play declines (Frost et al., 2008).

Developments in language and literacy provide children with the ability to engage in play in the form of telling jokes and engaging in social rituals such as trading playful insults with their friends and use special language with peers and their social groups. Social development is significant during this time because school-age children face challenges of becoming competent learners and members of social groups. They become aware of their strengths and weaknesses and begin to compare themselves in relation to their peers. Self-concept and self-esteem are a major part of the school-age child’s social development. With play, school-age children are interested in activities with a group of
peers. Gender differences in play are also typical, with girls more likely to engage in
conversations and play that requires taking turns, whereas boys are more likely to engage
in rough play and play outdoors (Barnes, 2006; Frost et al., 2008).
Chapter 3

METHODOLOGY

Planning for Training

The Transcultural Wellness Center (TWC) is a full service partnership administered by Asian Pacific Community Counseling, Inc. (APCC) and developed in collaboration with the Sacramento County Department of Mental Health. APCC is a community-based, nonprofit, tax-exempt agency, with a mission to promote the well-being of individuals and families through culturally and linguistically relevant, relationship-based counseling, outreach, prevention, and education with an emphasis on servicing Asian and Pacific Islander populations and their communities (Cameron, Ton, Yang, Endriga, Lan, & Koike, 2008). As part of staff development, in-service trainings are provided throughout the year in order for staff to better service the needs of the populations served.

One part of the training series requested by the TWC is to provide training on Play Therapy Techniques with Asian American children. Since the training was requested by the agency, the next step in developing the training was to define the target population for the training. Tannenbaum and Yukl (1992) recommend conducting a training needs analysis in order to design and develop a useful training program. Included in a training needs analysis is a task analysis and person analysis. A task analysis identifies the tasks performed on the job including the knowledge, skills, and abilities (KSAs) needed to perform these tasks. A person analysis, on the other hand, focuses on identifying who
should be trained and what training is needed by an individual (Tannenbaum & Yukl, 1992). For the training, the target population was staff members at the Transcultural Wellness Center (TWC) consisting of Clinicians, Counselor Specialists, and Supervisors with varying educational and professional experiences. The training coordinator and an outside consultant for TWC/APCC agreed that all levels of staff were in need of more KSAs related to interacting with young children in a developmentally and culturally sensitive manner. Further, they shared their long-term goals for use of the organization’s playroom that included therapeutic play activities for child consumers, siblings and their families.

The next step after identifying the target population was to develop training objectives based on the training needs analysis. The training objectives were as follows:

1. Provide a background on play therapy and its importance,
2. Review child development and its relationship to play therapy,
3. Provide recommendations for what should be included in a play therapy environment,
4. Introduce general play therapy techniques with Asian American children, and
5. Give examples of age appropriate toys and materials for paraprofessionals and/or therapists/counselors to utilize with Asian-American children that simultaneously support their development.

After defining training objectives, the following step was to synthesize the relevant literature regarding play therapy and child development as well as play therapy
with Asian American children into a PowerPoint presentation for the in-service training (see Appendix A). The review focuses on a plethora of the most recent research in these areas in order to provide the most up to date information on which to base the training objectives discussed above. The literature review presented in Chapter 1 was used as the basis for the training and included information from professional journal articles, periodicals, and books identified through psychological abstracts, bibliographies, literature reviews, database searches, and internet keyword searches. The methodology used for the recommendations are from the compilation and integration of the existing research on what constitutes a therapeutic environment that supports a multi-cultural population and developmentally appropriate play therapy toys and materials with children, specifically, Asian American children.

Finally, as part of planning for the in-service training, an evaluation form was constructed for the purpose of gathering feedback from participants for the training on Developmentally Appropriate Play Therapy with Asian American Children (see Appendix B). The questions on the evaluation forms were free response items beginning with the following stems: 1) Three things I learned from this training are, 2) Strengths of this training are, and 3) Weaknesses of this training/things that could be improved are. The purpose of the first item was to determine whether or not the training information was useful by having the training participants list three things they learned. The purpose of the second item was to collect information on what each participant felt were the strengths of the training in order to continue incorporating that into future trainings.
Finally, the purpose of the last item was to obtain input from the training participants in order to make necessary modifications to enhance the training in the future. The evaluation form constructed for this training was used in conjunction with the standard training evaluation tool used by TWC (see Appendix C).

Questions 1 through 6 on the evaluation tool used by TWC were rated on the following three point scale: Yes, No or Somewhat. The following is a list of questions asked:

1. Did the training meet your expectations?
2. Did you feel that the training was relevant to your work at APCC?
3. Did you feel that the training was interactive enough?
4. Was the presenter knowledgeable in the topic presented?
5. Was there adequate opportunity to ask questions?
6. Were your questions/concerns addressed?

Question 7 in the training evaluation form requested for staff to rate the following question on overall training on a scale of 1 to 5 with 1 being low and 5 being excellent:

7. Overall, how would you rate this training?

Additional questions on the training evaluation form were not rated on a scale, but rather allowed training participants to respond freely. The following is a list of the free response questions/items:

8. What would have made this training better?
9. Other trainings you’d like to see at APCC:

10. Would you be willing to provide training for staff about your culture?

The Pilot Training

After the planning for the training was completed, a pilot training was conducted at the Transcultural Wellness Center (TWC) on Tuesday, November 10, 2009 from 10:00AM to 12:00PM. Evaluation forms were given to all participants in attendance and collected at the end. Evaluation forms from the TWC were also provided to all participants in attendance, the results of which are presented in the Results section, below.

The current project has three end products (i.e., deliverables) based on the compilation of past and recent research on play therapy, child development and the research on play therapy with Asian American children. The first end product is the PowerPoint presentation provided to staff for the in-service training titled “Developmentally Appropriate Play Therapy with Asian American Children.” The second end product is a summary of recommendations for a play therapy environment and a detailed list of appropriate toys and materials for children, categorized by age and types of play. The third end product provided by this project is a resource list of materials and specific pricing for them. The three end products are attached as Appendices A, D, and E, respectively.
Chapter 4

RESULTS

In attendance for the Tuesday, November 20, 2009 training given at the Transcultural Wellness Center (TWC) and titled “Developmentally Appropriate Play Therapy with Asian American children” were 20 persons, including four supervisors. Of the 20, there were nine Clinicians pursuing hours for either Licensed Clinical Social Work (LCSW) or Licensed Marriage and Family Therapy (LMFT) and five Counselor Specialists. Table 1 shows an exact breakdown of questions and contains frequencies of respondent ratings across the three categories based on data gathered from the organization’s own evaluation tool.
Table 1

*Frequencies of Respondent Ratings on the TWC Evaluation Tool*

<table>
<thead>
<tr>
<th>QUESTIONS</th>
<th>YES</th>
<th>NO</th>
<th>SOMEWHAT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Did the training meet your expectations?</td>
<td>9</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>2) Did you feel that the training was relevant to your work at APCC?</td>
<td>11</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>3) Did you feel that the training was interactive enough?</td>
<td>7</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4) Was the presenter knowledgeable in the topic presented?</td>
<td>13</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>5) Was there adequate opportunity to ask questions?</td>
<td>14</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>6) Were your questions/concerns addressed?</td>
<td>15</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

The mean participant rating from question 7 of the organization’s training evaluation based on a scale from 1 to 5 (1 being low and 5 being excellent), was 3.86. According to question 8 from the organization’s evaluation tool, in general staff in attendance thought it was extremely helpful and would like to continue learning about play therapy with the Asian and Pacific Islander population. Specific comments in the free response section revolved around having a more interactive presentation, such as role-play, video, and case studies. One comment stated that it was “inappropriate to discuss options for play room because of budget, space, and structure.”
From the evaluation tool constructed for this project, 15 total forms were gathered from participants. Of the 15 evaluation forms collected from participants, 14 of the 15 participants listed at least one thing they learned from the training and nine listed three specific things they learned. Specifically, the participants felt that the strengths of the training included:

1. Presenters being knowledgeable in the area
2. Being detailed and organized
3. Nice preparation with developmental stages and play therapy techniques
4. Helpful materials and information dealing with Asian and Pacific Islander group
5. Having easy to read and clear power point presentation handouts to follow along
6. Being engaging with the participants
7. Being very informative for service providers with no or little play therapy background
8. Being informative about cultural considerations when working with Asian and Pacific Islander population
9. Having well researched material
10. Providing personal experiences and examples to illustrate point
11. Having open discussion
12. Having an extensive list of materials to choose from
Although several of those in attendance listed no weaknesses of the training, the rest of the participants listed the following as some of the weaknesses of the training or suggestions that could have been included to enhance the training:

1. Using video clips
2. Engaging participants with specific hands on exercises
3. Using case studies
4. Using role play
5. Provide ways of keeping child engaged in play therapy if client is not engaged or is losing interest during session
6. Provide specific examples of what to verbally say to a client to keep them engaged
Chapter 5

DISCUSSION

This project examined the following three areas of literature in relation to play therapy: therapy with Asian Americans, current theories of play therapy, and play therapy as it relates to child development. The objective of this project was to integrate the information gathered from the literature review to construct an in-service training on play therapy techniques with Asian American children to be used by community organizations that serve the mental health and wellness needs of the Asian American population. Other objectives included making recommendations for a play therapy environment that supports the development for Asian American children and giving specific examples and pricing of toys and materials for children of various age ranges.

The importance of researching play therapy with the Asian American population is established in the literature. Although there is presently a growing body of research for working with Asian Americans in therapy in general and the problems that may arise based on their cultural values, acculturation, and enculturation, the research on working specifically with Asian American children in play therapy is limited. Additionally, research on theories of play therapy and their applicability to Asian American children in play therapy is lacking. However, Gil and Drewes (2005) provide some useful guidelines for paraprofessionals and play therapists/counselors to use as a reference when working with Asian American children.
The stages of child development as they relate to specific age appropriate skills and developmental tasks have been well researched and documented in the literature. Specific literature on working with Asian American children in play therapy is a relatively new area that can benefit from further studies in the future. Perhaps future directions in this area could look at studying the effects and outcomes of utilizing the current guidelines provided in this project in combination with using the suggested toys and materials in the therapeutic process when working with Asian American children in play therapy.

Based on the evaluations gathered from the in-service training, participants felt that the training was helpful and that they learned some new things about the topic. Overall, participants thought that there were strengths to the training, but they also provided feedback in terms of weaknesses of the training and areas that could use improvement for the future. Suggestions for future enhancements to the training included the following: use video clips, provide specific hands on exercises, use case studies, use role-play, provide ways of keeping a child engaged in play therapy, and provide specific examples of what verbally to say to a client to keep them engaged.

To enhance this training in the future, video clips that demonstrate the need for mental health services to the Asian American population, specifically children, may be helpful in capturing the attention of participants. Clips from the film *Essentials of Play Therapy with Abused Children* by Eliana Gil (2006) can be used to start the presentation for the purpose of demonstrating to the audience the unique benefits of play therapy for
abused children. Hands on exercises and role-plays should include a demonstration of client and therapist interacting in the therapeutic process. Exercises should have specific examples of what interventions a therapist can use in a particular situation with a child. For instance, given a general activity of a child not initially engaging, the person who plays the role of the therapist can say, “Let’s make a list of five things that you like to do with your family.” The purpose of this intervention is to get the un-engaged child to focus on the positives of him/her self and provide potential for the therapist to be able to form an alliance. In this example, it is important to point out to the training participants the reasons for using this intervention. For one, Asians in general tend to be shy and have respect for authority figures; therefore, a therapist who takes a more directive approach may be more successful in engaging the child who may be shy or waiting for direction. Secondly, in general, Asian parents expect their children to attain high levels of academic achievement. So, when children fail to meet expectations, it is very likely they will be criticized which results in lowered self-esteem. Thus, the significance of the making a list intervention can help the child focus on his/her strengths and positive attributes. Other examples for future trainings could also include impromptu role-plays that utilize specific scenarios provided by participants.

Another modification to the training in order to enhance it in the future is to construct examples of case studies and/or scenarios in advance and then assign them to participants as part of a training exercise. In this exercise, participants can break into groups to evaluate, discuss, and come up with their own interventions for each case study
or scenario. Then, the small group discussion can be opened up to the larger group for
discussion and feedback to facilitate learning. This would be an enhancement to the
original training because it would help break up the didactic material and get the
participants more involved in an interactive learning process about specific interventions
that may be effective in working with Asian American children in play therapy.

The training may also be improved with a clip from the film *Preschool in Three
Cultures*, developed from a book of the same name and authored by Joseph Tobin, Yeh
Hsueh, and Mayumi Karasawa (2009). In the film a Japanese preschool teacher fails to
discipline a child who has hit another child, later explaining that the child is better taught
and disciplined by the other preschool children who ostracize him from their play. In this
example, small group discussion could include group versus individual cultural values
and their role in child discipline and behavior.

Taken as a whole, this project has both strengths and weaknesses. One of the
strengths is that the background information contained in the training is based on research
and theory that is well documented in the literature. The constructed training also
includes clear training objectives and a list of toys and materials as well as pricing so that
if a paraprofessional or therapist/counselor wants to know what to use in a session with a
client from a particular age group, toys and materials that are age appropriate for that
specific client can be looked up. Moreover, the training includes specific play therapy
techniques to be mindful of when working with Asian American children. Again, a
paraprofessional or therapist/counselor can simply look up this section of the training to
remind themselves of the guidelines suggested by Gil and Drewes (2005) when engaging with Asian American children and families in the therapeutic process in order to remain culturally sensitive while also providing developmentally supportive play therapy. Lastly, the training developed for this project can be replicated or modified if necessary, and conducted at other community organizations that may benefit from the information.

While this in-service training project attempted to provide the Transcultural Wellness Center (TWC) with developmentally appropriate play therapy techniques for Asian American children, the literature on working specifically with Asian American children in play therapy and outcomes data is still lacking. Future research is needed to test the efficacy of play therapy with Asian American children utilizing the guidelines provided by Gil and Drewes (2005) and describing specific interventions and outcome measures.

Additionally, another weakness of this training is in the methodology. More specifically, Tannenbaum and Yukl (1992) recommend conducting a training needs analysis in order to design and develop a useful training program. In their research, included in a training needs analysis is a task analysis and person analysis. A task analysis identifies the tasks performed on the job including the knowledge, skills, and abilities (KSAs) needed to perform these tasks and a person analysis, on the other hand, focuses on identifying who should be trained and what training is needed by an individual (Tannenbaum & Yukl, 1992). While this project identified the target population for the training and information was provided by the TWC training coordinator and outside
consultant for TWC/APCC that all levels of staff were in need of more KSAs related to interacting with young children in a developmentally and culturally sensitive manner, there were still limitations. For future trainings, whether at the same agency or another community organization, further development in terms of a training needs analysis may be helpful in order to develop a more useful training program. Thus, obtaining information on job qualifications, job description, job titles, and specific KSAs related to the positions of training participants would be helpful for the training developers before a training program is developed.

Furthermore, the TWC training coordinator shared their long-term goals for use of the organization’s playroom that included therapeutic play activities for child consumers, siblings and their families. While this project includes recommendations for a play therapy environment (see Appendix D) and specific materials and pricing (see Appendix E), the list is not exhaustive. Research in this area is invited to expand on the recommendations, specifically adding materials and toys and the pricing in order for paraprofessionals and/or therapists/counselors to have additional options to choose from when working with children in the therapeutic process. It would also be beneficial to have an updated list as new materials and toys are available and also to update the pricing for the items in order to have the most current information.

Increased attention to child therapy in the Asian American population can result in mental health and wellness gains for both the children in therapy as well as the larger family system. As mentioned in the literature review, some of the Asian cultural values
that may have implications for therapy include collectivism, conformity to norms, hierarchical relationships/family structure as well as deference to authority figures, filial piety, humility, maintenance of interpersonal harmony, avoidance of shame and saving face, emotional restraint, and academic and occupational achievement (Gil & Drewes, 2005; Kim et al., 2003; Kim, Li, & Liang, 2002; Kim, Ng, & Ahn, 2005; Kim & Omizo, 2005; Li, O’Brien, & Kim, 2007; Shea & Yeh, 2008; Sue & Sue, 2003; Yeh et al., 2004). Because of cultural values conflicts that occur for Asian Americans, increased attention to child therapy in the Asian American population can be beneficial by addressing issues at an early age.
APPENDICES
Developmentally Appropriate Play Therapy With Asian American Children

Kathy Nguyen and Mary Embree
Department of Psychology
C.I.U. Instruments

Training Objectives
1) Provide background on Play Therapy & Its Importance
2) Review Child Development & Its Relation to Play Therapy
3) Look at what’s in the Play Therapy Environment
4) Introduce General Play Therapy Techniques with Asian American children
5) List examples of age-appropriate toys & materials

WHAT BRINGS ASIAN AMERICAN CHILDREN TO COUNSELING?

Conflicts Involving Cultural Values
1) Collectivism
2) Conformity to Norms
3) Hierarchical relationships/family structure
4) Deference to authority figures
5) Filial piety
6) Humility
7) Maintenance of interpersonal harmony
8) Avoidance of shame and saving face
9) Emotional restraint
10) Academic and Occupational Achievement

Some Reasons Why Asian Americans Underutilize Mental Health Services:
- Cultural reasons
- Social barriers
- Service barriers
- Cultural differences between Asian American clients and non-Asian counselors (Kim, Atkinson, & Yang, 1999).

Statistics on Asian Americans
- Asian Americans currently constitute approximately 5% of U.S. population with 13.5 million individuals (U.S. Bureau of the Census, 2004)
- By 2050, this group is estimated to make up 10% of the U.S. population (U.S. Bureau of the Census, 2004)
Background on Play Therapy

Play therapy is an effective method for treating children in the areas of:
1. Self-concept
2. Behavioral change
3. Cognitive ability
4. Social skills
5. Anxiety

(Bratton & Ray, 2000)

Play Therapy continued

• Anna Freud (1982), Melanie Klein (1932) and Virginia Axline (1949) are some of the early developers of play therapy.

• In 1982, the Association for Play Therapy (APT) was founded and currently serves more than 5,000 play therapy professionals (Ray, 2006).

• According to the APT, “...trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development.”

Why is Play Therapy important?

Children learn to:
• Communicate with others
• Express feelings
• Modify behavior
• Develop problem-solving skills
• Learn a variety of ways of relating to others

Play Therapy & Child Development

Therapists must understand typical development in order to:
• Identify delays, deviations, fixations, or precocities.
• Plan for and implement effective interventions, including parent education.
• Establish realistic expectations for the content of play, choice of play activities, types of toys, continuity of play, ability to differentiate reality and fantasy, and degree of interaction with the therapist.
• Match and expand the child’s skills and developmental level of functioning (Gurlin-Weiner, 2006).

Play from Birth to Two Years

• Rapid physical and motor development
• By end of 1st year, infant has tripled its weight and increased its length by 75%.
• Full mobility by age 2 (e.g., climb stairs, run outdoors).
• Memory development includes emergence of object permanence (Piaget).
• Vocabulary ranges from 50 to 200 words by 2 years (Frost, Wortham & Reifen, 2008).

Play in the Years

• Play is the leading source of development in the ages of 2 and 6 (Vygotsky, 1970).
• Preschoolers refine mobility skills through gross-motor activities involving dexterity, balance, upper-body, and arms skills (e.g., rough-and-tumble play, hopping, skipping, chase games).
• Preschoolers gain more precision in fine-motor development.
Play in the Pre-school Years, continued

- Cognitive development is in the preoperational stage (Piaget, 1952).
- Social development includes sustained peer interactions and play episodes and budding friendships.
- Emotional development includes abilities to regulate attention, affect and activity level.
- Fantasy and play are key elements for healthy development (e.g., superhero and family play).

(Frost, Wortham, & Reifel, 2008; Rubin & Lissny, 2006; Johnson, 2006; Rase, 2005.)

Play in the School-Age Child

- Improved gross motor skills in flexibility, balance, agility (e.g., swinging a bat, hopscotch).
- Improved fine-motor skills shown by hand writing and drawing.
- Cognitive development stage of concrete operations (Piaget, 1962) involving logical and organized thinking and ability to play games with rules (e.g., board games).
- Gender differences in play emerge: Girls prefer conversation, turn-taking; boys prefer outdoor, rough play (Frost, Wortham, & Reifel, 2008; Barnes, 2006).

Play in the School-Age Child, continued

- Language and literacy allow children to engage in social rituals of telling jokes, trading playful insults, and using special language with friends, peers and social groups.
- Self-concept and self-esteem are a major part of social development at this age.

The Play Therapy Environment

- For any given child, the playroom should always be the same when they enter to give them a sense of predictability.
- Room should be carefully planned, prepared, cleaned, organized, and stocked.
- Décor should display paintings, prints, photos, textiles, artifacts reflecting the culture of the populations served (Glover, 1999).

Materials for the Playroom

In general, playroom materials should:

- Be Safe
- Be Durable
- Be ethically diverse
- Be multipurpose and able to be combined with other materials
- Be primarily non-commercial
- Reflect the natural environment
- Facilitate discovery
- Be balanced across different developmental domains (e.g., physical, cognitive, social)
- Match a range of children's interests

(Frost, 1992)

Playroom Materials for Infants & Toddlers

1. Self-awareness materials: unbreakable mirrors, baby dolls, puppets
2. Textured materials: hard, soft, fuzzy, squishy, bumpy, rough, smooth
3. Infant toys for mouthing, grasping, making noise (e.g., rattles)
4. Materials for cuddling/hugging: soft stuffed dolls, animals
5. Toys for nesting, stacking (e.g., nesting cups, blocks)
6. Materials for hiding games, peek-a-boo (e.g., scarves, bowls)
7. Simple dress-ups
8. Simple transportation toys (cars, trucks)
9. Simple sand and water play materials (from about 18 months)
10. 3 to 5 piece puzzles with knobs

(Decker, 1997; Bronson, 1995)
### Playroom Materials for Preschoolers

Basic play materials for preschool age categorized by functions (Frost, Wortham, & Reifel, 2008):

**Genus Motor Play**
- Large blocks
- Transportation toys
- Climbing equipment
- Tricycles, wagons, big wheels
- woodworking equipment and materials (child-size hammers, workbench, vise, screwdrivers, scrap lumber, etc.)

### Preschooler Materials, continued

**Fine-Motor Play**
- Clay
- Puzzles
- Arts and crafts supplies (finger and water paints, brushes, markers, crayons, scissors, etc.)
- Beads for stringing
- Construction materials (small blocks, Legos, Lincoln Logs, etc.)  
  (Frost, Wortham, & Reifel, 2008)

### Preschooler Materials, continued

**Language and Literacy**
- Books
- Writing materials (notepads, individual chalkboard, pens, pencils, old typewriters)
- Thematic props (e.g., puppers)

(Frost, Wortham, & Reifel, 2008)

### Preschooler Materials, continued

**Cognitive Play**
- Materials for water play (buckets, squirt guns, sieves, etc.)
- Simple board games
- Simple card games
- Materials for science experiments (e.g., balance scales, eye droppers)
- Objects from nature (leaves, bird’s nests, feathers, etc.)

(Frost, Wortham, & Reifel, 2008)

### Preschooler Materials, continued

**Sociodramatic Play**
- Dolls and stuffed animals
- Props for dramatic play (hats, neckties, child stethoscope, eyeglasses with lenses, etc.)
- Miniature life figures
- Housekeeping equipment and props (child-size broom, dishware, table and chairs, etc.)

(Frost, Wortham, & Reifel, 2008)

### Playroom Materials for School Age Children

- **Social and Fantasy Play Materials:** Similar as preschool but include smaller versions of human and animal figures, playsets (e.g., hospital, school, vehicles
- **Exploration and Mastery Play Materials**
  - Construction materials
  - Puzzles
  - Pattern-making materials
  - Dressing, lacing, stringing materials

Brotsos (1995)
### School Age Materials, continued

- Specific skill-development materials
  - Printing materials, typewriters, materials for books
  - Math manipulatives, fraction and geometric materials
  - Measuring materials – balance scales, rulers, etc.
  - Science materials – prism, magnifying materials, stethoscope
- Games
  - Simple card and board games
  - Word games, reading, and spelling games
  - Guessing games
  - Memory games (e.g., Concentration)
  - Number and counting games (e.g., dominoes)

### School Age Materials, continued

- Books
  - Range of reading levels
  - Storybooks for reading aloud
  - Poetry, rhymes, humorous books, adventure books, myths
  - Books made by children
  - Books about specific topics (e.g., death, divorce)
- Fine Motor
  - Building sets (e.g., K'Nex, small Legos)
  - Magnets, marbles, sewing/lacing

### School Age Materials, continued

- Gross-Motor Materials for Playroom
  - Soft (“nerf”) balls, various shapes & sizes
  - Small basketball hoop
- Gross-Motor Materials for Outdoor Space, if Available
  - Balls and sports equipment
  - Ride-on equipment (e.g., bicycles, scooters)
  - Gym equipment (e.g., complex climbing structures)

### Play Therapy Techniques with Asian Americans

- Adjusting the Frequency of Tracking Behavior
- Clarifying the Nature of Limit Setting
- Being Attentive and Sensitive to Neurological Cues
- Being Careful about Reflection of Feelings
- Being Continuous in Interpreting Play Behavior
- Taking a More Directive Approach
- Using More Self-Esteem-Building Skills
- Communicating Closeness and Trust through Neurological Skills

### Adjusting the Frequency of Tracking Behavior

- “Tracking” – describing the situation before the behavior occurs
- Play therapists usually use this technique to establish rapport with the child.
- Consideration ought to be given to “collectivism” in Asian cultures: a child may be more comfortable being a part of a group & not singled out.
- Constant tracking of behavior by therapist can be perceived by child as receiving too much attention and cause self-doubt.

### Clarifying the Nature of Limit Setting

- “Limit setting” – rules or limits
- Limit setting is important for any therapeutic relationship and is one of the main principles in psychotherapy.
- Can be perceived by some Asian children as criticism and cause them to feel that they have done something wrong or shameful.
- Limit setting that is clear and directed to a behavior and not the child is recommended.
- Stating that the limit setting is a rule may also prevent the child from taking it too personally.
### Being Attentive and Sensitive to Nonverbal Cues
- Most Asian children are seen as polite, quiet, cooperative, and hardworking.
- Language and cultural differences can present barriers in communication and also limit a child’s expression.
- Voicing personal opinions in the Asian culture is not considered desirable.
- Therapist may need to focus attention on nonverbal cues and behaviors in order to get a better assessment and understanding of the child’s play.

*What are some examples of nonverbal cues?*

### Being Careful about Reflection of Feelings
- Asians are generally more reserved than Westerners about openly expressing feelings.
- Older children are expected to be able to contain and regulate feelings and emotions since openly displaying feelings is a sign of immaturity.
- Contradicts the therapy process which is to explore openly underlying thoughts and feelings.
- Therapist should be careful in choosing words to reflect a specific feeling and avoid strong feeling words that may cause the child to feel awkward.

### Taking a More Directive Approach
- Many Asian children are more familiar with adults’ being authority figures and taking an educational role.
- A child may need to be prepared by the therapist and given clear expectations of what to receive from play therapy.
- A more directive approach may be useful in guiding the child through the therapy process.

*Can you provide examples of being directive in the therapeutic process?*

### Being Cautious in Interpreting Play Behavior
- Interpreting a child’s behavior can vary depending on the therapist’s cultural perspective.
- It is advised that therapists keep an open mind and use observations to generate hypothesis and make interpretations.
- Therapists should also leave room for a child to correct an interpretation and not view it as resistance in therapy.

*What are some examples of behavior that may be misinterpreted?*

### Using More Self-Esteem-Building Skills
- Encouragement is a very helpful strategy in building a positive relationship with a child.
- Because a therapist is viewed similar to a teacher (an authority figure from a Chinese point of view), children feel a sense of accomplishment when being praised or recognized by an authority figure.

*What are some examples of ways to provide encouragement?*

### Communicating Genuineness and Trust through Nonverbal Skills
- Communication between two people can go beyond words to include facial expressions and gestures and tone of voice.
- It is suggested that the therapist and child accept that cultural limitations exist and acknowledge efforts made in communication.
- The child can sense the therapist’s efforts and can change and grow in response to the therapist’s genuineness.
QUESTIONS OR COMMENTS?

Thank you for completing your evaluation!

Thank you for your time and participation!

Thank you for all that you do for the Asian/Pacific Islander Community!

Please feel free to contact us by email:
Kathy Nguyen – thanhluong79@yahoo.com
Marya Endriga – mendriga@csus.edu
APPENDIX B

Evaluation Form
EVALUATION FORM

Thank you for your time and participation in this training on Developmentally Appropriate Play Therapy with Asian American Children. Please take a moment to complete this evaluation – your feedback is very much appreciated. Thank you!

THREE THINGS I LEARNED FROM THIS TRAINING ARE:

1) ___________________________________________________________________

2) ___________________________________________________________________

3) ___________________________________________________________________

STRENGTHS OF THIS TRAINING ARE:

1) ___________________________________________________________________

2) ___________________________________________________________________

3) ___________________________________________________________________

WEAKNESSES OF THIS TRAINING/THINGS THAT COULD BE IMPROVED ARE:

1) ___________________________________________________________________

2) ___________________________________________________________________

3) ___________________________________________________________________
APPENDIX C

Training Evaluation
TRAINING EVALUATION

DATE:

TOPIC:

PRESENTERS:

1. Did the training meet your expectations?: Yes No Somewhat
2. Did you feel that the training was relevant to your work at APCC? Yes No Somewhat
3. Did you feel that the training was interactive enough? Yes No Somewhat
4. Was the presenter(s) knowledgeable in the topic presented? Yes No Somewhat
5. Was there adequate opportunity to ask questions? Yes No Somewhat
6. Were your questions/concerns addressed adequately? Yes No Somewhat
7. Overall, how would you rate this training? 1 2 3 4 5 (1 is low, 5 is excellent)
8. What would have made this training better? ________________________________

______________________________________________________________________________

9. Other trainings you’d like to see at APCC: ________________________________

______________________________________________________________________________________

______________________________________________________________________________________

10. Would you be willing to provide training for staff about your culture? Yes No

If yes, please let your supervisor know!

Your Name (OPTIONAL): __________________________________________

THANK YOU!!!
APPENDIX D
Recommendations for Play Therapy Environment

THE PLAY THERAPY ENVIRONMENT

The play therapy room is a special place used for the specific purpose of conducting play therapy. Therefore, the environment should be carefully arranged with toys or play materials to accommodate a range of children’s play. Because different therapists have different views about which play materials to provide and why they are important, playrooms may vary based on the theoretical views of the therapist and the nature of the child’s needs. The play materials do not need to be manufactured or expensive since children can use simple raw materials to represent almost anything.

For any given child, the playroom should always be the same when they enter. It should be carefully planned, prepared, cleaned, organized, restocked with disposable materials, and most importantly, predictable after the initial visit. The size of the room may vary with availability in different settings, but the typically desired size is about 12 to 14 feet by 14 to 16 feet, or approximately 150 to 250 square feet. Even though specifically designed play rooms are desirable, effective therapy can be conducted in a child’s hospital room, using play materials carried in by the therapist, or in an equipped section of an unused room such as an office, classroom, or workroom (Frost et al., 2008).

With regard to decorating, Glover (1999) suggests therapists consider hanging paintings, prints, and photos by artists of various cultures that reflect the populations
served. Moreover, rugs and other textiles, as well as sculptures, pottery, baskets, and other artifacts are some recommendations that can also be displayed (Glover, 1999).

**TOYS AND MATERIALS**

Toys and materials recommended in a play therapy room can vary, but can be separated and categorized according to functions as well as different age groups. For infants and toddlers, selection of toys should include a balance of the following categories (Deiner, 1997):

- Materials that encourage awareness of self and others: toys with mirrors, dolls, and puppets
- Materials with varied textures: textured rattles and blocks and fuzzy puppets
- Materials that make noise: musical toys, rattles, and squeaky toys
- Materials that reflect ethnic diversity
- Materials for cuddling: soft stuffed dolls, animals, toys, and other huggables (p. 337)

More specifically, Bronson (1995) has developed lists of toys for different ages and developmental levels of infants and toddlers:

**Basic play materials for young infants (birth through 6 months):**

- Unbreakable mirrors that can be attached to a crib, changing table, or other play area
• One or two special items, such as dolls and stuffed animals, that may be brought from home as comfort items for individual children (for hygienic reasons, not to be used by other infants)

• A variety of toys that infants can bat or kick, mouth, grasp, and manipulate

• Rattles and bells (with a handle or for the wrist or ankle) that make interesting sounds when manipulated

Basic play materials for older infants (7 through 12 months):

• Large, unbreakable mirror(s) placed so that children can see themselves move

• A few soft, washable dolls and stuffed or other play animals

• A small selection of soft, lightweight blocks

• A variety of grasping toys that require different types of manipulation

• A varied selection of skill-development materials, including nesting and stacking materials, activity boxes, and containers to be filled and emptied

• A variety of small cloth, plastic, or cardboard books for children to handle, and additional books for adults to read

• A few varied bells and rattles that produce interesting sounds

• Several types of one-piece push toys (cars, animals) for children who can crawl

• A variety of balls, including some with interesting special effects

• A climbing platform for crawlers

Basic play materials for young toddlers (1 year old):

• A sturdy, unbreakable, full-length mirror
• A few simple, washable dolls
• A few small wood or sturdy plastic people and animal figures
• Simple dress-ups (kept very clean), and a doll bed and carriage that a toddler can fit into
• Several lightweight transportation toys (cars, trucks)
• Simple sand and water play materials (from about 18 months)
• A beginning set of small, lightweight blocks and simple, press-together bricks
• A variety of 3 to 5 piece puzzles with knobs
• A number of large, colored pop beads or stringing beads (after about 18 months)
• A variety of specific skill-development materials, including shape-sorters, stacking and nesting materials, pop-up and activity boxes, and simple matching materials
• Foam/wood/plastic pegboard(s) with large, blunt-ended pegs
• A variety of sturdy books for children to handle and additional books for adults to read
• A supply of sturdy paper and large, nontoxic crayons in bright, primary colors
• A beginning set of simple musical instruments (from about 15 months)
• Recorded music and a record, CD, or tape player
• A variety of push and pull toys
• Several types and sizes of balls
• A few stable ride-on toys with four wheels or casters and no steering mechanism or pedals

• Low, soft, climbing platform(s) and tunnel for crawling through

Basic play materials for older toddlers (2 years old):

• A sturdy, full-length, unbreakable mirror

• Dolls with simple garments and caretaking accessories

• Role-play materials, including a selection of dress-ups, large, sturdy doll bed; child-sized stove and refrigerator; simple pots and pans; and a cleaning set

• A variety of wood, plastic, rubber, or vinyl people and animal figures to use with blocks

• Vehicles (cars, trucks) to be used with blocks; a few large ride-on trucks (if cost permits)

• Sand/water table(s) with containers and simple pretend materials

• A set of unit blocks and other materials, such as plastic bricks and large plastic nuts and bolts

• An assortment of fit-in puzzles

• Pegboards with large pegs

• Large beads for stringing; lacing shoes or cards with large holes; and materials to practice buttoning, snapping, buckling, etc.

• Simple matching and sorting materials; graduated nesting, stacking, and ordering materials; simple lock boxes; and sensory materials, such as “feel bags”
• Simple lotto games and giant dominoes
• A variety of sturdy books
• A supply of crayons, paints, paintbrushes, markers, clay or dough, scissors, chalkboard, chalk, paint and colored paper, and adjustable easel
• A standard rhythm instrument set
• Recorded music and a record, CD, or tape player
• Push toys that support pretend play (vacuum cleaner, baby carriage)
• Large ball(s) to kick, throw, and catch
• Stable ride-on materials pushed by feet
• A low climbing structure and slide

Frost (1992) gives the following suggestions for selecting toys for preschool play:

• Select multipurpose toys (a gun can be used for one purpose only).
• Select materials that allow children to make their own toys (tools, blocks, erector sets).
• Combine toys with natural materials (sand, water, etc.) and in natural settings (backyard, etc.).
• Select toys that expand discovery – seeds, soil, magnifying glass, etc.
• Select safe toys. Look for sharp edges, parts that can break off, parts that can cause choking, parts that can puncture or cut.
• Select toys that are durable – expect heavy use, abuse.
• Consider ages of children – select toys that can be used in different ways at different levels of development.

• Balance your selection – promote physical, intellectual-emotional, language, creative development.

• Match toys to developing interests (music, pets, board games).

• Avoid bombarding children with too many toys.

• Avoid toys that encourage violent fantasy or games that encourage physical risk.

• Discuss toy selections with children.

• Limit the number and variety of “bought” toys, especially theme-specific toys. Encourage children to make or adapt toys.

• Consider involving children in donating toys to charitable organizations as they are outgrown and more appropriate ones are purchased.

• Ensure that toys reflect ethnic/culture balance.

Basic play materials for preschool age categorized by functions (Frost et al., 2008):

**Gross-Motor Play**

• Large blocks

• Transportation toys

• Climbing equipment

• Tricycles, wagons, big wheels

• Woodworking equipment and materials (child-size hammers, workbench, vise, screwdrivers, scrap lumber, etc.)
Fine-Motor Play

- Clay
- Puzzles
- Art supplies (finger and water paints, brushes, markers, crayons, scissors, etc.)
- Beads for stringing
- Construction materials (small blocks, Legos, Lincoln Logs, etc.)

Language and Literacy

- Books
- Writing materials (notepads, individual chalkboard, pens, pencils, old typewriters, sand trays, etc.)
- Thematic props (teddy bears for “Goldilocks,” puppets, etc.)

Cognitive Play

- Materials for water play (buckets, squirt guns, sieves, etc.)
- Simple board games
- Simple card games
- Materials for science experiments (balance scales, eye droppers, animal cages, aquariums, terrariums, etc.)
- Objects from nature (leaves, bird’s nests, feathers, etc.)

Sociodramatic Play

- Dolls and stuffed animals
• Props for dramatic play (hats, neckties, child stethoscope, eyeglasses with lenses, etc.)

• Miniature life figures

• Housekeeping equipment and props (child-size broom, dishware, table and chairs, etc.)

Toys and materials shifts in primary school age play in order to complement children’s abilities. Bronson (1995) has outlined play materials that are appropriate for school-age children (6 through 8 years):

**Social and Fantasy Play Materials:**

• Mirrors – same as for adult use

• Dolls
  1. washable, rubber/vinyl baby dolls (with culturally relevant features and skin tones for younger children-age 6)
  2. Accessories (culturally relevant) for caretaking – feeding, diapering, and sleeping (for younger children – age 6)
  3. Smaller people figures for use with blocks or construction materials (for fantasy scenes and models)

• Role-play materials
• Puppets
  1. Puppets that represent familiar and fantasy figures for acting out stories
     (children can create props and scenery)
  2. Simple puppet theater – children can construct own (children can create props
     and scenery)
• Stuffed toys/play animals
  1. Realistic rubber, wood, or vinyl animals to incorporate into scenes and models
     or that show characteristics of animals being studied (such as reptiles and
     dinosaurs).
• Play scenes
  1. Small people/animal figures and supporting materials with which to construct
     fantasy scenes or models related to curriculum themes
• Transportation toys
  1. Small, exact (metal) replicas preferred by children of this age range are not
     usually used in school settings, but more generic small models are useful
  2. Construction or workbench materials for children to use to make models of
     forms of transportation

*Exploration and Mastery Play Materials*

• Construction materials
  1. Large number of varied materials for detailed construction and for creating
     models (can use metal parts and tiny nuts and bolts)
• Puzzles
  1. Three-dimensional puzzles
  2. Jigsaw puzzles (50 to 100 pieces)

• Pattern-making materials
  1. Mosaic tiles, geometric puzzles
  2. Materials for creating permanent designs (art and craft materials)

• Dressing, lacing, stringing, materials
  1. Bead-stringing, braiding, weaving, spool-knitting, and sewing materials now used in arts and crafts

• Specific skill-development materials
  1. Printing materials, typewriters, materials for making books
  2. Math manipulatives, fraction and geometrical materials
  3. Measuring materials – balance scales, rulers, graded cups for liquids, etc.
  4. Science materials – prism, magnifying materials, stethoscope
  5. Natural materials to examine and classify
  6. Plants and animals to study and care for
  7. Computer programs for language arts, number, and concept development and for problem-solving activities

• Games
  1. Simple card and board games
  2. Word games, reading, and spelling games
3. Guessing games
4. Memory games (Concentration)
5. Number and counting games (dominoes, Parcheesi)
6. Beginning strategy games (checkers, Chinese checkers)

• Books
  1. Books at a variety of difficulty levels for children to read
  2. Storybooks for reading aloud
  3. Poetry, rhymes, humorous books, adventure books, myths
  4. Books made by children

*Music, Art, and Movement Play Materials*

• Art and craft materials
  1. Large variety of crayons, markers, colored pencils, art chalks, and pastels (many colors)
  2. Paintbrushes of various sizes
  3. A variety of paints, including watercolors
  4. A variety of art papers for drawing, tracing, painting
  5. Regular scissors
  6. Pastes and glues (nontoxic)
  7. Collage materials
  8. Clay that hardens
  9. Tools (including pottery wheel)
10. More complex printing equipment

11. Craft materials, such as simple looms, leather for sewing and braiding, papier-mache, plaster of paris, small beads for jewelry making, etc.

12. Workbench with more tools and wood for projects (with careful supervision)

- Musical instruments
  1. Real instruments, such as recorders (sometimes used for group lessons in school settings)
  2. A wider range of instruments for children to explore (borrowed or brought in by parents or special guests)

- Audiovisual materials
  1. Music for singing
  2. Music for movement, including dancing (folk dancing by age 8)
  3. Music, singing, rhymes, and stories for listening
  4. Audiovisual materials that children can use independently

*Gross-Motor Play Materials*

- Balls and sports equipment
  1. Youth or standard size balls and equipment for beginning team play (kickball, baseball, etc.)
  2. Materials for target activities (to practice skills)

- Ride-on equipment
1. (Children may be very interested in riding bicycles, but this is no longer included as a school activity)

- Outdoor and gym equipment
  1. Complex climbing structures, such as those appropriate for age 5 (including ropes, ladders, hanging bars, rings)
APPENDIX E

Specific Materials and Pricing

Art and Craft Supplies

1. 8-Count Large Multicultural Crayons (http://www.crayola.com/store) - $2.49
2. 8-Count Washable Multicultural Markers (http://www.crayola.com/store) - $4.99
3. 8-Count Multicultural Pencils (http://www.crayola.com/store) - $1.99
4. 8-Count Washable Multicultural Markers (http://www.ssww.com) - $5.99
5. 80-Count Multicultural Markers Classpack (http://www.ssww.com) - $48.99
6. 12x18” Multicultural Construction Paper (http://www.ssww.com) - $3.28

Board Games & Card Games

1. Multicultural Bingo/Grades 1-6 (http://www.marcoproducts.com) - $16.99
2. Common Ties (http://www.creativetherapystore.com) - $39.95

Books

1. Allison by Allen Say, 1997, Houghton Mifflin. ISBN 039585895X. (http://www.amazon.com) - $0.01 (used) to $6.95 (new)
   (http://www.amazon.com) - $2.44 (used) to $5.99 (new)


*Dramatic Play*

1. Multicultural Food Set (http://www.childcraft.com) - $73.99

2. 16-Pieces Breakfast Foods Basket (http://www.childcraft.com) - $19.99
5. 11-Pieces Dinner Foods Basket (http://www.childcraft.com) - $19.99
8. 16” Multi-Ethnic Doll – Asian Girl (http://www.childcraft.com) - $29.99
9. 16” Multi-Ethnic Doll – Asian Boy (http://www.childcraft.com) - $29.99
10. 14”H Multi-Ethnic Baby Dolls (http://www.childcraft.com) - $64.99
11. 10”H Multi-Ethnic Baby Dolls (http://www.childcraft.com) - $41.99
13. Set of 8 Multi-Ethnic Washable Cloth Baby Dolls (http://www.childcraft.com) - $84.99
15. Traditional Doll House (http://www.childcraft.com) - $129.99
17. Tabletop Puppet Theatre (http://www.childcraft.com) - $31.90
18. Theatre Stage (http://www.manhattantoy.com) - $25.00
20. Set of 6 Community Helpers Career Dress Up (http://www.childcraft.com) - $99.95
22. Doctor’s Stethoscope (http://www.childcraft.com) - $7.99
23. Medical Kit (http://www.childcraft.com) - $14.99
24. Dress Up Storage Unit (http://www.childcraft.com) - $269.99
REFERENCES


