

EXPLORING THE EFFECTIVENESS OF CHILD-CENTERED PLAY THERAPY IN
YOUNG CHILDREN: A QUANTITATIVE SINGLE CASE RESEARCH DESIGN

A Dissertation

by

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This dissertation meets the standards for scope and quality of
Texas A&M University-Corpus Christi and is hereby approved.

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ABSTRACT

Play therapy is a growing form of counseling that allows children to express themselves in the most natural way possible. Virginia Axline (1969) applied Roger's person centered theory and core conditions (empathic, genuineness and honesty, unconditional positive regard) to working with children in a therapeutic setting calling it Child Centered Play Therapy. Landreth (2002) further explored and developed child-centered play therapy concepts and techniques and emphasized the art of the relationship between the child and the counselor. Extant research on the effects of CCPT with children with different diagnoses, age groups, and settings is well-documented. However, there is a dearth of information concerning using CCPT in a school setting with children of ages 3-6 who were identified by the teachers as experiencing behavioral difficulties. Thus, the purpose of the study was to see if CCPT would help change behaviors with students that were identified as having behavior difficulties in the classroom.

Three teachers observed and identified 12 students in grades pre-kinder 3, 4, and Kindergarten with behavioral difficulties in the classroom. Each of the 12 students was selected to receive an intervention using CCPT. For each of the 12 students, one parent/guardian completed the Child Behavior Check List forms each week, and the respective classroom teacher completed the Caregiver-Teacher Report form each week for the 12-week duration of the study. A single case research design was used, which included three weeks of baseline observation, followed by six weeks of CCPT with treatment twice per week, and three weeks of post baseline observation.

Findings revealed that play therapy was a highly effective treatment for reducing negative behaviors in most students. Parents' ratings of behaviors indicated an 88.30% improvement in

behaviors, and 50% of teachers' ratings indicated improved behavior change after receiving CCPT.

In summary, 71% of all scores indicated change in behavior. Under further evaluation during the post baseline stage of the study, 90% of parents and 80% of teachers rated the student's behavior as improved. The results are indicative of CCPT being a very efficacious treatment intervention for students in grades pre-kinder 3, 4, and Kindergarten.

DEDICATION

This dissertation is dedicated to my parents for all their love and understanding that got me to where I am today!

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My Heart can never say it enough I am beyond thankful to God for all he has done in me and will continue to do. I would like to thank my parents for always encouraging, believing and praying for me, as well as my family and friends that stood by me throughout all the difficult moments and are still by my side. I love you all for being so supportive and loving. You know who you are, Ashley Cornelius, Christi Walker, Buttercup, Brooke Falcon, Ms. Dolores, Brenda Garcia, Veronica Miles, Julie Joffray, and Dragon.

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She is Clothed in Strength and Dignity and She Laughs without Fear of the Future

- Proverbs 31:25

You can be anything you want...but you have to be STRONG FIRST

-Pavel

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Chapter 1

Introduction

Play therapy is a growing form of therapy for children. Play therapy is becoming more evidence-based in the treatment outcomes for children of all ages, disabilities and diagnoses. Although play therapy has been a form of treating children's mental health needs, it has been overlooked and underestimated as a strong therapeutic technique for many years. Now in the twentieth-century, play therapy is growing stronger in research and acceptance (Ray, 2011). Play therapy was developed by Virginia Axline in the 1950s. She was a student of Carl Rogers', who developed and established client- or person-centered counseling (VanFleet, Sywulak & Sniscak, 2010). Rogers (1951) is known for his foundation of the core conditions: empathic understanding (the ability to feel what the client feels), congruency (genuineness, honesty with the client), and unconditional positive regard (respect and acceptance for the client as they are) (Rogers, 1951). Axline took Roger's core conditions of empathy, congruence, and unconditional positive regard and applied them to developing a counseling technique for children, which is now known as Child-Centered Play Therapy (CCPT) (Landreth, 2002). Landreth (1982, 2002) further explored and developed child-centered play therapy concepts, theory, and techniques.

In 1982, the Association of Play Therapy (APT) was established to support and educate about the importance of play in counseling and research. APT (2012) established a clinical definition of 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." Axline (1982) defined play therapy as a play experience that becomes therapeutic by providing a safe place for expression and a strong and healthy relationship between the

counselor and the child, in order for the child to have the freedom and room to express themselves on their own terms. Whereas play therapy provides foundation of history, techniques, and skills, CCPT integrates play therapy with Carl Rogers' theory of counseling.

Landreth (2002) defined child-centered play therapy as a powerful relationship between a child and counselor trained in play therapy. A child's natural form of communication is play, which serves as a medium to help children express their feelings in a healthy manner. This in turn results in healthy development as children grow. In child-centered play therapy the child leads the way through the therapeutic process, while the counselor makes no attempt to control or change the child and his/her meaning of play (VanFleet, et al., 2010). In child-centered play therapy the counselor works to cultivate a therapeutic relationship by the counselor provides empathy, congruence, and unconditional positive regard (Landreth, 2002). Providing the child freedom to decide which aspects of change that is desired (Landreth, 2002). According to Landreth (2002), "children will play out their feelings and needs in a manner or process of expression that is similar to that of adults" (p.16).

An additional core belief in child-centered play therapy is that a child contains intrinsic ability to solve their own emotional problems. By allowing children to take the initiative to heal themselves, children are taking control over their own feelings and future while increasing their self-mastery, competence, and self-confidence (VanFleet, et al., 2010). As children use play as their form of expression, counselors should demonstrate involvement and interest in the child, this interest is shown by the counselor tracking the child's behavior (Landreth, 2002). Tracking the child's behavior involves the counselors' verbal responses to their observations during the play session such as facial expressions, energy, and play (Ray, 2011). For example, a child is punching the bobo doll, and the counselor responds, "You are punching that as hard as you can."

In another example, the child took their time to draw a picture and the counselor responds, “You worked really hard on that picture, and you wanted it to be perfect.” By making such statements a counselor responds to both the psychological and emotional components of the child’s behavior.

An additional aspect of child-centered play therapy occurs in the playroom when the counselor provides children with the opportunity and permission to be themselves. Allowing children to be themselves is a very important and powerful aspect of play therapy, especially in a school setting (Landreth, 2002). The playroom may be a place where children are free to be themselves, because when rules are not imposed by an authoritative figure children are able to use their creativity and imagination without feeling constrained. Child-centered play therapy provides the child with unconditional acceptance that does not evaluate or pass judgment upon the child (VanFleet, et al., 2010). In the playroom children are in charge of what they say, what they explore, and what they disclose, as well as their own personal progression in counseling (Landreth, 2002). Although the counselor allows clients to be free in the playroom and use the toys in many of the ways they would like, the counselor does not allow clients to destroy toys or the playroom (Ray, 2011). The counselor gives the child choices, which come with consequences that are referred to as limit setting. In the play sessions the counselor is able to set limits for the child according to the counselor comfort level.

Other reasons for setting limits in the playroom are if the child’s behavior causes physical harm to self or the counselor or if the child harms the use of the playroom such as breaking toys, writing on walls and so forth (Ray, 2011). Through limit setting the child learns to respect the limits both in and out of the playroom. In the same way, children learn consequences for not respecting the limits that were set in the playroom. At the same time as limits are being set, the

counselor attends to what has been said and chosen by the child.

Statement of the Problem

Extant research concerning the use of play therapy in a school setting with children within the ages of 3-6 years is limited. This age group has been somewhat over looked in the history and research of play therapy. Bratton and Ray (2000) looked at existing research in a comprehensive analysis that consisted of 93 play therapy studies. In this analysis the mean age of the children were 7.9 to 10.5 years of age, as opposed to the most common age groups play therapists work with which is 3 to 8 years of age (Dougherty & Ray, 2007). Dougherty and Ray (2007) stated, “although age was not found to be a significant predictor of play therapy treatment outcomes, the broad age range was cited as a possible factor obscuring the analysis of the relationship between age and play therapy treatment effects”(p. 5).

Purpose of the Study

The purpose of this study is to see the impact child-centered play therapy has on students in Preschool and Kindergarten that are between the ages of 3-6 and have been identified by the teachers as having behavioral difficulties in the classroom. In this study, analysis of each individual student in a quantitative single-case study research design will be evaluated to measure the impact child-centered play therapy has in each individual student. Through the play therapy process, the child will be able to express feelings freely with a counselor who will show empathy, congruency and unconditional positive regard. Through the use of play therapy, the child will learn to meet their own personal needs in a socially acceptable manner (Landreth, 2002). In this study, the parents are aware of their children’s behavior difficulties in the classroom. Teachers were in contact with parents since the beginning of the school year. This study takes place in the second half of the school year allowing the teachers to have a clear

understanding of the students that they believe would benefit from a behavioral intervention being child-centered play therapy.

Research Questions

Past research focusing on behavioral intervention consisted of different forms and theories of play therapy with students that have behavioral difficulties in the classroom. There is little research in play therapy that focuses on students with behavioral difficulties within the ages of 3-6 from a strictly CCPT perspective. This study will answer the following research questions regarding students that have behavioral difficulties between the ages of 3-6.

1. To what extent will play therapy help to change students' behavior in the classroom?
2. What are the differences in respondents' ratings scores (i.e. Parent (s)/guardian(s), teacher) in the students' behavior change?

Significance of the Study

Extant research focused on the importance of play therapy in a school setting that is primarily focused on improving student's behaviors using filial therapy, group play therapy, and different theoretical orientation in play therapy. There is still a lack of research examining students with behavioral difficulties within the ages of 3-6 years, particularly from a CCPT orientation. Three forms of data collection, including perspectives of the teacher, a parent (s)/guardian (s), and the researcher assessing the child's behavior for 12 weeks, will be incorporated into the study. Although there are many different ways to help students with behavior difficulties, many times the student behavior difficulties arise from a need to gain attention (Ray, 2011). Whether the students' behavioral difficulties in the classroom are a way to gain the teacher's attention or a sign of something deeper, these behaviors may be an indication of a need not being met. Bratton and Ray's (2000) overview of play therapy revealed positive

effects of play therapy in many different and diverse areas with school behavior being one of the many areas of positive outcomes of play therapy.

Participants

The participants for this study will be students from a South Texas elementary school from Preschool and Kindergarten. There will be a total of 12 students in this study, 6 of which will be from a kindergarten class and 5 students from a Pre-Kindergarten 4 class and 1 student from Pre-Kindergarten 3 class. The teachers identified students that were having behavioral difficulties in the classroom. The student's parent(s)/guardian(s) were aware of the students' difficulties in the classroom. The teachers were in contact with the parents since the difficulties have arisen. The students in this study range from 3-6 years of age. The ethnicity makeup of the six kindergarten students consists of one male whose parent identified as being Hispanic with English as their first language, one female student whose parents identified as being bi-racial (Hispanic and African American) with English as their first language, and four students (three male and one female) whose parents identified as being Hispanic with Spanish as their first language.

Participants in Pre-Kindergarten 4 included two male students whose parents identified as being Hispanic with Spanish as their first language, one female student whose parents identified as being White with English being their first language, one female student whose parents identified as being Hispanic with English being their first language, one female student whose parents identified as being bi-racial (White and African American) with English is their first language.

The participant in Pre-Kindergarten 3 is a female student whose parents identified as being Hispanic with Spanish as their first language.

Procedure

For this study a quantitative single case study research design will be used to evaluate the students' behavior prior, during, and after child-centered play therapy for a total of 12 weeks of observation and assessing progress. The researcher, teacher, and parent(s)/guardian(s) will fill out the Child Behavior Check List (CBCL) on each student that was selected to be a part of the study. Weekly forms will be filled out on the students 3 weeks prior to play therapy in order to obtain a solid baseline for the students' behavior. The students will receive child-centered play therapy twice a week for 45-minute sessions, for 6 weeks for a total of 12 sessions of play therapy. At the end of each week, the teacher and researcher will complete the CBCL on each student in the study for 12 weeks. The parent(s)/guardian(s) will also complete weekly assessments of their child's behavior using the CBCL form for 12 weeks.

Data Collection and Analysis

For this study a single case study design will be used in order to analyze each student's behavior. Two forms of data collection will take place. First, the teacher will complete the Caregiver-Teacher Report form (C-TRF) three weeks prior to the treatment of child-centered play therapy, weekly on each student during the six weeks the student is receiving play therapy, and three weeks after play therapy. Second, parent (s)/ guardian (s) will complete weekly Child Behavior Check List (CBCL) three weeks prior to play therapy treatment, during the six weeks of play therapy, and three weeks after play therapy. The forms that will be used for this study are the CBCL for ages 1 ½- 5 years of age (preschool), the C-TRF form for the same age group, and the Spanish version of CBCL (if needed). If students exceed six years old they will be assessed using the CBCL for ages 6-18 and the Teacher's report form (TRF). The CBCL for ages 1 ½- 5 years of age scoring profiles questions are broken down into two groups Internalizing and

externalizing problems. This is further broken down into seven syndrome scales: Emotionally Reactive, Anxious/Depressed, Somatic Complaints, Withdraw, Sleep Problems, Attention Problems, and Aggressive Behavior (Achenbach & Rescorla, 2000). The CBCL has one hundred questions, ninety-nine of which can responses to the question with: 0- not true, 1- somewhat or sometimes, 2- very true or often true. Question one hundred is a written response to: Any problems the child has that were not listed in the above questions (Achenbach & Rescorla, 2000). Overall the parent/ guardian and teachers will be filling out the forms for a total of 12 weeks and answering the CBCL and C-TRF which both are 100 questions, per student, per week.

At the end of the study all data from the teacher and parents will be analyzed using a single case-study design. Single case-study is a research design that investigates causal or functional relationships between both the baseline measure of behavior and subsequent measures of behaviors (O'Neill, McDonnell, Billingsley & Jenson, 2011). The purpose of this research design is to learn more about the individuals and the effectiveness of the counselor treatment, as well as investigating clinical significance (Foster, 2010). According to Chambless et. al. (1998) this study may demonstrate probable efficacious treatment by having nine or more participants in a SCR but may be limited by only having one examiner rather than the recommended two (O'Neill, et.al., 2011). Collected data of each student's progress or lack thereof will be presented in a graph.

Single case study design not only looks at each participant individually but also the functional relationship between both the independent and dependent variable across treatment points (O'Neill, et al., 2011). In order to see the extent to which play therapy helps or does not help students' behavior, the researcher may examine the overlapping data, which refers to "the

extent to which data points in different phases fall within the same range of values, and is the results of changes (or lack thereof) in the basic characteristics of levels, trend, and variability across phases” (O’Neill, et al., 2011, p. 59). In order to evaluate the extent to which the data points overlap in the study the Percentage of the Nonoverlapping Data points (PND) will be calculated. The researcher will calculate the PND by looking at “the percentage of data points in an intervention phase that are either higher or lower than the highest or lowest data point in a baseline phase” (O’Neill, et al., 2011, p.59). These processes help identify the progress (or lack there of) of the students behavior throughout the play therapy treatment.

Basic Assumptions

The researcher assumes that the teacher, researcher, and parent/guardian will take the time each week to fill out the Child Behavior Checklist and answer each question objectively and honestly. Also, the researcher assumes that the students involved in the study will be willing participants and present on the days of play therapy. The researcher is also assuming that the same parent/guardian will be consistently filling out the forms each week.

Organization of Remaining Chapters

Chapter one was an introduction into the study to provide background information on child-centered play therapy, research, theory, and to acquaint the readers into the purpose of this study in play therapy working with young children who have behavioral difficulties in the classroom. Further chapters for this study will consist of chapter two, providing an in-depth literature review over the history, development, process, materials, and research in the field. The methodology of the study will be presented in chapter three describing the research process, participants and research questions. Chapter four will answer the research questions and explain the research method of single case study design. Chapter five will discuss the results of the study

and how it helps to fill the gap in play therapy research. Additionally in this chapter both the history and outcome of the study will come together to support the importance of play therapy research.

Definition of Terms

Clinical definition of play therapy - Play therapy is 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, 2012, Play therapy defined).

Child-centered play therapy- Child-centered play therapy is a powerful relationship between a child and counselor trained in play therapy. A child’s natural form of communication is play, which in play therapy is used to help the child express their feelings in a healthy manner. This in turn results in a healthy development as children grow (Landreth, 2002).

Symbolic expression- The symbolic expression of the child’s play within the playroom invites the counselor into the child’s worldview. The child is no longer confined by reality but is able to pretend, creating freely while expressing emotions and building their coping skills (Ray, 2011).

Limit Setting- This is a skill used to keep both the counselor and the child safe during play therapy. It also helps the counselor to set their authority when and if needed in the playroom, in order to provide safety to the child, counselor, and all property in the playroom (VanFleet, et al., 2010; Ray, 2011).

Empathy- The ability to feel what the client is feeling and see through the client’s eyes their worldview and experiences (Rogers, 1951).

Congruence/Genuineness- Being honest and real with the client (Rogers, 1951).

Unconditional Positive Regard and Acceptance- The counselor shows the client deep and genuine caring by treating them with respect and acceptance for who they are, as they are (Rogers, 1951).

Single case research (SCR)- A form of behavioral and experimental research techniques that is used to investigate a causal or functional relationships, between both the variables (IV & DV) (O'Neill, et al., 2011).

Summary

As research in play therapy continues to grow and become stronger in the clinical field of counseling, children become understood and given a voice. Through the language of play the child so graciously and courageously takes the counselor into their world to become a part of the healing, growth and transformation that the child goes through in the therapeutic process (Landreth, 2002). Through the use of play therapy process the child is able to be in the moment, but also the counselor is allowed to be in that exact moment with the child and experience the world through their eyes. This study will strive to help students that have been identified to have behavioral difficulties in the Preschool and Kindergarten classroom through the use of child-centered play therapy for six weeks. This study provides three forms of data collection over the child's' behavior from parent(s)/ guardian (s), teacher, and the researcher on a weekly base for a total of 12 weeks of behavior assessment in a single case study design.

Chapter 2

Literature Review

This chapter will focus on play therapy literature broken down into areas such as history, theory, core beliefs, evidence-based play therapy, counselor role, therapeutic responses, playroom materials, limit setting, and termination.

History and Theory

Carl Rogers established a client-centered approach to counseling in the 1940s. He strongly believed that people are trustworthy and that they have the ability to resolve their own problems without much direction from a counselor (Rogers, 1951). Rogers is known for his assertions regarding the core conditions necessary in a therapeutic relationship: (a) empathic understanding—the ability to feel what clients feel, congruency—(b) genuineness and honesty with clients, and (c) unconditional positive regard—respect and acceptance for the clients as they are (Rogers, 1951).

These core conditions are a vital part of not only client-centered theory but also child-centered play therapy (CCPT). According to Axline (1969), a counselor must demonstrate empathy, congruence, and unconditional positive regard to each child in the playroom. This allows for the child and counselor to establish trust, which in turn develops and grows the therapeutic relationship between both. The therapeutic relationship is a special connection that only the child and his/her counselor understands (Axline, 1969). Each child and counselor bring in unique qualities that cannot be replicated by others, making the relationship even more special for both individuals (Rogers, 1951).

Axline (1969) further developed the principle and core of nondirective play therapy. Axline utilized Carl Rogers' theory of non-directive counseling and applied it to counseling with children. Axline believed Rogers' theory would provide a framework for working with children;

A play experience that is therapeutic because it provides a secure relationship between the child and the adult, so that the child has the freedom and room to state himself in his own terms, exactly as he is at that moment in his own way and in his own time. I am using the play as the freedom or room to act rather than in the usual recreational sense. (Axline, 1982, p. 47)

Counselors who use nondirective play therapy make no attempt to control or change the child. The theory is based on the child's self-realization and internal desire to change (Axline, 1969; Landreth, 2002). In nondirective play therapy the child is the one directing the play session. The counselor has a playroom with all the tools the child needs to express feeling and make sense of his/her world (Landreth, 2002). In the playroom the children have the freedom to choose what they want to play with, how they want to play, what they express, and what they let go of in play therapy (Landreth, 2002). The counselor "actively reflects the child's thoughts and feelings, believing that when a child's feelings are expressed, identified, and accepted, the child can accept them and then is free to deal with these feelings" (Landreth, 2002, p.35).

Axline (1969) first named this therapeutic process Nondirective play therapy, but her theory became known as child-centered play therapy (Landreth, 2002). The heart of child-centered play therapy is allowing the child the opportunity for self-exploration in a safe and consistent environment. Children's natural form of communicating is through the use of play, allowing children to be in a non-threatening environment where they are directing the therapeutic process (Landreth, 2002; Axline, 1969). A premise in child-centered play therapy theory is that

children are capable of solving their own problems, addressing their feelings, learning limits, independence, and maturity (Axline, 1969). Growth is a strengthening process of change that is never rushed by the counselor (Axline, 1969). This process is both relative and dynamic, as experiences change the child perspective and focus (Axline, 1969). Part of Axline's (1969) nondirective play therapy theory is the personality structure. The personality structure is based on the force or a drive for independence, self-direction and maturity. Within each child is a continuous striving toward self-realization (Axline 1969). However, a well-balanced structure is necessary to facilitate the child's striving toward self-realization. A well-balanced structure consists of establishing permissiveness with children, in order for the children to be able to be themselves in the playroom. Part of this structure is the complete acceptance of self, as well as by others. In this structure the child has the right to be an individual in order to achieve direct satisfaction of this growth impulse (Axline, 1969). Individuals strive for self-realization, thereby constantly working to satisfy their needs (Axline, 1969). Axline (1969) stated, "When there is a relatively direct satisfaction, the individuals is said to be well adjusted. When the seeking-effort to satisfy the needs is blocked, devious paths are taken to bring about satisfaction, and the individual is said to be maladjusted" (p.12). As all individuals strive for self-realization each individual has their own personal perspective of self, as well as the reality of their own world (Landreth, 2002). The view of self and the limitless potential within each individual are a basis of which the personality structure of nondirective play therapy was established (Landreth, 2002).

Core Conditions

Roger's theory and beliefs in client-centered therapy applies to the relationship and development of child-centered play therapy. Empathic understanding is the counselor's ability to know the client's experiences, worldview, values, and feelings accurately (Roger, 1951).

Counselors are sensitive to clients and their issues; the counselor connects with the clients through the sharing of feelings and experiences. However, counselors must remain empathic to the clients and their feeling without losing the separateness of their own personas (Roger, 1951).

Likewise, congruence in counselors comes in the form of being genuine with clients by sharing their feeling and experiences when deemed appropriate. A counselor that is being open with a client expresses feelings, thoughts, reactions, and attitudes to the client (Roger, 1951). A third condition—unconditional positive regard—occurs when counselors show deep and genuine care for clients as they are in a specific moment (Roger, 1951). Unconditional positive regard is a non-evaluation of the client; it is the absolute acceptance of the client. A counselor with unconditional acceptance allows the client to be free in expressing feelings, beliefs, and values without the threat of losing the therapeutic relationship (Roger, 1951). This leads to clients being honest not only with their counselors but also, most importantly, with themselves.

Client-centered theory focuses on the positive aspects of the client rather than considering what is wrong with the client; the counselor desires to know what is right with the client and what assets the client brings to the counseling session (Roger, 1951). Rogers (1951) emphasized the importance of the counselor trusting the client, believing that most people are trustworthy, capable of both self-understanding and direction. Also individuals are able to make constructive changes, live effective and productive lives, and be resourceful as needed. When the counselors are able to experience and communicate to the clients their genuineness, support, caring, and nonjudgmental understanding, significant changes in the clients may occur. Rogers believed that clients are fully capable of working through issues and moving forward in their lives. When the core conditions—empathic understanding, congruency, and unconditional positive regard—are

present during the counseling session, the clients will begin to understand themselves and their world, while becoming aware of their need to move forward (Roger, 1951).

Another aspect of client-centered theory is looking at how clients interact with others, how they continue to progress, and how they positively encounter both Internalizing and externalizing obstacles that may prohibit growth (Roger, 1951). The focus of client-centered therapy is on the clients and their desired goals, not on their problems. The objective is for the client to achieve a higher level of independence and integration, which provides the client with better coping skills for both present and future problems (Roger, 1951). Another goal of this type of therapy is to provide an atmosphere conducive to the client becoming a fully functional person. Rogers (1961) wrote that the goal of client-centered counselors is to facilitate clients becoming increasingly actualized by achieving these four characteristics: 1) being open to experiences, 2) trusting in themselves, 3) having an Internalizing evaluation process, and 4) pursuing further growth (Corey, 2009).

The relationship between client and counselor

Rogers believed that no one could re-create the client/counselor relationship and that each therapeutic relationship is different and special in its own way. Both the client and the counselor have unique characteristics, values, personalities, perspectives, and life experiences that are interpreted differently on an individual basis. The relationship between the counselor and client is something that is powerful, special, and, when used in a therapeutic manner, influential for the client (Roger, 1951). Rogers hypothesized the ideal relationship between the client and counselor and indicated six circumstances that are important in building a strong therapeutic relationship:

1. Two individuals that are in psychological contact.

2. The first individual, the client, is in a place of vulnerability or anxiety and incongruence.
3. The second individual, the counselor, is congruent (real and genuine) in the therapeutic relationship.
4. The counselor shows the client unconditional positive regard.
5. The counselor feels empathy for the client and expresses those feelings to the client.
6. The counselor communicates the ability to empathize and to offer unconditional positive regard.

Rogers believed that, as long as the counselor adhered to the core conditions, nothing else would be needed in the therapeutic relationship for change to occur in the client (Roger, 1951). As part of Rogers' theory, counselors show clients how much they care and how much they value them as they are; this, in turn, may result in clients finding within themselves the value, strength, and growth necessary to move forward (Roger, 1951).

These core conditions are the very essence of not just client-centered therapy but also child-centered play therapy. In order for the counselor to help the child grow in the therapy, the counselor must demonstrate the core conditions to the child. Axline (1969) established guiding principles of child-centered play therapy, and they are known as the core beliefs and values that incorporate the core conditions.

Role of the counselor and principles of child-center play therapy

According to Landreth (2002) in child-centered play therapy, being a counselor is not a role but rather a way of being with children in the present and accepting children as they are and not as anyone may wishes they were. A child-centered play therapist should, according to Landreth and Sweeney (1997):

Relate to the child in ways that will release the child's inner directional, constructive, forward-moving, creative, self-healing power. When children experience this philosophical belief within the playroom, they are empowered and their developmental capabilities are released for self-exploration and self-discovery, resulting in constructive change. (p. 17)

Axline (1969) established eight principles that guide the counselor in the non-directive therapy process. Axline emphasized the importance of the counselor following the eight principles sincerely, consistently, and intelligently when working with children in a therapeutic manner. The principles are as follows:

1. "The counselor must develop a warm, friendly therapeutic relationship with the child, in which good rapport is established as soon as possible" (Axline, 1969, p.73). In order to build and establish a therapeutic relationship with the child, the counselor must be attuned to the needs of each child, responding to such needs in an empathic way (Axline, 1969). Building rapport with the child requires patience. Through the relationship, the counselor shows the child that he/she is attuned and nonjudgmental, consistently establishing limits when needed and allowing for the self-direction of the child (VanFleet, Sywulak, & Sniscak, 2010). As the child begins to trust the play therapy process and the therapeutic relationship, the child begins to trust him/herself (VanFleet, Sywulak, & Sniscak, 2010).
2. "The counselor accepts the child exactly as he/she is" (Axline, 1969, p. 73). The counselor accomplishes this through a tolerant attitude (Axline, 1969). The counselor remains calm, friendly, and patient and guards against any criticism or praise for actions or words (Axline, 1969). The complete acceptance of the child is of primary importance

to the success of play therapy (Axline, 1969). With this in place, the child is able to find the courage to express feelings freely and completely. The counselor's should avoid taking care of children, but rather accept them exactly where they are and, as they are (VanFleet, Sywulak, & Sniscak, 2010).

3. "The counselor establishes a feeling of permissiveness in the therapeutic relationship so that children feel free to express their feelings completely" (Axline, 1969, p. 73). The way the counselor establishes permissiveness is through attitude, nonjudgmental facial expressions, tone of voice, and a nondirective manner (Axline, 1969; VanFleet, Sywulak, & Sniscak, 2010). The permissiveness of the counselor allows children to go deeper into their feelings and expressions in the playroom (Axline, 1969).
4. "The counselor is alert to recognize the feelings the child is expressing and reflects those feelings back to the child in such a way that the child gains insight into his/her behavior" (Axline, 1969, p. 73). The counselor creates an environment in the playroom that establishes acceptance, permissiveness, and the foundation for a secure therapeutic relationship (VanFleet, Sywulak, & Sniscak, 2010). Empathic listening is a skill that starts with the recognition of feelings in the form of a verbal response and conveys the specific feelings of the child in an accepting and nonjudgmental manner back to the child (VanFleet, Sywulak, & Sniscak, 2010). The counselor must be in tune with the child and what the child is expressing, whether through direct conversation or through play (Axline, 1969).
5. "The counselor maintains a deep respect for the child's ability to solve his/her own problems if given an opportunity to do so. The responsibility to make choices and to institute change is the child's" (Axline, 1969, p.73). In order for children to grow in self-

esteem and self-confidence, they must first feel respect and empathy from the counselor (Axline, 1969). Just as Rogers' strong belief that, given the opportunity, a client can solve his/her own problems with little direction from the counselor, it is the same in CCPT (Landreth, 2002). CCPT counselors believe that children will become confident in their ability to take responsibility for their actions and problems when given opportunity and respect by the counselor (Axline, 1969). In CCPT, the counselor has a deep respect for the child's ability to solve his/her own problems; therefore, any way the child chooses to play or not play is considered to be what the child needs to do in order to achieve mastery of the self and the play environment (VanFleet, Sywulak, & Sniscak, 2010).

6. "The counselor does not attempt to direct the child's actions or conversation in any manner the child leads the way; the counselor follows" (Axline, 1969, p.73) CCPT is nondirective, and counselor does not judge children or suggest, praise, question, criticize, or interpret the children's play (VanFleet, Sywulak, & Sniscak, 2010). The counselor allows the child to be free in the playroom and to use the toys and materials symbolically in whatever manner necessary to express feelings (Axline, 1969). In the playroom, children are in charge of and responsible for themselves and their actions; counselors who are in sync with children follow where the children lead the therapy (VanFleet, Sywulak, & Sniscak, 2010).
7. "The counselor does not attempt to hurry the therapy. Therapy is a gradual process and is recognized as such by the therapist" (Axline, 1969, p. 73-74). The counselor makes no attempt to rush the child in the playroom or in the progression of play therapy. The playroom is the one place the child is able to take time without an adult rushing or helping to finish faster (Axline, 1969). Allowing children to take their time in the

playroom and allowing them to lead the way helps them to gain readiness of expression that encourages them to gaining mastery over their feelings (Axline, 1969; VanFleet, Sywulak, & Sniscak, 2010). This process also helps children to learn about themselves (VanFleet, Sywulak, & Sniscak, 2010). The play therapy process cannot be rushed; children need time, space, and acceptance to complete the play therapy process in a healthy fashion (VanFleet, Sywulak, & Sniscak, 2010).

8. “The counselor establishes only those limitations that are necessary to anchor the therapy to the world of reality and to make the child aware of his/her own responsibility in the therapeutic relationship” (Axline, 1969, p.74). There are many reasons to have limits in the playroom. Limits keep the child, counselor, and materials safe, and they help the child take responsibility for actions. Limits allow the child to understand what is not socially acceptable in the playroom and in society (Axline, 1969). Limits also keep the child and counselor physically and emotionally safe (Axline, 1969). Limits help the child feel safe in the playroom, as the counselor maintains consistency in setting limits (VanFleet, Sywulak, & Sniscak, 2010). Limits are an important part of play therapy because they give the child the opportunity to grow, to learn, and to express feelings appropriately (Landreth, 2002).

These eight principles of play therapy defined by Axline (1969) are guidelines that help the counselor to establish trust, respect, limits, and growth and to allow the child to lead the way through treatment. These eight principles serve as a foundation for all play therapy theories, but they hold a deeper significance for child-centered play therapy. The eight principles are the core of child-centered play therapy and allow counselors to understand their role in the therapeutic process (Axline, 1969).

Therapeutic Responses in Play Therapy

A main component in play therapy is the ability for the counselor to provide therapeutic responses, which come in the form of reflecting and tracking what the child is expressing, both verbally and non-verbally, through play. The therapeutic relationship between the child and the counselor allows the counselor to develop accurate reflections and tracking of the child's play (VanFleet, Sywulak, & Sniscak, 2010). Tracking occurs when the counselor acknowledges the child's behavior by verbally stating what is being observed (Ray, 2011). This technique sends the message that the counselor is interested and accepting the child (Landreth, 2002). Tracking also helps counselors immerse themselves in the children and their world, helping children to feel that their counselors are participating in the process with them (Landreth, 2002; Ray, 2011).

Ray (2011) established three forms of reflection: reflection of content, reflection of feelings, and reflection of larger meaning. For reflection of content, the counselor paraphrases the verbal interaction of the child. This allows children to feel validated in their perception of their experiences and feelings and helps them to understand themselves.

Reflection of feelings is when the counselor verbally responds to what the child is expressing emotionally. Expressing emotions in play can take the form of facial expression, body language, and verbal communication. An example of this would be a child who draws a picture of her grandmother in the playroom and expresses love for her grandmother. The counselor may respond with, "She must mean a lot to you. I can tell that you and your grandmother must have a very special relationship and that you love her." The counselor must be aware that reflecting feelings can be threatening to a child and should be used and stated carefully (Ray, 2011). However, reflection of feelings can help children become aware of their emotions, which allows them to learn the appropriate acceptance and expression of feelings (Ray, 2011). Reflecting

feelings is considered to be a higher-level skill for a counselor, although tracking and reflecting are considered to be some of the most basic skills in play therapy (Ray, 2011).

For reflection of larger meaning, the counselor pays close attention to the child's play and verbalizes observed patterns. For example, the counselor may respond to a child after noticing that at the end of each session the child puts every toy back where he/she found it. The counselor may respond, "It's important for you to put everything right where you found it." Reflecting larger meaning allows the children to become aware of the significance of their play, along with the counselor's broader empathy and understanding (Ray, 2011).

Landreth (2002) explained that therapeutic responses to a child's play should flow smoothly without interrupting the child's expression. A therapeutic response should be short and interactive with the child. In the playroom, both the counselor and the child are moving as one; the counselor is attuned to what the child is feeling and expressing (Axline, 1969; Landreth, 2002). In order for the counselor to provide therapeutic responses, the counselor must pay close attention to the child's statements, tone of voice, facial expressions, and body language to get a clear understanding of the child's expression of feelings (VanFleet, Sywulak, & Sniscak, 2010). In both tracking and different forms of reflection, these verbalizations are made in the form of statements, not questions (VanFleet, Sywulak, & Sniscak, 2010). VanFleet, Sywulak, & Sniscak (2010) stated that the counselor's goal is to understand the child's world and to accept the child as he/she is. Counselor should not expect to get the play interpretation and dialog correct or understand the play theme accurately every time, as it is a learning process for the counselor.

Playroom Materials and Purpose

If play therapy is a natural form of expression for children, counselors should use the play process as a form of healing for children (Landreth, 2002). The materials in the playroom serve

as a medium through which children express their feelings (Axline, 1969). The toys in the playroom not only reflect the words and feelings of the child but also facilitate a therapeutic relationship between the child and counselor (Schaefer, 2003). Not all toys and games are appropriate for a counselor conducting child-centered play therapy because many games and toys already have rules that do not allow for the child's expression of feelings, needs, and experiences (Landreth, 2002; Ray, 2011; Schaefer, 2003).

The size of the playroom is important, but variations are not detrimental to the therapeutic outcome. The size of the playroom allows children the freedom to explore, move, and express all types of feelings in an appropriate and safe manner (Landreth, 1982). Landreth (1982) stated that in order for the child to do effective therapeutic work in the playroom, the child must first have a sense of safety. This is created by having a strong physical structure (walls or clear markings of the parameter of the room), as well as by setting limits when needed. A playroom should have appropriate child-sized furniture to allow children to use the playroom without limiting their ability to move and explore freely (Landreth, 1982).

Landreth (1982) developed a list of playroom toys and materials needed to conduct child-centered play therapy (see Appendix A). Landreth (2002) established three categories of toys that facilitate a wide range of expressive feelings, and each child can decide and label how they use the toys.

The first category is real-life toys, which consist of a medical kit, dolls, a dollhouse, stuffed animals, puppets, cars, an ambulance, a police car, a cash register, a kitchen, food, dishes, and a chalkboard. These toys allow children to symbolically play out real-life scenarios and to make sense of their own feelings (Ray, 2011). Also, through playing with real-life toys, children

learn to take control of the environment. This might, for example, take the form of retelling a story as the child wishes it would have happened in real life.

The second category of toys is acting out, aggressive-release toys. Bobo dolls, pounding blocks, toy soldiers, guns, plastic knives, puppets, handcuffs, wild animals, dinosaurs, jump ropes, play dough, egg cartons, and popsicle sticks can all be used to express aggressive feelings. Items like egg cartons and popsicle sticks are used for breaking, whereas the other items are used to express aggression and related feelings in an appropriate manner. Aggressive toys allow the child to fully express anger and deal with issues such as power and control (Ray, 2011). In the playroom, aggressive behavior is appropriate, and the counselor can set limits as needed to ensure safety for both the therapist and the child. Aggressive toys also include a selection of toys such as spiders, snakes, and insects that allow the child to express fears and anxiety (Ray, 2011).

The third category of toys is creative expression and emotional release toys and include items such as water, sand, paint (washable), crayons, dress-up clothing, and masks that can all be used by the child to express creativity (Ray, 2011). Creative expressions can take many forms. For example, one child may choose to express feelings by drawing a scenario, while another child may choose to act out such scenarios. In the playroom, the child is the one who directs the play (Axline, 1969); every toy and item in the playroom is a means of expression (Landreth, 1982).

When selecting toys and items for the playroom, counselors should identify how selections will help children express themselves, build therapeutic relationships between the counselor and the child, and serve a therapeutic purpose in the play room (Ray, 2011). The playroom must be set up the same way every time. Each item in the playroom must be in the same place at the start of each play session; this allows the child to feel safe (Landreth, 2002;

Ray 2011). This consistency at every play session gives children the impression of a stable and reliable environment where they are in control and where they are able to master their feelings in a safe place (Ray, 2011).

Limit Setting

Limit setting in the playroom is a vital part of the therapeutic relationship between the child and counselor. Limits are a way to provide structure for children and to help them understand the boundaries in the counseling relationship and outside the playroom (Landreth, 2002). Limit setting is a way to keep the client, counselor, and materials safe, and also helps children learn responsibility for their own actions and for what happens in the playroom if they choose to break limits after being set (VanFleet, Sywulak, & Sniscak, 2010).

In child-centered play therapy, each session starts the same way: “In the special playroom, you get to play with the toys in many of the ways that you would like.” This phrasing allows the counselor to later set any needed limits. Both Axline (1969) and Landreth (2002) agreed that in child-centered play therapy limits should not be introduced unless absolutely necessary. The limits are few, but they are of the utmost importance (Landreth, 1982). In CCPT, counselors take the pervasive yet passive role of authority, allowing children to navigate through their feelings symbolically and trusting them to make self-enhancing decisions (Ray, 2011).

Landreth, (2002) clearly defined seven reasons for setting limits in the playroom. Limit setting is not negative. In fact, through limit setting, a child learns self-control, responsibility, and acceptable behavior in and out of the playroom; without limits, the child is deprived of the opportunity to become more self-aware and to learn about socially acceptable behavior (Landreth, 2002).

1. **“Limits provide physical and emotional safety and security for the child”** (Landreth, 2002, p. 250). In the playroom, the child needs limits in order to be physically safe. For example, the child is not allowed to eat clay, because it is not food. The child is not allowed to hurt, attack, or act out in an inappropriate manner toward the counselor at any point (Ginott, 1982; VanFleet, Sywulak, & Sniscak, 2010). In addition to causing harm to the counselor, such actions may cause the child to feel guilty or anxious (Landreth, 2002). Although limits in the playroom may be few, they reinforce feelings of security and reality (Axline, 1947). When boundaries in counseling are consistent, they provide stability and predictability in the relationship and in the playroom (Landreth, 2002).
2. **“Limits protect the physical well-being of the child and the counselor and facilitate acceptance of the child”** (Landreth, 2002, p. 251). Safety is a basic necessity. Therefore, children are not allowed to hurt themselves or their counselors physically, as this would send children the message that the playroom is not a safe place (Ray, 2011). Rather, a limit is set for the safety of both individuals, and a reflection of feelings should follow. Limits may provide opportunities for children to grow (Landreth, 2002). This growth occurs when the counselor exhibits the core conditions, and limit setting allows the counselor to remain accepting of the child throughout the play therapy process (Landreth, 2002). Ginott (1982) noted that “[t]he invoking of limits prevents the therapist from exceeding his own capacity for tolerance and enables him to remain consistently unperturbed and tranquil” (p. 162). The counselor remains empathic rather than feeling angry, rejected, or hurt, which would affect not only the therapeutic relationship but also the progress of the child (Landreth, 2002).

3. **“Limits facilitate the development of decision-making, self-control, and self-**

responsibility of children” (Landreth, p. 252). In play therapy, children learn about their feelings and find ways to express them in the playroom. Landreth (2002) argued that “before children can resist following through and expressing feelings in ways dictated by first impulses, they must have an awareness of their behavior; a feeling of responsibility, and exercise self-control” (p. 252). Limit setting does not stop the expression of feeling; rather, it provides the child with an acceptable alternative (Landreth, 2002). Counselors reflect the feelings and expressions of children back to them in such a way that the children understand themselves better (Axline, 1947). For example, the counselor may not feel comfortable with the child shooting the dart gun at her/him. The counselor may tell the child, “I can tell you really want to shoot me, but I am not for shooting. You can shoot the Bobo doll.” This allows the child to release feelings in an appropriate manner while learning self-control (Landreth, 2002).

4. **“Limits anchor the session to reality and emphasize the here and now”** (Landreth, 2002, 255). In play therapy, children can become lost in the play, causing them to avoid any personal responsibility for their behavior and actions (Landreth, 2002). When the counselor expresses a limit verbally, the child is brought back to the present moment, where certain behaviors are not acceptable (Landreth, 2002). The child and counselor have a therapeutic relationship, and limits exist in every relationship that has any significance. Without limits, there is little value or respect in a relationship (Landreth, 2002).

5. **“Limits promote consistency in the playroom environment”** (Landreth, 2002, p. 254).

The child should have a place where limits are consistent, because limit-setting allows the

child to have a clear understanding of what is and what is not acceptable behavior. At times, parents and teachers may not provide the child with consistency when monitoring behavior. However, consistency is the key to helping the child feel that the playroom is safe and predictable (Landreth, 2002). For the counselor, consistency in limit setting serves as a function of attitude, and it tangibly demonstrates commitment to the safety and acceptance of the child (Landreth, 2002).

6. **“Limits preserve the professional, ethical, and social acceptable relationship”**

(Landreth, 2002, p.256). Limit setting allows children to express their feelings symbolically in an appropriate and socially acceptable manner. Children in the playroom are not allowed to urinate on the floor or write on the walls because those are socially unacceptable both in and out of the playroom (Ginott, 1982; Landreth, 1982). Landreth (2002) stated, “As with many other acting-out behaviors, therapeutic limit setting enables the child to express the behavior and accompanying feelings symbolically and allows the therapist to be an objective but involved participant thus preserving the professional and ethical therapeutic relationship” (p. 256). Additionally, the counselor should maintain an ethical code for the safety of both the child and the counselor.

7. **“Limits protect the play therapy materials and room”** (Landreth, 2002, p. 257). The playroom is a place where the child can express feelings and make sense of the world. Each child expresses and releases feelings differently. In the middle of expressing feelings of anger or frustration, some children may want to destroy toys in the playroom. The counselor may verbalize such feelings to the child while setting a limit in a calm voice: “I can tell you are very angry and you want to break that toy, but the toys are not for breaking.”

Limits help the child know that certain behaviors are not socially acceptable (Landreth, 2002). In order to keep the toys, materials, and room consistently looking the same, children are not allowed to break, take, borrow, or ruin anything in the playroom. Allowing such behavior would be unrealistic and would not help the child learn; in addition, counselor should not be expected to replace toys and other materials so often (Ginott, 1982; Landreth, 2002; Ray 2011).

In limit setting, the goal is not to stop the child from expressing feelings but rather to help the child learn self-control, boundaries, and social acceptability. Successful play therapy results in the release of feelings that transform into insight and bring awareness and positive self-direction to the child (Axline, 1969). Limit setting is about keeping the child, counselor, materials, and playroom safe while allowing the child to use the toys symbolically to express feelings (Ginott, 1982).

Termination

Termination is a part of any therapy or treatment, and in child-centered play therapy the ending of the therapeutic relationship between the child and the counselor is just as important as the start of the relationship (Landreth, 2002). Play therapy literature reflects a difficulty in assessing when termination should take place. Because of the core belief that the child leads the way, there is no set goal to work toward. The therapeutic relationship itself causes change to occur at the child's pace (Landreth, 2002).

Ray (2011) developed a form that allows the counselor to assess each child's progression of play in order to help determine the appropriate time for termination. This form is called the Assessment of In-Session Progress, and it allows the counselor to measure a child's progress on a case-by-case basis along the following scales (Ray, 2011):

- aggressive \leftrightarrow no aggressive behavior

- self-directed play \leftrightarrow dependence on therapist for play initiative
- low energy \leftrightarrow high energy
- sustained play behaviors to inability \leftrightarrow sustain play or carry out play scene
- destructive \leftrightarrow constructive
- messy \leftrightarrow clean
- highly verbal \leftrightarrow no verbalization
- responds to limits appropriately \leftrightarrow breaks limits
- involves therapist in play \leftrightarrow plays alone
- involves therapist in verbalization \leftrightarrow no verbalization or verbalizes as narrative without therapist interaction
- play is thematic, seemingly meaningful \leftrightarrow play is rote, seemingly meaningless to child
- no affect observed \leftrightarrow intensity of affect expressed
- positive affect (laugh, smiles, content) \leftrightarrow negative affect (anger, cries, sadness)
- age-appropriate play \leftrightarrow regressed play
- mastery play \leftrightarrow no mastery play
- inability to tolerate frustration \leftrightarrow high level of frustration tolerance
- keeps trying when play is difficult \leftrightarrow gives up when play gets difficult

The assessment would be completed based on what the child demonstrated in the play session.

As termination is part of the therapeutic process, both the child and counselor have shared a journey together that progressed. The therapeutic relationship may be difficult to terminate and should be done openly and not abruptly (Landreth, 2002). The child needs to be given time to process and live out the ending of the relationship (Landreth, 2002). At the end of

the play therapy process, children take responsibility for their feelings and express them honestly and openly. As they develop personal coping skills through the play therapy process, they feel more secure and more equipped to deal with future problems rather than developing feelings of fear and repression (Axline, 1982).

Evidence-Based Play Therapy

As the field of play therapy is growing so is the demand for evidence-based research with in this field. Past research has shown the importance of play therapy in different settings and diagnoses.

Ray D. C., Blanco P. J., Sullivan J. M., Holliman R. (2009) conducted a study to explore CCPT in children demonstrating aggressive behaviors in several settings such as family, school, and social context (Ray et al., 2009). The researchers identified aggressive behaviors in children doing any of the following: pushing, hitting, kicking and throwing. The researchers suggested that there is no specific age onset for aggressive behavior, but adolescents that demonstrate aggressive behavior could most likely be identified in the early elementary years of the child (Ray et al., 2009). This study on the exploration of children-centered play therapy with aggressive children showed that students that were assigned to the treatment group of receiving 14 CCPT sessions decreased in aggressive behaviors, and children assigned to the control group demonstrated no statistically significant difference in their aggressive behavior. Ray et al. identified the importance for children to have early intervention for their aggressive needs and that CCPT helped to decrease such behaviors (Ray et al., 2009).

Ray, Henson, Scottelkorb, Brown, Muro (2008) placed children in one of two intervention group. The first group was short-term, consisting of 16 sessions of CCPT in 8 weeks. The second group was long-term treatment, in which students received 16 sessions of

CCPT over 16 weeks (Ray et. al., 2008). The results of this study indicated that both long-term and short-term intervention groups demonstrated significant improvement in teacher-student relationship stress from pre- to posttest scores as a result of CCPT (Ray et. al., 2008).

Dougherty and Ray (2007) explored the impact CCPT on children within the stages of Piaget's preoperational and concrete operational development stages. Twenty-four children between the ages of 3-8 received 19-23 individual CCPT session. Dougherty and Ray reported 14 of the 24 (58%) children scored in the clinical range on the child domain scale at the pretest before receiving 19-23 CCPT sessions treatment. After treatment 9 out of the 14 (64%) children scoring in the clinical range, decreased to the normal range. In the results "it is notable that CCPT demonstrated statistical, practical and clinical significance when all children in the study were analyzed together" (Dougherty & Ray, 2007, p. 14). For children in the preoperational development stage 7 of the 12 (58%) children had scores in the clinical range at pretest (Dougherty & Ray, 2007), and 4 of the 7 (57%) children scored in the normal range at posttest (Ray & Dougherty, 2007). As for the children in the concrete operational development treatment group, 7 of the 12 (58%) children scored in the clinical range at pretest (Dougherty & Ray, 2007). After the children received 19- 23 sessions of CCPT, 5 of the 7 (71%) children scored in the normal range (Dougherty & Ray, 2007). All results for this study show that CCPT had a strong impact that was clinically significant (Dougherty & Ray, 2007).

Muro, Ray, Schottelkorb, Smith and Blanco (2006) measured the impact of CCPT in 23 children identified by teachers as exhibiting behavioral and emotional difficulties. The researchers used a repeated measure design in order to explore the use of CCPT in pre-intervention to mid-intervention, which was 16 sessions, to post-intervention, being 32 weeks (Muro, et. al., 2006). Muro et al. (2006) showed statistically significant improvements in several

areas, such as the teacher stress and student improvements related to ADHD domains. Although play therapy researchers published numerous articles on how play therapy helped children in various areas such as reading scores, behavior, grades, and much more, well designed studies in the play therapy literature are limited (Ray, 2011). Ray (2011), established criteria for a well-designed/well-established study. According to Ray (2011) criteria for a well-established studies include the following:

- Comparison group receiving an EBT preferably, or at least a placebo psychotherapy
- Randomized assignment
- Adequate sample size
- Reliable and valid measures of specific problem with blind administration and scoring
- Treatment manuals implemented with fidelity checks
- Therapist appropriately trained and supervised in treatment approach
- Specific client characteristics: diagnosis or presenting problems age, and culture
- Appropriate statistical analysis
- Problems or limitations addressed
- Detailed description for replication by independent teams (Ray, 2011, p.468).

The field of play therapy is moving toward evidence-based research in order to establish the power and importance of play therapy within both the counseling and research fields. As play therapy literature grows, it is important to understand the core belief of child-centered theory. The therapeutic relationship between the counselor and child is the key for progress in the play session and also has an effect outside of the playroom. Play therapy is more than just a room with toys; the counselor offers the child an opportunity to be the one in charge of the counseling.

The child gets to decide what to play with, what to label it, what issues to explore, and what to let go. The child uses the toys as a way of expressing feelings (Axline, 1969). Toys are the language of children, and using them in a therapeutic manner allows children the freedom to be themselves and to make progress (Landreth, 2002).

Chapter 3

Methods

Participants

The participants in the study were selected from a South Texas elementary school and included teachers, parents, and children. The teachers in preschool and Kindergarten classes identified the students they considered to have behavioral difficulties in the classroom.

Teachers

The teachers with students who represented the populations needed for this study were asked to meet with the researcher to discuss the purpose of the study and the procedure for those willing to participate. The Kindergarten, Pre-Kinder 4, and Pre-Kinder 3 teachers agreed to fill out the Caregiver-Teacher Report Form (C-TRF) weekly for each student that would be a part of the study.

The Kindergarten teacher identified herself as a Hispanic female who has taught at the elementary level for over 35 years and at the university level for five years. At the time of the study, she was working on her doctorate in bilingual education. The Pre-Kinder 4 identified herself as a Hispanic female teacher who has taught elementary level education for 15 years, and has a doctorate in Early Childhood Education. The Pre-Kinder 3 teacher identified herself as a Hispanic female who has taught elementary level education for 16 years. Because of their experience, they all have a thorough understanding of age appropriate behaviors in the classroom.

Students

There were a total of 12 students in this study—six from a Kindergarten class, five from a Pre-Kinder 4 class, and one from a Pre-Kinder 3 class. The students in this study ranged from

three to six years of age. The age and ethnicity makeup of the six Kindergarten students consisted of one six-year-old male whose guardian identified as Hispanic with English as her first language, one five-year-old female whose parents identified as bi-racial (Hispanic and African American) with English as their first language, and four five-year-olds (three male and one female) whose parents identified as Hispanic with Spanish as their first language.

Participants in Pre-Kinder 4 included two males—one four and the other five—whose parents identified as Hispanic with Spanish as their first language, one four-year-old female whose parents identified as white with English as their first language, one five-year-old female whose parents identified as Hispanic with English as their first language, and one five-year-old female whose parents identified as bi-racial (White and African American) with English as their first language. The participant in Pre-Kinder 3 was a three-year-old female whose parents identified as Hispanic with Spanish as their first language.

Parents/Guardians

The parents/guardians whose children were selected to be a part of the study gave consent for their children to take part in the study and agreed to fill out the Child Behavior Checklist weekly for the 12 weeks of the study. For the student information sheet, the researcher asked the parents/guardians for their preferred language in order to communicate further in the appropriate language and to send the CBCL in the preferred language. Parents/guardians were asked that the same person fill out the form weekly in order to maintain consistency within the data.

Measures

For this study, the Achenbach System of Empirically Based Assessment (Achenbach & Rescorla, 2000) preschool forms and profiles, which are the Child Behavior Checklist (CBCL) for ages 1 ½- 5 and the Caregiver-Teacher Report Form (C-TRF), were used. Also, the ASEBA

school-age forms and profiles, which are the Child Behavior Checklist for ages 6-18 and the Teacher Report Forms (TRF), were used. In order to score each form, a hand-scoring profile was used for each CBCL 1½-5, C-TRF, CBCL 6-18, and TRF collected.

Child Behavior Checklist for Preschool Age 1 ½ -5 and Hand-scoring Form

The child behavior checklist was used to conduct research in many different settings, such as educational institutions, private practices, mental health agencies, medical facilities, and child and family services, and to examine several different research aspects, such as behavioral disorders, attention deficit disorder, anxiety, and depression (Achenbach & Rescorla, 2000; Ray, 2011). A researcher can obtain standardized ratings for diverse social functioning and behavioral/emotional aspects (Achenbach & Rescorla, 2000). The CBCL is easy for parents/guardians of all ages to understand and fill out without any prior training, and it is available in several different languages.

The CBCL consists of 99 items that can be rated with 0 for *not true of the child*, 1 for *somewhat or sometimes true*, and 2 for *very true or often true*. There is a final question that asks for a written response regarding any additional problems that the child may have that were not previously listed on the form. Although it is a written response, question 100 also asks for a rating of 0, 1, or 2 as the other 99 questions do. The CBCL also includes three open-ended prompts that are not rated: Does the child have any illness or disability? What concerns you most about the child? Describe the best things about the child (Achenbach & Rescorla, 2000).

The CBCL questions will be placed into two broad groups: Internalizing and Externalizing syndrome scales. Internalizing refers to problems that occur within the self, externalizing refers to problems that involve conflicts with other people and with the expectations they have of the child (Achenbach & Rescorla, 2000). These syndrome scales

exclude other questions and the sub-group of sleeping problems. The Internalizing syndrome scale is comprised of four sub-groups: emotionally reactive, anxious/depressed, somatic complaints, and withdrawn (Achenbach & Rescorla, 2000). The externalizing syndrome scale is comprised of two sub-groups: attention problems and aggressive behavior. There are two additional groups—other problems and sleep problems.

On the hand-scoring form, the seven syndrome scales (emotionally reactive, anxious/depressed, somatic complaints, withdrawn, sleep problems, attention problems, and aggressive behavior) can be analyzed and totaled individually. However, they can be further analyzed within the two syndrome scales of Internalizing and externalizing, and both the sleep problem and other problem questions are added to the total problem score (Achenbach & Rescorla, 2000). The total problem score is made up of adding the subgroup scores for the Internalizing and externalizing syndrome scales, adding both syndrome scales together, and adding the other problem and sleep problem scores together for a total problem score. This total is displayed in raw scores, and T-scores are given to Internalizing and externalizing problems, as well as the total problem score.

T-scores can be seen on the CBCL hand-scoring form and graphed for each syndrome scale. All raw scores for the Internalizing, externalizing, and total problem score are given T-scores, which are used to see how a student scores on each scale and compares the scores with those of the normative sample of peers (Achenbach & Rescorla, 2000).

The CBCL hand-scoring form displays the empirically-based scale for boy and girls on one side and the Diagnostic Statistical Manual (DSM)-Oriented scale on the other. The empirically-based scale was used for this study because this study desired to see the change, or lack thereof, in each student's behavior. Using the empirically-based scale allowed the researcher

to see the students as they compared to the national nominal sample using T-scores as the data points to show the student scores for each of the 12 weeks. The DSM-Oriented scale was omitted from this study because T-scores can easily be explained and understood by parents/guardians and teachers. The DSM scale would be better for use in a clinical setting rather than in a school setting because of the diagnoses scale this form has. The CBCL form also includes the Language Development Survey (LDS) form that was omitted because it was not relevant to the goals of this study.

Caregiver-Teacher Report Form (C-TRF)

The Caregiver-Teacher Report Form was also used for this study; it takes 10-15 minutes to complete. The Kindergarten, Pre-Kinder 3, and Pre-Kinder 4 teachers filled out the C-TRF for each of their participant students. The format and questions are very similar to the CBCL 1 ½-5 form that parents/guardians fill out. The C-TRF can be filled out by teachers, daycare providers, and others who have observed the child in the school setting (Achenbach & Rescorla, 2000). The C-TRF consists of 100 questions, 99 of which can be answered by circling 0 for *not true (as far as you know)*, 1 for *somewhat or sometimes true*, or 2 for *very true or often true*. The last question is an open-ended question asking respondents to describe any problems the child has that were not already listed; the response to this question can be filled in and given a rating of 0, 1, or 2 according to what the teacher observes. This form also includes open-ended items that ask teachers to describe the child and his/her best qualities (Achenbach & Rescorla, 2000).

The six syndrome scales—emotionally reactive, anxious/depressed, somatic complaints, withdrawn, attention problems, aggressive behavior (Internalizing and externalizing)—are the same as the CBCL 1 ½-5 except that sleeping problems are not considered on the C-TRF. The form used to hand score the C-TRF is the empirically-based scale for boys and girls. The process

for hand scoring the C-TRF mirrors the CBCL 1 ½ -5: it is divided into the six syndrome scales, placed under the two main scales of Internalizing and externalization, and added together with the additional other problems; all three are added to obtain the total problem score for the child. T-scores are given to the raw score for each main syndrome scale and the total problem score. The T-scores for the C-TRF are divided into normal and clinical scores. A normal T-score is in the 50 (or less) to 69 range, a clinical T-score is in the range of 70 or greater, and a borderline score is between 65 and 69.

Child Behavior Checklist for School Age 6-18 Forms

The Child Behavior Checklist for school age 6-18 was also used in this study. The CBCL 6-18 and the TRF forms take approximately 15-20 minutes to complete. Unlike the CBCL 1 ½ -5 that can assess both genders, the CBCL 6-18 and the TRF are gender specific. For this study, only one male student was assessed using the CBCL 6-18. The first page of the CBCL 6-18 form include demographic information, parent employment, sports and activities, hobbies, and chores. The form also included information about the child's social life, including questions regarding close friends, siblings, and academic performance. These can be answered by checking *below average*, *average*, and *above average* (Achenbach & Rescorla, 2001). Further questions about special education, repeating a grade level, problems in school, illnesses, and personal concerns about the child are also addressed.

The Teacher Report Form (TRF) follows the same format of questions and answers as the CBCL 6-18 form. For this study, the hand-scoring form was used to analyze the data for the CBCL 6-18, and the TRF profile specifically for boys was used. Teachers or any other school personnel who know the child (counselor, teacher assistant, etc.) can fill out the TRF. For this study, the main teacher for each child's grade level completed the form. The first page of the

TRF asks question regarding the respondent, such as the role he/she has at the school, how long he/she has known the child, the amount of time he/she spends with the child, and if the child has been placed or referred for a special class or services. They are also asked to evaluate and rate the student's performance in academic subjects and to provide demographic information about the student (if known). Pages three and four consist of behavioral questions that can be answered by circling 0 for *not true (as far as you know)*, 1 for *somewhat or sometimes true*, or 2 for *very true or often true* (Achenbach & Rescorla, 2001).

The CBCL 6-18 and TRF questions are divided into two categories—internalizing and externalizing—which are further broken down into eight syndrome scales: I. Anxious/Depressed, II. Withdrawn/Depressed, III. Somatic Complaints, IV. Social Problems, V. Thought Problems, VI. Attention Problems, VII. Rule-breaking Behavior, VIII. Aggressive Behavior (Achenbach & Rescorla, 2001). All other questions that do not fit into these eight syndrome scales are placed under other problems. Much like the CBCL for young children scales I, II, and III are added to find the raw Internalizing score, scales VII and VIII are added to find the raw externalizing score, and scales IV, V, and VI are added to find the raw score for other problems (Achenbach & Rescorla, 2001). To obtain the total score, the raw scores for Internalizing, externalizing, and other problems are added together then changed to a T-score, which can be found on the right side of the hand-scoring profile.

According to the student's score per syndrome scale, the results are charted on the hand-scoring profile to show where the child falls within these syndrome scales based on normal, borderline, or clinical ranges. ASEBA (2002) has established the scores considered to be clinical, borderline, and normal: "The clinical range is $T < 37$ ($< 10^{\text{th}}$ percentile); the borderline range is from $T = 37$ to $T = 40$ (10^{th} to 16^{th} percentiles); and the normal range is $T > 40$ ($> 16^{\text{th}}$ percentile)"

(Achenbach & Rescorla, 2001, p.20). The ASEBA school-age forms and profiles offer not only the CBCL 6-18 and the TRF but also the youth self-reporting form and profile, which was not used for this study. “ASEBA forms capture both the similarities and differences in how children function under different conditions and with different interaction partners” (Achenbach & Rescorla, 2001, p.16).

Reliability and Validity

Reliability and validity are crucial to picking an instrument for the study. The *reliability* of an instrument provides “agreement between repeated assessments of phenomena when the phenomena themselves are expected to remain constant” (Achenbach & Rescorla, 2001, p. 99). There are two forms of reliability inter-interviewer reliability and test-retest reliability. *Inter-interviewer reliability* consists of whether various interviews obtain similar item scores (Achenbach & Rescorla, 2001). *Test-retest reliability*, “is the degree of agreement between items scores obtained from the same respondent over brief intervals when the children’s behavior was assumed to remain constant” (Achenbach & Rescorla, 2001, p. 99). Another important aspect to consider when looking at an instrument for a study is the Internalizing consistency. *Internalizing consistency* is data that specifies the degree to which the individual score items of a scale correlate with each other (Achenbach & Rescorla, 2001). In table 1. The alphas competence scales are displayed. The alpha competence scales were moderately high, ranging from .63 to .79 for the CBCL and on the TRF an alpha level of .90 for total adaptive scales.

The Reliability for Preschool age 1 1/2 -5 shows the score for test-retest reliability ranging from .80 to .90s. and for total problem score r was .90 on the CBCL and .80 on the C-CTRF (Achenbach & Rescorla, 2000).

Table 1.

Test-Retest Reliability and alpha coefficients: Empirically Based

Scales	CBCL ^a		YSR ^a		TRF ^a	
	r	Alpha	r	Alpha	r	Alpha
Internalizing	.91 ^d	.90	.80 ^{d,e}	.90	.86 ^{d,e}	.90
Externalizing	.92	.94	.89 ^{d,e}	.90	.89	.95
Total problem	.94 ^{d,e}	.97	.87 ^d	.95	.95 ^{d,e}	.97
Mean r^c	.90	NA	.82	NA	.90	NA

^a Mean test-retest interval for CBCL= 8 days; for YSR= 8 day, Cronbach's alpha was computed for the demographically matched referred and nonreferred samples.

^b Parentheses indicate scales that are only on TRF.

^c Mean r computed by z transformation.

^d Time 1 > Time 2 by t test.

^e When corrected for the number of comparisons, time 1 Vs. Time 2 difference was not significant.

Table 2.

Test-Retest Reliability of Scales Scores for CBCL Preschool age

Scales	CBCL	C-TRF
	8- Days r	8-Day r
Internalizing	.90a	.77
Externalizing	.87a	.89a
Total problem score	.90a	.88a

Note: all Pearson r were significant at $p < .01$.

Design

This study used a single-case research design, also known as single-subject research or single-system design, a method in which the researcher gathers information on any system treated as a single unit (Lundervold & Belwood, 2000). This study will use the term *single-case research (SCR)* in reference to this design (O'Neill et al., 2011). SCR is a quantitative, experimental design where data and information is collected for a single individual or for several individuals (Lundervold & Belwood, 2000). SCR is useful to monitors change (or the lack thereof) within the individual, as opposed to comparing an individual to a control group. In SCR, baseline scores for each individual are used as a control in order to compare behavior between baseline conditions (no intervention) and an intervention condition (O'Neill et al., 2011).

This form of research has two types of phases of interventions: baseline and treatment (Lundervold & Belwood, 2000). These phases are “a period of time during which a specific

counselor action is taking place. The effectiveness of counseling is based on comparisons of the client's behavior across varying phases of counseling, for example, before during, and after (follow up)" (Lundervold & Belwood, 2000, p. 94). In single-case study research, baseline is labeled "A" and Treatment is labeled "B."

Baseline is "used as the standard by which subsequent improvement is judged" (Lundervold & Belwood, 2000, p.94). Lundervold and Belwood (2000) recommended a minimum of three observations to establish strong baseline measure. Baseline observation takes place prior to administering an intervention or treatment to the client. This allows the researcher to obtain a sense of the participant's typical and current behavior or performance (O'Neill et al., 2011) A baseline serves descriptive and predictive functions. Descriptive functioning provides information on how often behaviors of interest occur and/or how long they last (O'Neill et al., 2011) Predictive functioning indicates patterns that allow the researcher to predict how a behavior would continue if an intervention/treatment were not implemented (O'Neill et al., 2011).

The treatment phase begins after the collection of baseline data. An ongoing assessment of the participant's behavior to take place during the intervention phase is important as this allows for the comparison of data from the baseline and treatment phases (O'Neill et al., 2011). In SCR, research can be categorized as withdrawal or reversal; each is structured to answer different research questions (O'Neill et al., 2011). Withdrawal design "document[s] whether the introduction of the intervention consistently leads to a change in the study participant's behavior" (O'Neill et al., 2011, p. 85). The most commonly used forms of a withdrawal design are A-B-A (baseline-treatment-withdrawal) and A-B-A-B (baseline-treatment-withdrawal-treatment). A reversal designs "compare[s] the effects of two or more interventions by

alternating them in the experimental sequence and observing their differential impact on the target behavior” (O’Neill et al., 2011, p. 92). This design strengthens the effect of the treatment (O’Neill et al., 2011). For this study, a withdrawal A-B-A research design was used. Finding the baseline included three weeks of the teacher and parent observing the child’s behaviors and filling out the appropriate forms. The treatment for this study included 45-minute child-centered play therapy sessions twice a week for six weeks. Once treatment ended, a secondary baseline was obtained by assessing the child’s behavior for three weeks after treatment/intervention.

The A-B-A design allows for the researcher to demonstrate an experimental control or functional relationship by assessing a second baseline and to create a visual representation of a change in performance at a second point in time (O’Neill et al., 2011). This design also helps to control for some of the threats to Internal validity such as history, maturations, testing or practice, measurement or instrumentation, regression, selection bias, participant attrition, diffusion of treatment, and multiple-treatment interference (O’Neill et al., 2011). Internal validity occurs when “the intervention or independent variable was responsible for any observed changes [and] any observed changes in behavioral performance are not due to uncontrolled or extraneous factors or variables encountered by the participants” (O’Neill et al., 2011, pp. 39-40).

Externalizing validity is concerned with how generalizing the results of a study or experiment past the situation of that particular study and understanding the implications of the results concerning their applications to other people, situations, and behaviors. These factors may limit generalizability, and they are threats to externalizing validity (O’Neill et al., 2011). Another important aspect of single-case research design is the number of participants in a study. As the name implies, an SCR study can be done with a single participant (O’Neill et al., 2011).

According to O'Neill et al., (2011), a typical single-case experimental study has about three to five participants, which allows for the replication of demonstrated effects.

For a single-case study to be considered evidenced-based (empirically supported), it must meet certain and specific criteria. Chambless et al. (1998) determined what is needed for research to be considered evidence-based: a series of single-case design experiments ($n \geq 9$) demonstrating efficacy. Repeated measures over time allow for an ongoing evaluation of the participant's behavioral performance and the decisions about the appropriate time to change phases (O'Neill et al., 2011).

Data Analysis

SCR data displayed in a visual graph format indicate that treatments are evidence-based, while also demonstrating causality and generalizability (Lundervold & Belwood, 2000). A visual representation of the data is graphed in order to determine a pattern (Lundervold & Belwood, 2000). Graphing data can be used to analyze five primary findings: trends, slope, stability, level, and overlap (Lundervold & Belwood, 2000). Trends in the data show a pattern where the target behavior is increasing (upward trend), decreasing (downward trend), or staying the same (stable). These trends may also specify deterioration or improvement in the target behavior (Lundervold & Belwood, 2000). Slope is the magnitude or steepness of the trend. Level refers to the relative magnitude of change observed, and it can be assessed at any point during baseline or intervention. The main and last determination of a change in levels occurs immediately after the intervention has ended (Lundervold & Belwood, 2000). O'Neill et al. (2011) stated that significant change between the baseline and intervention phases is an important indicator of a change in the target behavior and that it is reliable for the hypothesis that the intervention is the reason for the change.

Another indicator of the strength of the intervention effects is the overlap of the data between phases (O'Neill et al., 2011). O'Neill et. al. states that “overlap refers to the extent to which data points from different phases fall within the same range of values, and is the result of changes (or lack thereof) in the basic characteristics of level, trend, and variability across phases” (p. 59). In order to calculate the numerical overlap of data points between phases, researchers use the percentage of nonoverlapping data (PND). The PND is “the percentage of data points in an intervention phase that are either higher or lower than the highest or lowest data points in a baseline phase. Such measures have been used to aggregate data across larger numbers of studies” (O'Neill et al., 2011, p. 59). In an analysis of the overlap, the lower the degree of overlap between phases in the study, the stronger the argument for the functional effects of the independent variable on the dependent variable (Lundervold & Belwood, 2000).

Procedure

At the start of this study, the researcher met with the principal of the elementary school to discuss the research study; this meeting took place in November 2011 to prepare for the following semester. The researcher explained the purpose and desired population of the study. The purpose of this study was to see how child-centered play therapy may result in changes for preschool and Kindergarten students between the ages of three and six who were identified by the teachers as having behavioral difficulties in the classroom. This study analyzed each student individually in a quantitative single-case study research design. This form of analysis evaluated the impact child-centered play therapy has on each student's progress (or lack thereof). This study has two forms of data collection—teachers and parents. The principal agreed to allow the researcher to conduct the study, and the researcher met with the three teachers who were asked to be a part of the study: one teacher each from Kindergarten, Pre-Kinder 3 and pre-Kinder 4. The

researcher explained the study and what the teachers would be asked to do as part of the study. All three teachers agreed to take part in the study and to fill out the Caregiver-Teacher Report Form (C-TRF) weekly for each student. Once the principal and teachers agreed to the study, the researcher submitted the study to the IRB board of Texas A&M University—Corpus Christi. It was approved in January 2011, and the study started upon IRB approval.

Teachers were asked to identify students they believed to have behavioral difficulties in the classroom. The researcher explained to the teachers that they would be asked to fill out the C-TRF on a weekly basis for students whose parents agreed to allow their children to be part of the study. The teachers provided a list of the students they believed to have behavioral difficulties in class. The parents of the listed students had been notified throughout the school year regarding behavioral difficulties in the classroom. Once the teachers provided the list of student names, the researcher sent home consent form, and student information sheets provided in English and Spanish were sent home in the selected students' folders. In addition to sending the forms with the 24 selected students, the researcher also called the parents to let them know why their children were selected to participate in the study. The researcher obtained phone numbers through the school after being encouraged by the principal and teachers to call parents prior to sending the forms home. Teachers selected a total of 24 students, but only 12 parents agreed and returned the forms to the researcher. In addition to giving their consent, parents also committed to filling out the CBCL weekly for the length of the study.

The study consisted of 12 weeks broken down into three periods. The study started with three weeks of observing and assessing student behavior prior to child-centered play therapy (CCPT) to obtain a behavior baseline. Using the lowest score during the observation phase of the study a line is draw across the treatment and follow up stage. After the three weeks of

observations is complete it is followed by six weeks of child-centered play therapy that students received twice a week for 45 minutes for a total of 12 play therapy sessions per student. During the six weeks of intervention, the students continued to be assessed using the CBCL from the parents and the C-TRF from the teachers. The students were also assessed during the withdrawal period for another three weeks following child-centered play therapy.

The researcher read the students the consent form and had them write their names or check a box if they agreed to engage in play therapy with the researcher; all 12 students agreed to participate. The researcher conducted CCPT with the Kindergarten students every Monday and Wednesday and the Pre-Kinder 4 and Pre-Kinder 3 students every Tuesday and Thursday. If students were absent on their play therapy days, they were seen on Friday in order to ensure they received CCPT twice a week for the six weeks. At the start of the school day, the researcher went to the assigned class of the day to pick up a student for play therapy; after the 45-minute play session, the researcher would take the student back to class. The researcher would then clean the playroom and put everything in its place for the next student. The researcher sent CBCL forms home every week after the student received their two play therapy sessions.

Every Friday after school, the researcher prepared the C-TRF by filling out the student names and writing the week of treatment in the top right hand corner and gave them to the appropriate teachers to fill out according to the week that had just passed. Every Monday, the researcher collected the forms from the teachers. The researcher chose to provide the teachers with the forms on Friday in order to give them time to reflect on the entire week of each child. If the researcher passed out the forms earlier, the teachers could have filled them out early or when they were upset, causing the data to be a bad indicator of student behavior for the week. Most parents returned the forms no later than Friday. If forms were not received by Friday afternoon,

the researcher called the parents on Monday to remind them to send forms back in the students' folders. The teachers and the parents turned in all the forms for the 12 weeks of the study.

During the play sessions, the researcher strictly used child-centered play therapy. All toys selected for the playroom were from the Landreth 1982 list of playroom materials. Once the 12 weeks of the study were completed, the researcher began analyzing the data using the appropriate hand-scoring forms: the CBCL 1 ½-5 empirically-based scale for boys and girls, the C-TRF empirically-based scale for boys and girls, the CBCL 6-18 profile for boys syndrome scales, and the TRF profile for boys syndrome scales.

Chapter 4

Results

This study was designed to examine the effects of child-centered play therapy of 12 students with behavioral difficulties in early elementary. Using a single case study research design, changes in participant's problem behaviors were evaluated across a baseline of behavioral observations, a series of treatments, and post baseline (withdrawal) measures. In this chapter the findings of this study are presented, including both parent and teachers results. On the same visual graph a light gray line represents the score from the teacher rating and a black line represents the score from the parent rating in (a) Internalizing behavior, (b) externalizing behavior, and (c) total behavioral issues as measured on the CBCL.

The percent of non overlapping data (PND) is a recognized method used to measure the strength of effects of a single case study. The goal of PND is to examine the overlap of the data between phases (O'Neill et al., 2011). O'Neill et al. stated that "overlap refers to the extent to which data points from different phases fall within the same range of values, and is the result of changes (or lack thereof) in the basic characteristics of level, trend, and variability across phases" (p. 59). This overlap is the numerical overlap of data points between phases. The PND is "the percentage of data points in an intervention phase that are either higher or lower than the highest or lowest data points in a baseline phase." (O'Neill et al., 2011, p. 59). In this study, the PND was measured using the lowest baseline data point from the three baseline measures collected, which provided the most conservative estimate of progress. Lundervold and Belwood (2000) stated that the lower PND provided evidence of stronger functional effects of the intervention. A single subject, A-B-A design was used to examine changes in behaviors of students, or the lack thereof, across pre-intervention, intervention, and post-intervention phases. Overall, visual

analysis and descriptive statistics revealed that play therapy was a highly effective treatment for reducing negative behavior in most students. Sruggs and Mastropieri (1998) determined the effect size as follows: .90 and greater are indicative of very effective treatment; those ranging from .70 to .89 represent moderate effectiveness of treatment; those between .50 to .69 are debatably effective and score less than .50 are regarded as ineffective (not effective) treatment.

Student 1: Johnny

Johnny is a 5 years old, Hispanic male, Spanish speaking kindergarten student. Johnny's mother was the parent that was responsible for filling out the CBCL weekly and identified herself as Hispanic, Spanish speaking. Results are shown in Figures 1, 2 and 3, and Table 1.

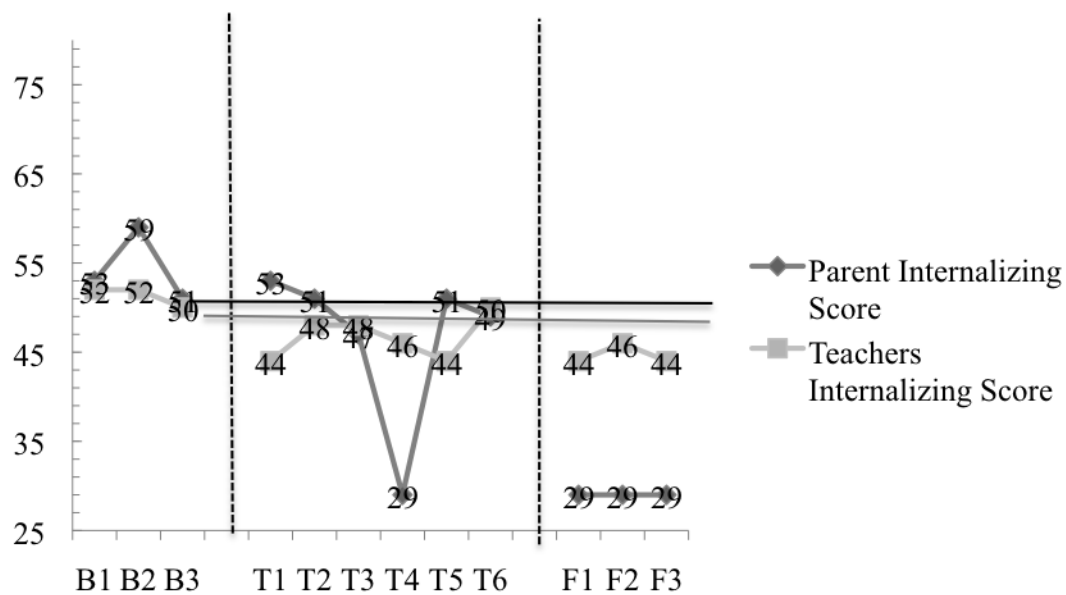


Figure 1. Student 1: Internalizing scores as rated by parent and teachers during the three phases of the study (3 weeks of baseline, the lowest baseline score was used, 6 weeks of treatment, and 3 weeks of withdraw phase).

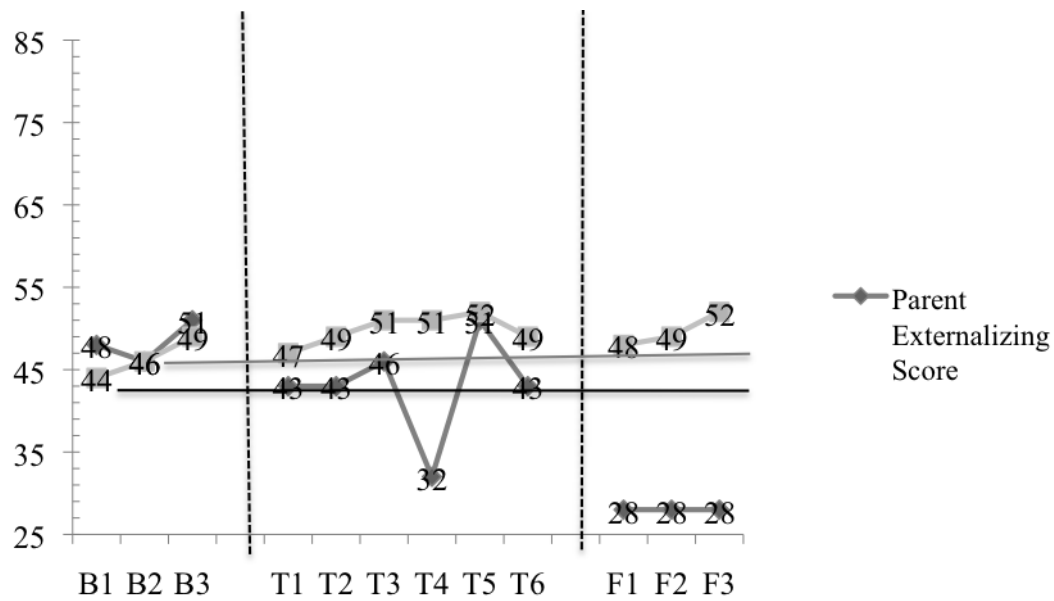


Figure 2. Student 1: Externalizing scores as rated by parent and teachers during the three phases of the study (3 weeks of baseline, the lowest baseline score was used, 6 weeks of treatment, and 3 weeks of withdraw phase).

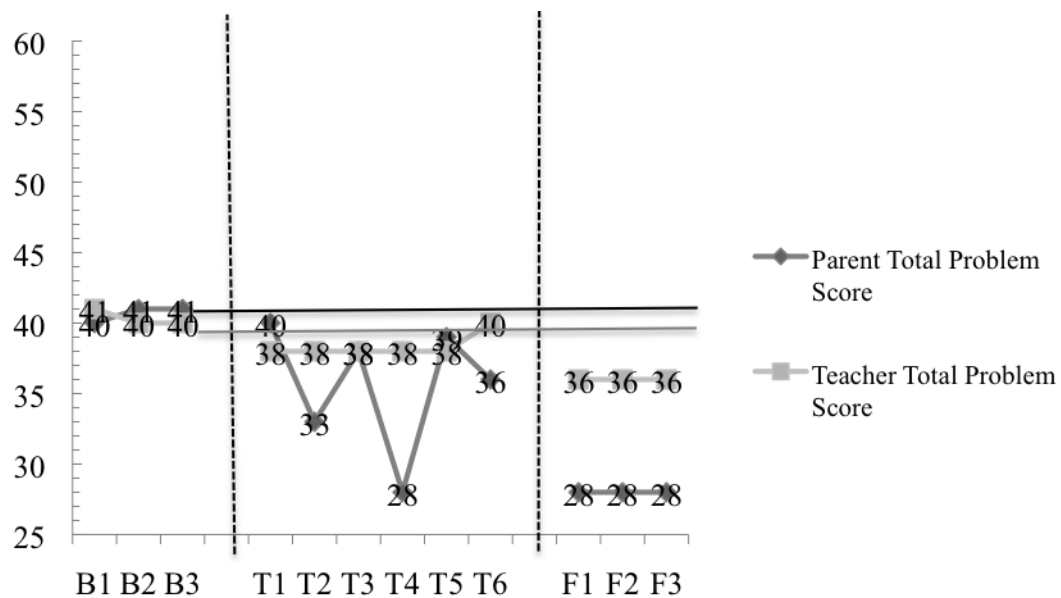


Figure 3. Student 1: Total problem score as rated by parent and teachers during the three phases of the study (3 weeks of baseline, the lowest baseline score was used, 6 weeks of treatment, and 3 weeks of withdraw phase).

Table 3.*Overlap of the Data between Phases (% Lower than the Lowest) – Student 1-Johnny*

		Intervention	Withdrawal	Combined
Internalizing	Parent	50.00	100.00	66.66
	Teacher	83.33	100.00	88.88
Externalizing	Parent	66.66	100.00	77.77
	Teacher	00.00	00.00	00.00
Total problem score	Parent	83.33	100.00	88.88
	Teacher	100.00	100.00	100.00

Note: Combined phases refer to both treatment and withdraw scores added together to equal the combined score.

Both Figures 1, 2 and 3, and Table 3, indicate that the parent ratings were lower for Internalizing and total problem score in the intervention and combined phase. Conversely, in the withdrawal phase the teacher ratings were very low when compared to the parent ratings.

Parent treatment effect sizes for PND was debatably effective for the internalizing score. Moderately effective for the externalizing score and moderately effective for the total problem score. According to the parent rating there was change in behavior for all three behaviors.

Teacher treatment effect size for PND was moderately effective for the internalizing scores; ineffective for the externalizing scores and very effective for the total problem score. According to the teachers rating there was change in internalizing behavior and a large improvement for total problem score, whereas externalizing behavior had no change reported.

Student 2: Allison

Allison is a 5 year old, Hispanic female, Spanish speaking kindergarten student. Allison's mother was the parent that was responsible for filling out the CBCL weekly and identified herself as Hispanic, Spanish speaking.

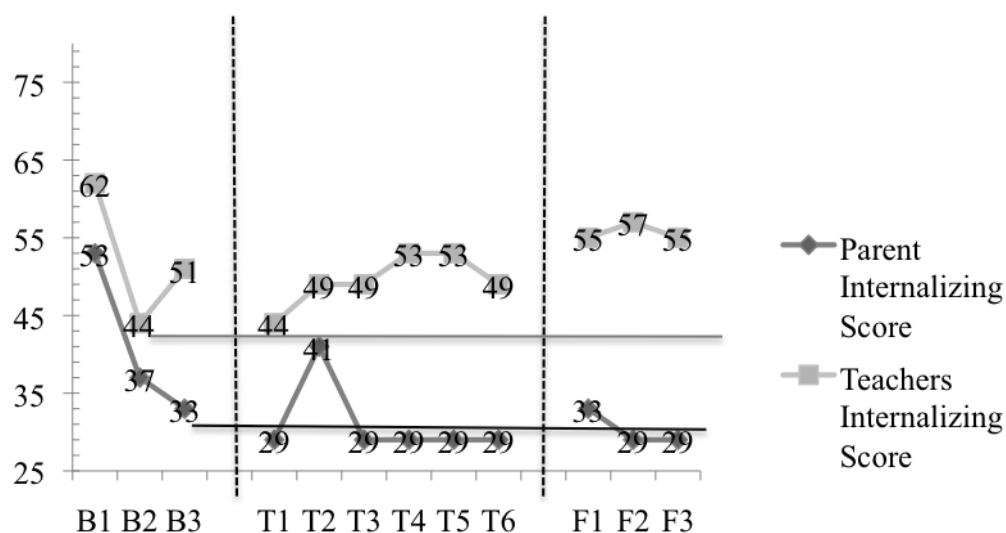


Figure 4. Student 2: Internalizing scores as rated by parent and teachers during the three phases of the study (3 weeks of baseline, the lowest baseline score was used, 6 weeks of treatment, and 3 weeks of withdraw phase).

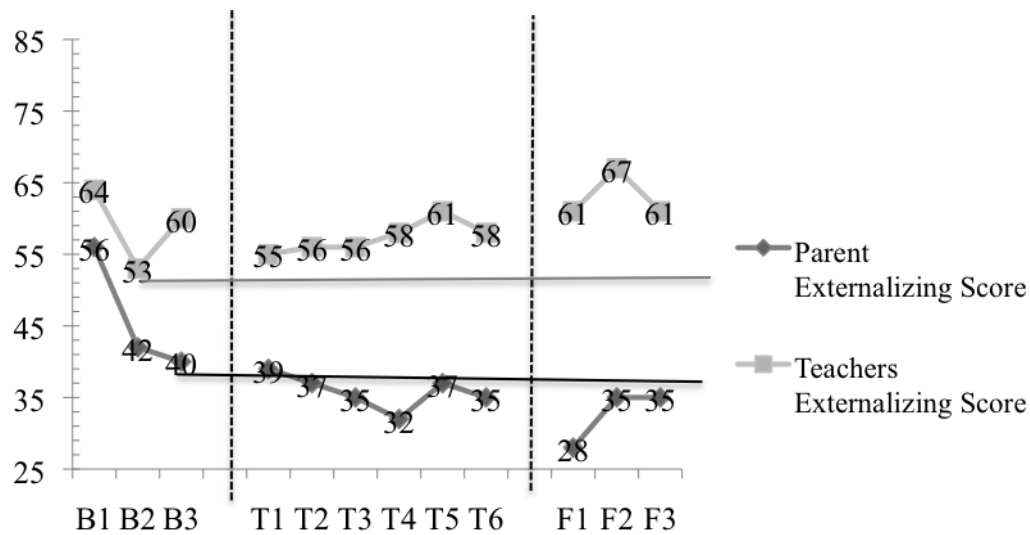


Figure 5. Student 2: Externalizing scores as rated by parent and teachers during the three phases of the study (3 weeks of baseline, the lowest baseline score was used, 6 weeks of treatment, and 3 weeks of withdraw phase).

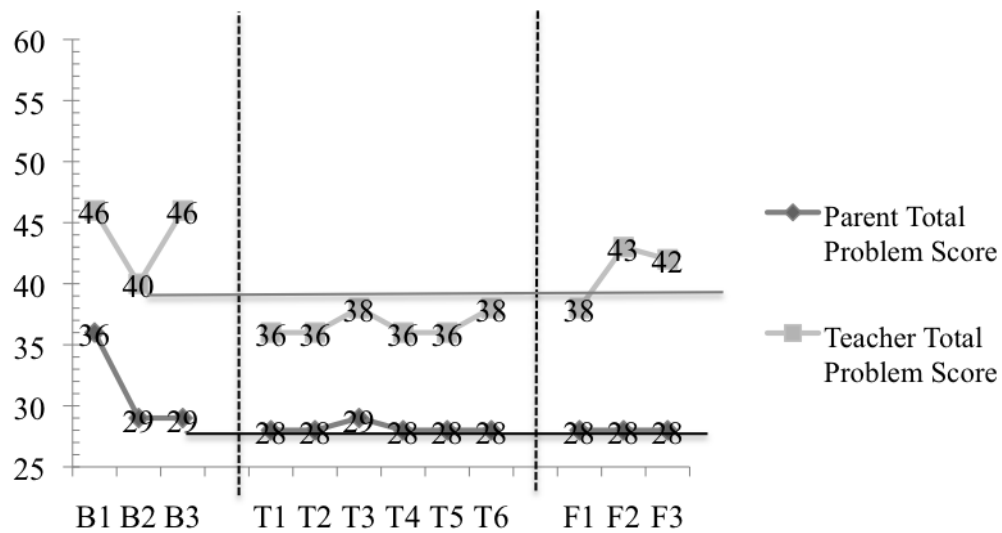


Figure 6. Student 2: Total problem score as rated by parent and teachers during the three phases of the study (3 weeks of baseline, the lowest baseline score was used, 6 weeks of treatment, and 3 weeks of withdraw phase).

Table 4.*Overlap of the Data between Phases (% Lower than the Lowest) – Student 2-Allison*

		Intervention	Withdrawal	Combined
Internalizing	Parent	83.30	66.66	77.77
	Teacher	00.00	00.00	00.00
Externalizing	Parent	100.00	100.00	100.00
	Teacher	00.00	00.00	00.00
Total problem score	Parent	83.30	100.00	88.88
	Teacher	100.00	100.00	100.00

Note: Combined phases refer to both treatment and withdraw scores added together to equal the combined score.

Both Figures 4, 5 and 6, and Table 4, indicates that the parents ratings were lower in all three Internalizing, externalizing, and total problem score when compared to the teachers rating scores.

Parent treatment effect sizes for PND was moderately effective for the internalizing score. Very effective for the externalizing score and moderately effective for the total problem score. According to the parent rating there was change in behavior for all three behaviors.

Teacher treatment effect size for PND was ineffective for the internalizing scores; ineffective for the externalizing scores and very effective for the total problem score. According to the teachers rating there was change in total problem behavior and no change reported for internalizing and externalizing scores.

Student 3: Ashley

Ashley is a 5 years old Hispanic/African American, English speaking female kindergarten student. Ashley's mother was the parent that was responsible for filling out the CBCL weekly and identified herself as Hispanic, English speaking.

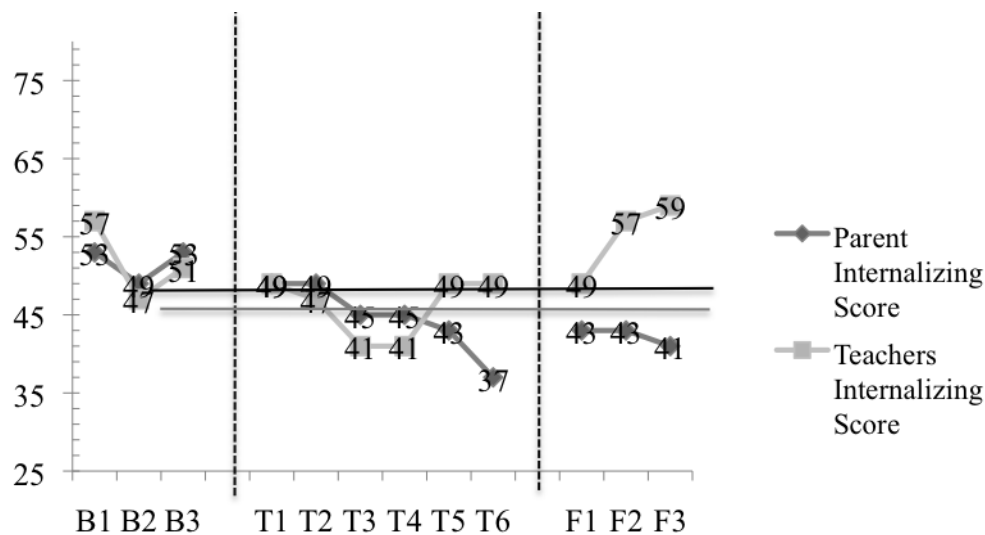


Figure 7. Student 3: Internalizing scores as rated by parent and teachers during the three phases of the study (3 weeks of baseline, the lowest baseline score was used, 6 weeks of treatment, and 3 weeks of withdraw phase).

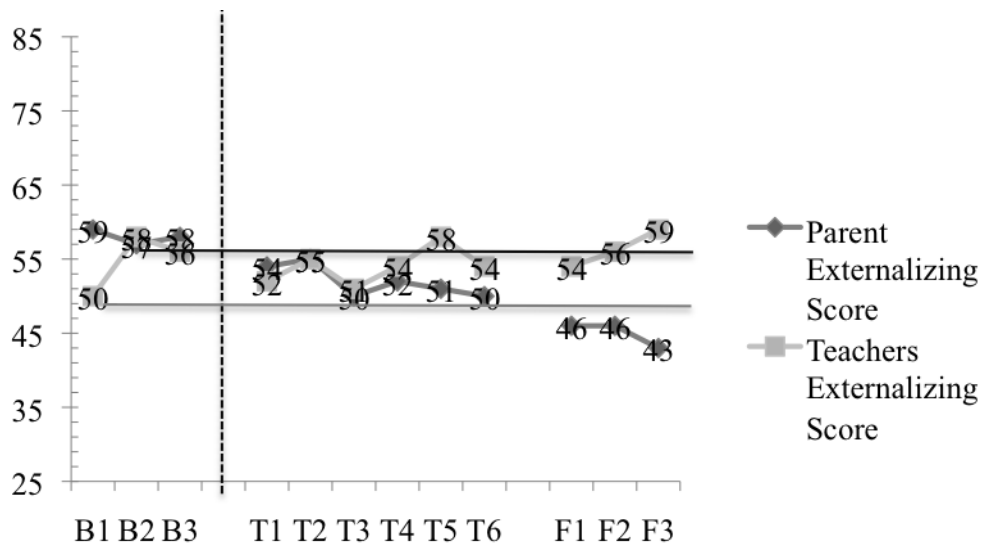


Figure 8. Student 3: Externalizing scores as rated by parent and teachers during the three phases of the study (3 weeks of baseline, the lowest baseline score was used, 6 weeks of treatment, and 3 weeks of withdraw phase).

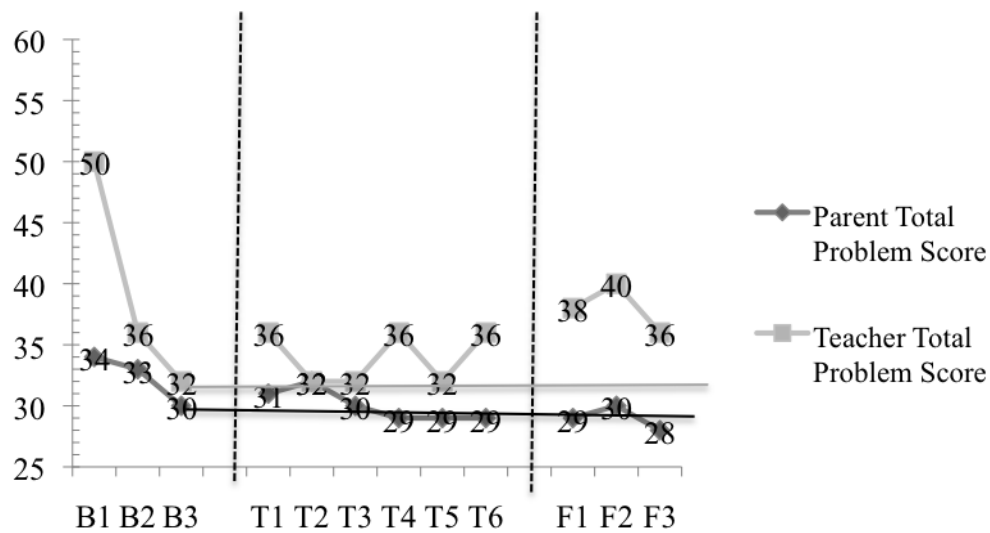


Figure 9. Student 3: Total problem score as rated by parent and teachers during the three phases of the study (3 weeks of baseline, the lowest baseline score was used, 6 weeks of treatment, and 3 weeks of withdraw phase).

Table 5.

Overlap of the Data between Phases (% Lower than the Lowest) – Student 3 Ashley

		Intervention	Withdrawal	Combined
Internalizing	Parent	66.66	100.00	77.77
	Teacher	33.33	00.00	22.22
Externalizing	Parent	100.00	100.00	100.00
	Teacher	00.00	00.00	00.00
Total problem score	Parent	50.00	66.66	55.55
	Teacher	00.00	00.00	00.00

Note: Combined phases refer to both treatment and withdraw scores added together to equal the combined score.

Both Figures 7, 8 and 9, and Table 5, indicate that the teacher ratings were extremely low for all three behaviors in all three phases, when compared to the parent ratings of the student.

Parent treatment effect sizes for PND was moderately effective for the internalizing score. Moderately effective for the externalizing score and very effective for the total problem score. According to the parent rating there was change in behavior for all three behaviors.

Teacher treatment effect size for PND was ineffective for the internalizing scores; ineffective for the externalizing scores and ineffective for the total problem score. According to the teachers rating there was no change reported.

Student 4: Anibal

Anibal is a 5 years old, Hispanic, Spanish speaking male kindergarten. Anibal's mother was the parent that was responsible for filling out the CBCL weekly and identified herself as Hispanic, Spanish speaking.

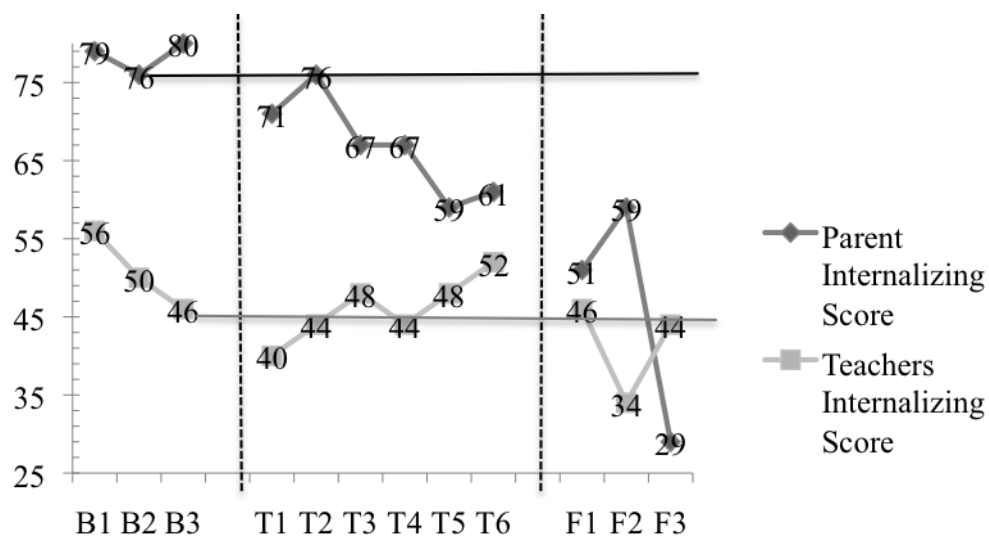


Figure 10. Student 4: Internalizing scores as rated by parent and teachers during the three phases of the study (3 weeks of baseline, the lowest baseline score was used, 6 weeks of treatment, and 3 weeks of withdraw phase).

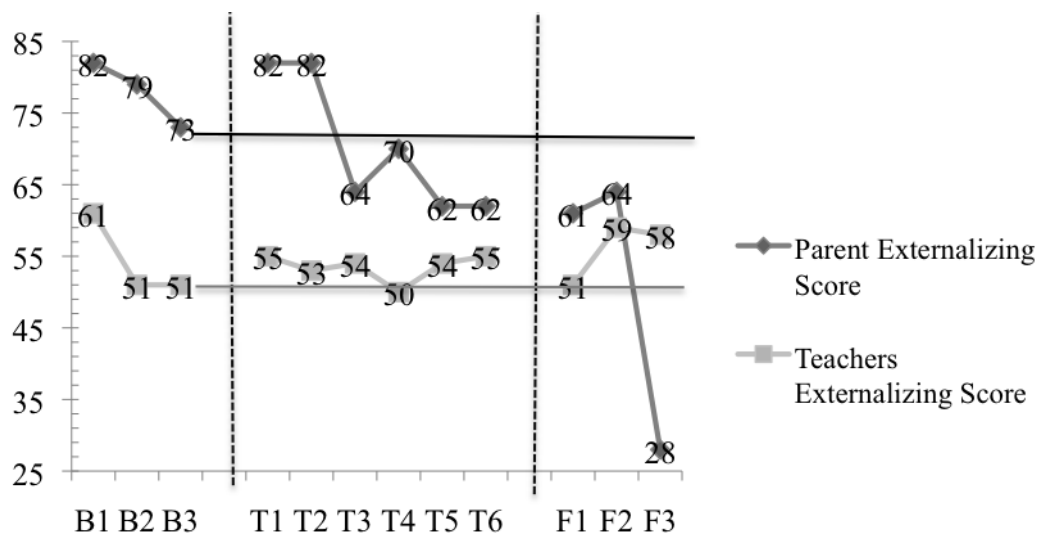


Figure 11. Student 4: Externalizing scores as rated by parent and teachers during the three phases of the study (3 weeks of baseline, the lowest baseline score was used, 6 weeks of treatment, and 3 weeks of withdraw phase).

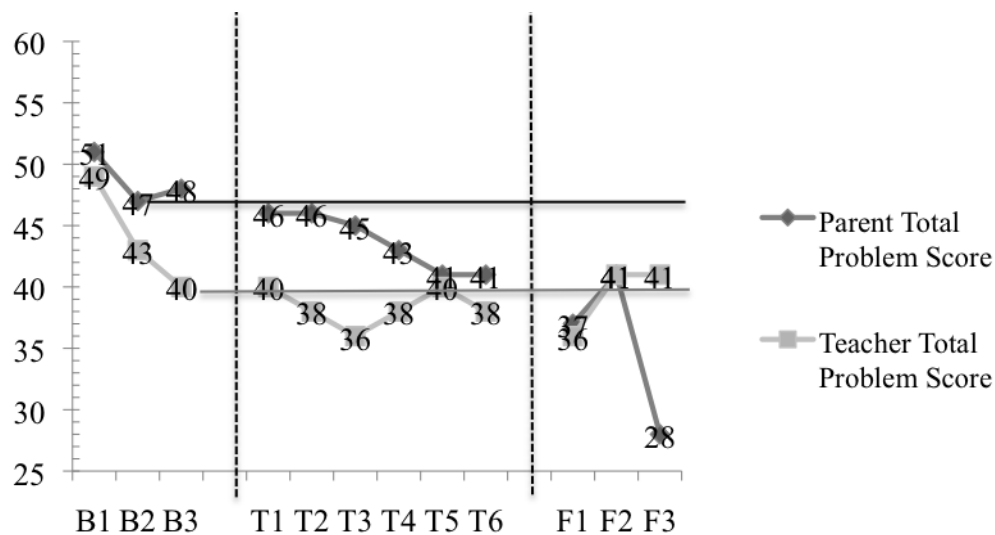


Figure12. Student 4: Total problem score as rated by parent and teachers during the three phases of the study (3 weeks of baseline, the lowest baseline score was used, 6 weeks of treatment, and 3 weeks of withdraw phase).

Table 6.

Overlap of the Data between Phases (% Lower than the Lowest) – Student 4 Anibal

		Intervention	Withdrawal	Combined
Internalizing	Parent	83.33	100.00	88.88
	Teacher	50.00	66.66	55.55
Externalizing	Parent	66.66	100.00	77.77
	Teacher	16.66	00.00	11.11
Total problem score	Parent	100.00	100.00	100.00
	Teacher	66.66	33.33	55.55

Note: Combined phases refer to both treatment and withdraw scores added together to equal the combined score.

Both Figures 10, 11 and 12, and Table 6, indicate that the teacher ratings were lower for all three behaviors in all three phases, when compared to the parent ratings. Anibal is the only student that scored in the clinical range of all three behavior when parents rated the behavior.

Parent treatment effect size for PND for internalizing score was moderately effective; the PND for externalizing score was moderately effective; the PND for total problem score was very effective. According to the parent rating there was change in behavior for all three behaviors.

Teacher's Internalizing scores were debatably effective; externalizing scores were ineffective; total problem score were debatably effective. According to the teachers rating there was change in behavior, except for externalizing behavior, which had no change reported.

Student 5: Alexis

Alexis is a 5 years old, White/ Africa American, English speaking, female in prekindergarten-4. Alexis's mother was the parent that was responsible for filling out the CBCL weekly and identified herself as White, English speaking.

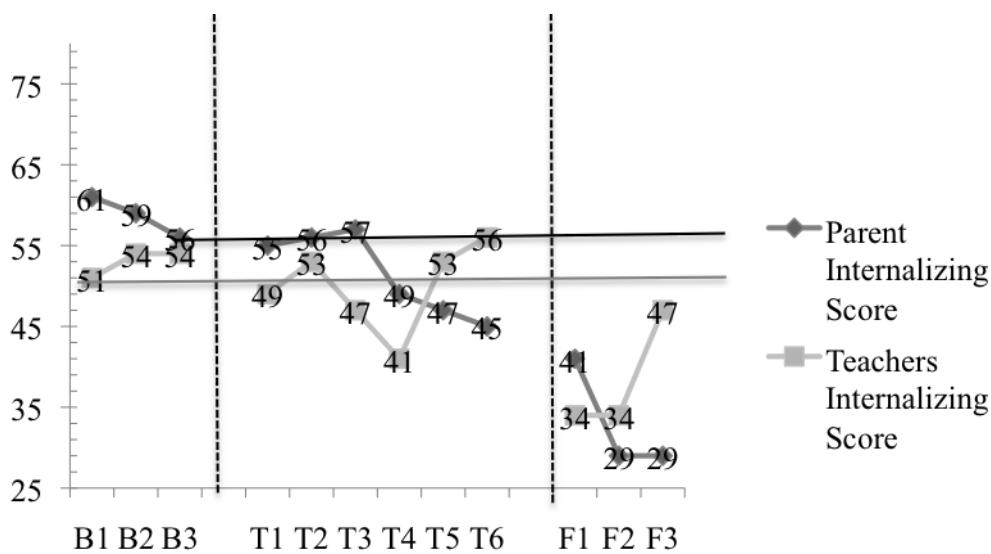


Figure 13. Student 5: Internalizing scores as rated by parent and teachers during the three phases of the study (3 weeks of baseline, the lowest baseline score was used, 6 weeks of treatment, and 3 weeks of withdraw phase).

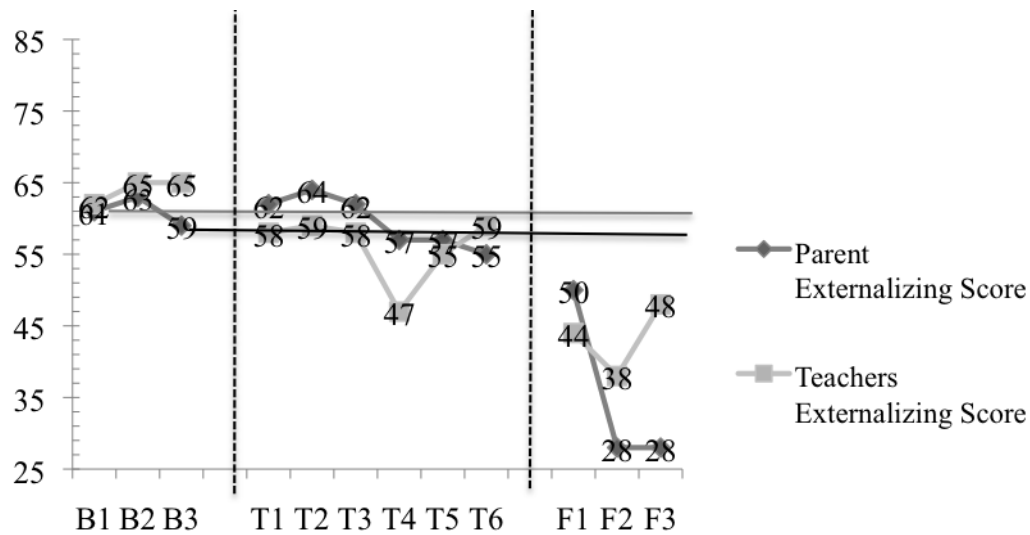


Figure 14. Student 5: Externalizing scores as rated by parent and teachers during the three phases of the study (3 weeks of baseline, the lowest baseline score was used, 6 weeks of treatment, and 3 weeks of withdraw phase).

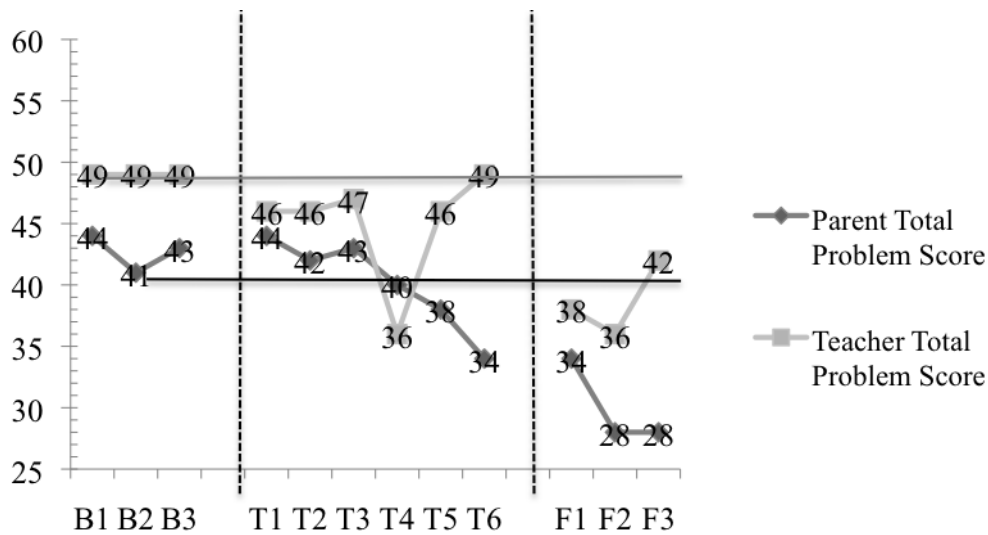


Figure 15. Student 5: Total problem score as rated by parent and teachers during the three phases of the study (3 weeks of baseline, the lowest baseline score was used, 6 weeks of treatment, and 3 weeks of withdraw phase).

Table 7.

Overlap of the Data between Phases (% Lower than the Lowest) – Student 5Alexis

		Intervention	Withdrawal	Combined
Internalizing	Parent	66.66	100.00	77.77
	Teacher	50.00	100.00	66.66
Externalizing	Parent	50.00	100.00	66.66
	Teacher	100.00	100.00	100.00
Total problem score	Parent	50.00	100.00	66.66
	Teacher	83.33	100.00	88.88

Note: Combined phases refer to both treatment and withdraw scores added together to equal the combined score.

Both Figures 13, 14 and 15, and Table 7, shows that the teacher ratings were slightly lower for the Internalizing behavior in the intervention and combined phase. Conversely, for the externalizing behavior and total problem score behavior the parent ratings were somewhat lower when compared to the teacher ratings.

Parent treatment effect sizes for PND was moderately effective for the internalizing score. Debatably effective for the externalizing score and debatably effective for the total

problem score. According to the parent rating there was some change in behavior for all three behaviors.

Teacher treatment effect size for PND was debatably effective for the internalizing scores; very effective for the externalizing scores and moderately effective for the total problem score. According to the teachers rating there was change in internalizing behavior and a large improvement for total problem score, according to the teachers rating there was change in all three behavior areas.

Student 6: Carmen

Carmen is a 5 years old, Hispanic, English speaking female, in prekindergarten-4. Carmen's mother was the parent that was responsible for filling out the CBCL weekly and identified herself as Hispanic, English speaking.

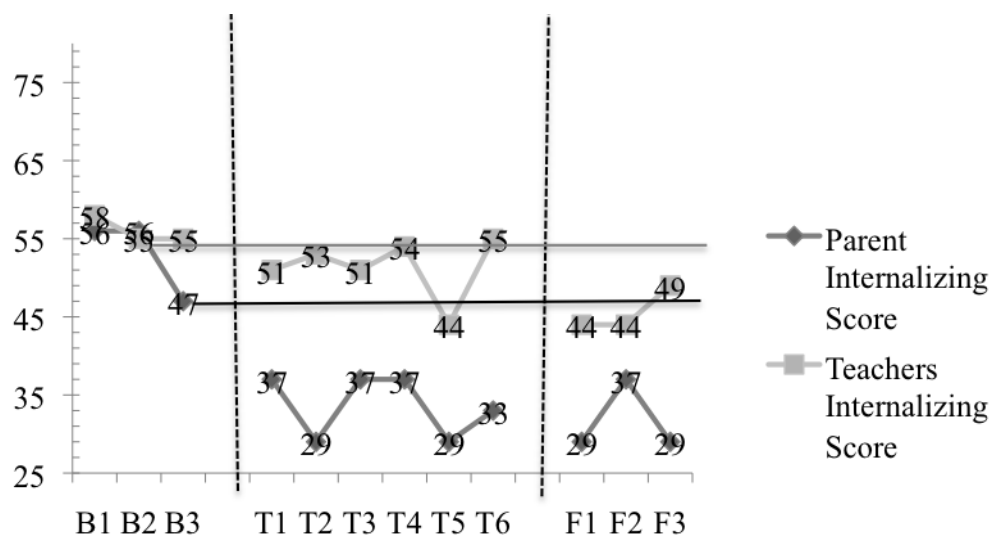


Figure 16. Student 6: Internalizing scores as rated by parent and teachers during the three phases of the study (3 weeks of baseline, the lowest baseline score was used, 6 weeks of treatment, and 3 weeks of withdraw phase).

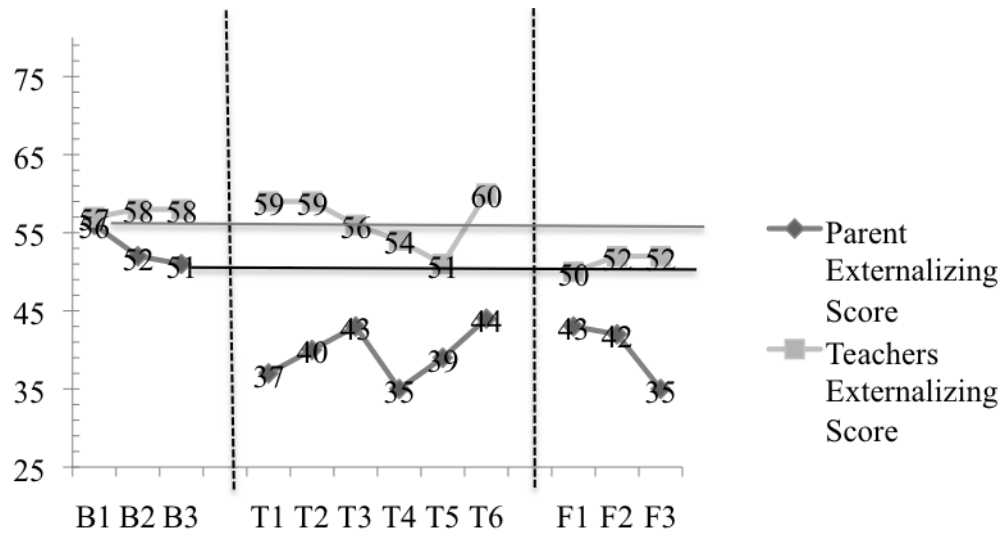


Figure 17. Student 6: Externalizing scores as rated by parent and teachers during the three phases of the study (3 weeks of baseline, the lowest baseline score was used, 6 weeks of treatment, and 3 weeks of withdraw phase).

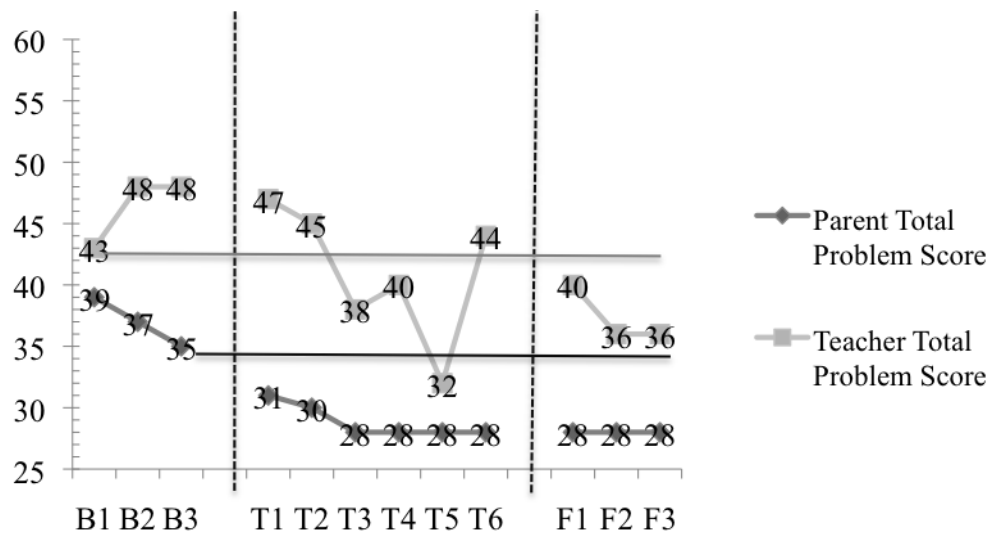


Figure 18. Student 6: Total problem score as rated by parent and teachers during the three phases of the study (3 weeks of baseline, the lowest baseline score was used, 6 weeks of treatment, and 3 weeks of withdraw phase).

Table 8.

Overlap of the Data between Phases (% Lower than the Lowest) – Student 6 Carmen

		Intervention	Withdrawal	Combined
Internalizing	Parent	100.00	100.00	100.00
	Teacher	83.33	100.00	88.88
Externalizing	Parent	100.00	100.00	100.00
	Teacher	50.00	100.00	66.66
Total problem score	Parent	100.00	100.00	100.00
	Teacher	50.00	100.00	66.66

Note: Combined phases refer to both treatment and withdraw scores added together to equal the combined score.

Both Figures 16, 17 and 18, and Table 8, shows that the teacher ratings were slightly lower for all three behaviors in the intervention and combined phase. Conversely, for the withdrawal phase both teacher and parent ratings were extremely high (100%) for all three behaviors.

Parent treatment effect sizes for PND was very effective for the internalizing score. Very effective for the externalizing score and very effective for the total problem score. According to the parent rating there was major change in behavior for all three behaviors.

Teacher treatment effect size for PND was moderately effective for the internalizing scores; debatably for the externalizing scores and debatably effective for the total problem score. According to the teachers rating there was change in all three areas in behavior. According to the teachers rating there was change in behavior in all three areas.

Student 7: Zoe

Zoe is a 4 years old, Whit, English speaking female, in prekindergarten-4 . Zoe's mother other was the parent that was responsible for filling out the CBCL weekly and identified herself as White, English speaking.

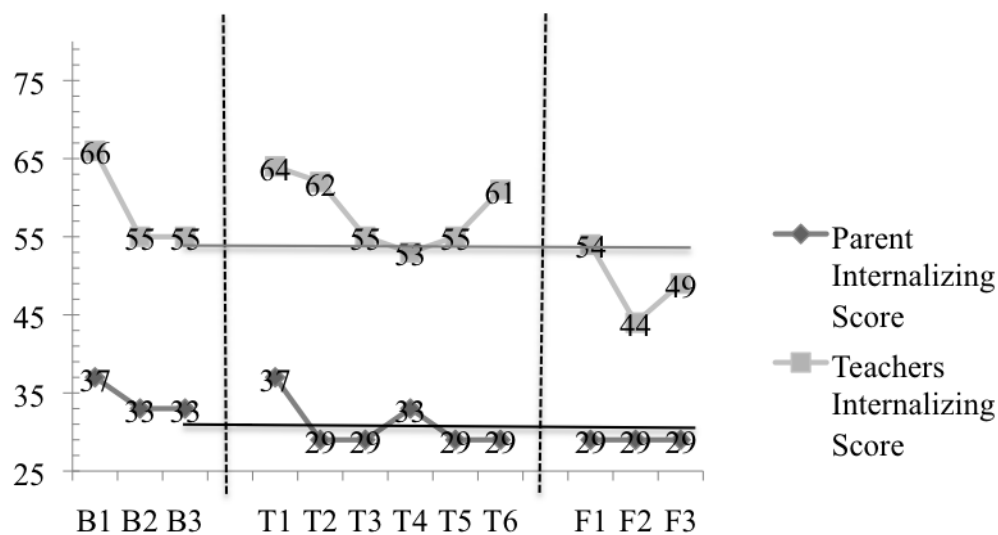


Figure 19. Student 7: Internalizing scores as rated by parent and teachers during the three phases of the study (3 weeks of baseline, the lowest baseline score was used, 6 weeks of treatment, and 3 weeks of withdraw phase).

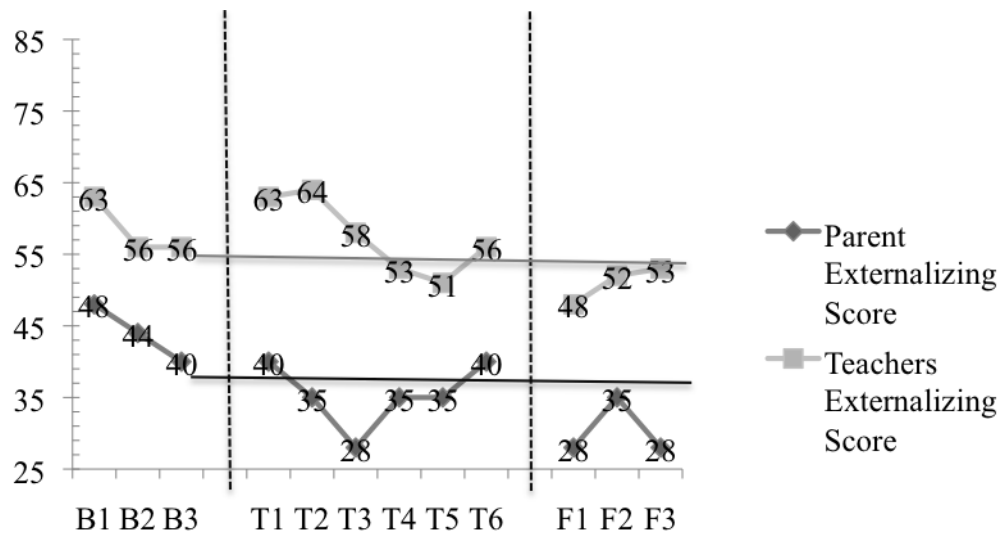


Figure 20. Student 7: Externalizing scores as rated by parent and teachers during the three phases of the study (3 weeks of baseline, the lowest baseline score was used, 6 weeks of treatment, and 3 weeks of withdraw phase).

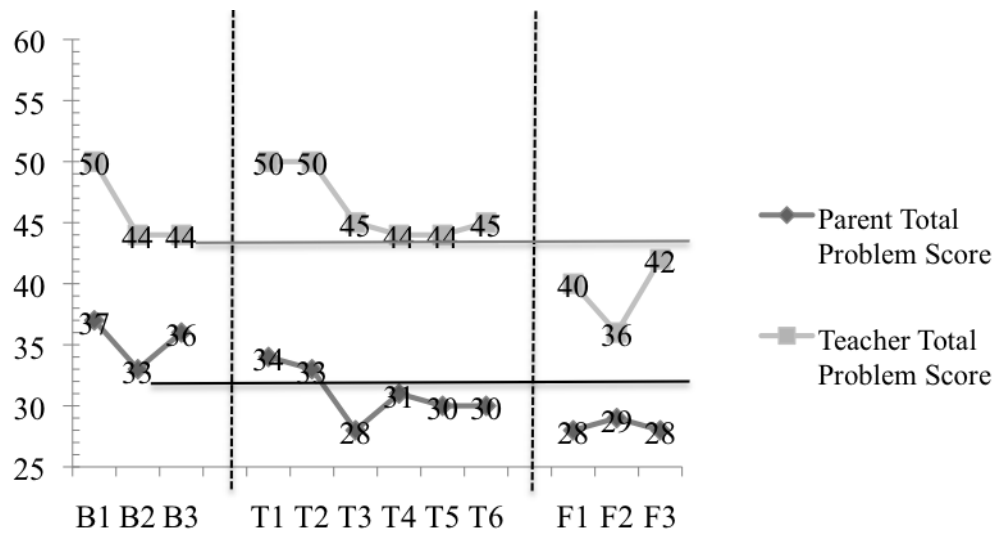


Figure 21. Student 7: Total number scores as rated by parent and teachers during the three phases of the study (3 weeks of baseline, the lowest baseline score was used, 6 weeks of treatment, and 3 weeks of withdraw phase).

Table 9.

Overlap of the Data between Phases (% Lower than the Lowest) – Student 7 Zoe

		Intervention	Withdrawal	Combined
Internalizing	Parent	83.33	100.00	88.88
	Teacher	16.66	100.00	44.44
Externalizing	Parent	66.66	100.00	77.77
	Teacher	33.33	100.00	55.55
Total problem score	Parent	66.66	100.00	77.77
	Teacher	00.00	100.00	33.33

Note: Combined phases refer to both treatment and withdraw scores added together to equal the combined score.

Both Figures 19, 20 and 21, and Table 9, shows that the teacher ratings were lower for all three behaviors in the intervention and combined phase. Conversely, for the withdrawal phase both teacher and parent ratings were extremely high (100%) for all three behaviors.

Parent treatment effect sizes for PND was moderately effective for the internalizing score. Moderately effective for the externalizing score and moderately effective for the total problem score. According to the parent rating there was change in behavior for all three behaviors.

Teacher treatment effect size for PND was ineffective effective for the internalizing scores; debatably for the externalizing scores and ineffective for the total problem score. According to the teachers rating there was slight change in externalizing behavior, whereas internalizing and total problem score had no change reported.

Student 8: Iris

Iris is a 3 years old, Hispanic, Spanish speaking female, in prekindergarten-3. Iris's mother was the parent that was responsible for filling out the CBCL weekly and identified herself as Hispanic, Spanish speaking.

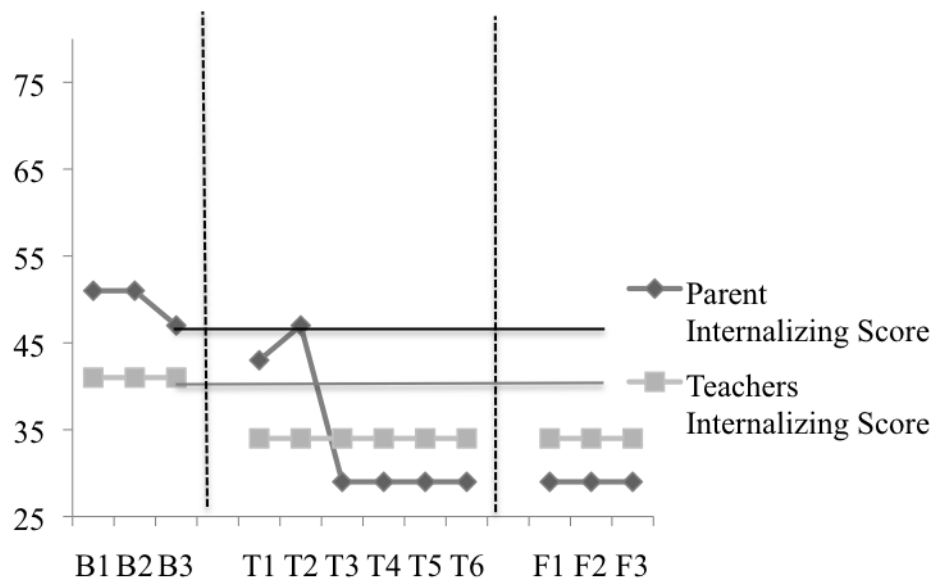


Figure 22. Student 8: Internalizing scores as rated by parent and teachers during the three phases of the study (3 weeks of baseline, the lowest baseline score was used, 6 weeks of treatment, and 3 weeks of withdraw phase).

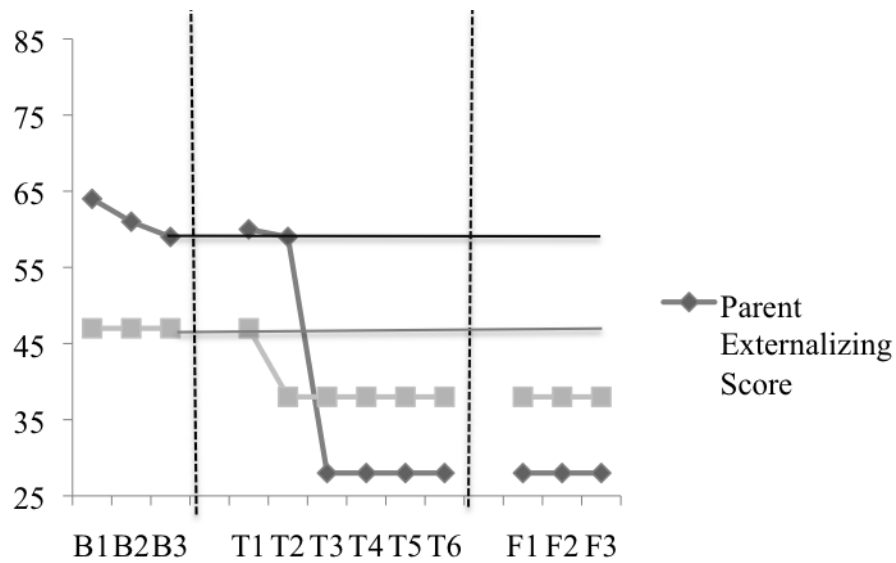


Figure 23. Student 8: Externalizing scores as rated by parent and teachers during the three phases of the study (3 weeks of baseline, the lowest baseline score was used, 6 weeks of treatment, and 3 weeks of withdraw phase).

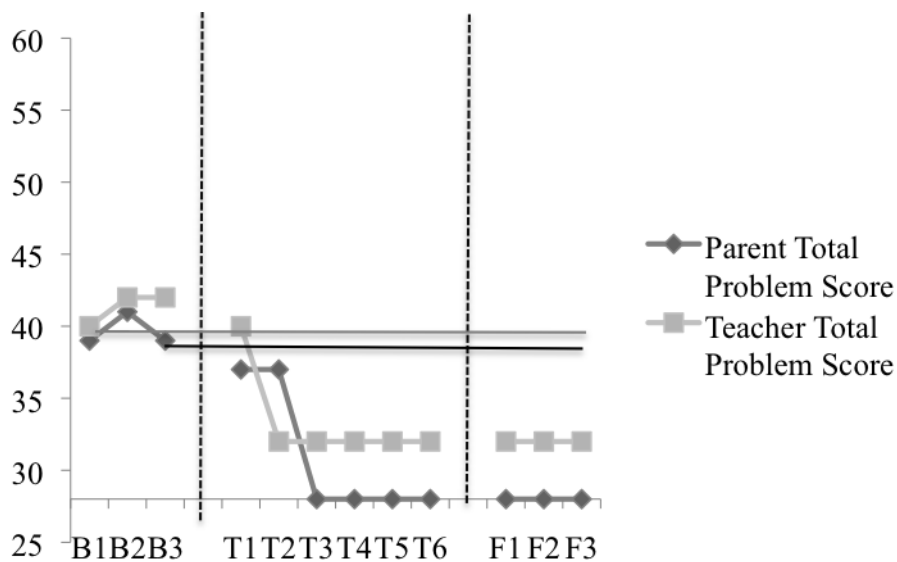


Figure 24. Student 8: Total number scores as rated by parent and teachers during the three phases of the study (3 weeks of baseline, the lowest baseline score was used, 6 weeks of treatment, and 3 weeks of withdraw phase).

Table 10.

Overlap of the Data between Phases (% Lower than the Lowest) – Student 8 Iris

		Intervention	Withdrawal	Combined
Internalizing	Parent	83.33	100.00	88.88
	Teacher	100.00	100.00	100.00
Externalizing	Parent	66.66	100.00	77.77
	Teacher	100.00	100.00	100.00
Total problem score	Parent	100.00	100.00	100.00
	Teacher	100.00	100.00	100.00

Note: Combined phases refer to both treatment and withdraw scores added together to equal the combined score.

Both Figures 22, 23 and 24, and Table 10, indicate that the teachers ratings were lowered in two areas of Internalizing, externalizing behaviors. In the rating for total problem score parents ratings scores were much lower then the teachers rating.

Parent treatment effect sizes for PND was moderately effective for the internalizing score. Moderately effective for the externalizing score and moderately effective for the total problem score. According to the parent rating there was change in behavior for all three behaviors.

Teacher treatment effect size for PND was ineffective for the internalizing scores; debatably effective for the externalizing scores and ineffective for the total problem score. According to the teachers rating there was no change in behavior for internalizing and total problem score, whereas externalizing behavior was somewhat improved.

Student 9: Franklin

Franklin is a 5 years old, Hispanic, Spanish speaking male, in prekindergarten-4. Franklin's mother was the parent that was responsible for filling out the CBCL weekly and identified herself as Hispanic, Spanish speaking.

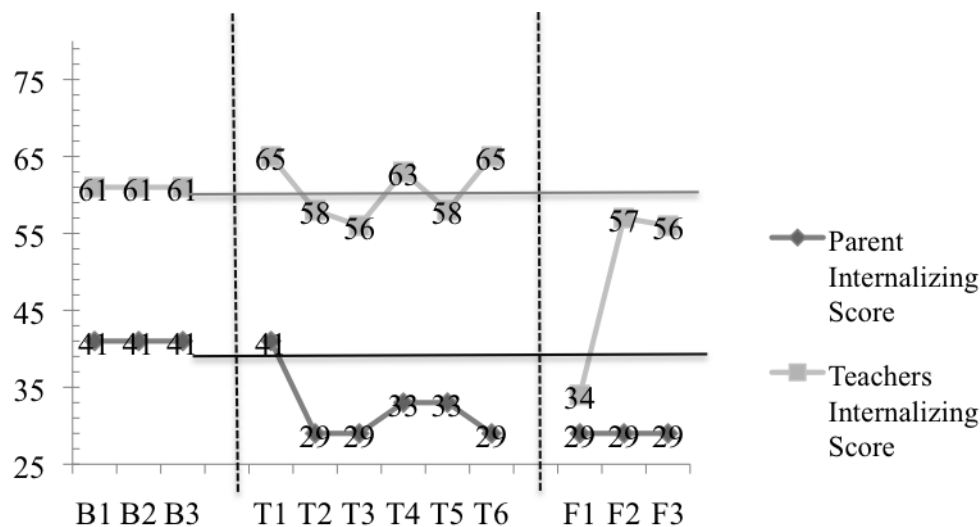


Figure 25. Student 9: Internalizing scores as rated by parent and teachers during the three phases of the study (3 weeks of baseline, the lowest baseline score was used, 6 weeks of treatment, and 3 weeks of withdraw phase).

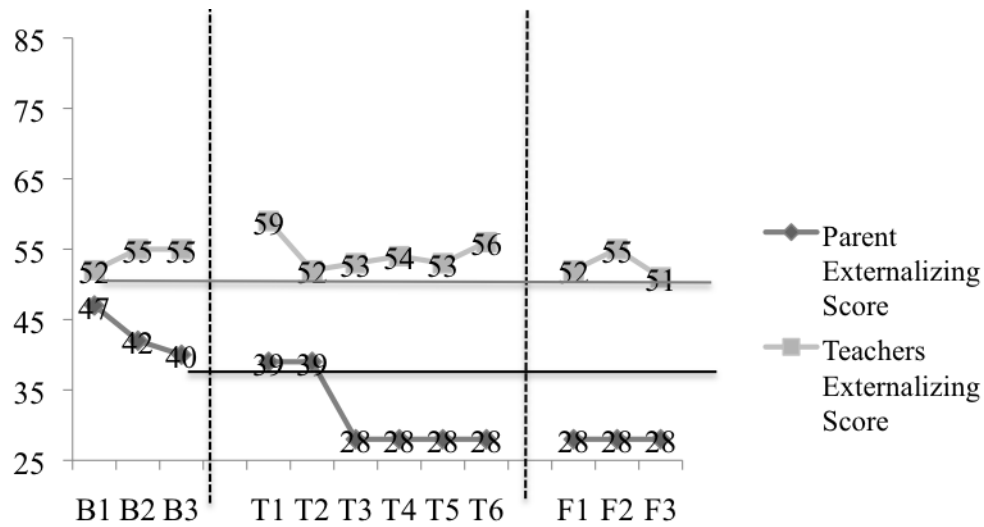


Figure 26. Student 9: Externalizing scores as rated by parent and teachers during the three phases of the study (3 weeks of baseline, the lowest baseline score was used, 6 weeks of treatment, and 3 weeks of withdraw phase).

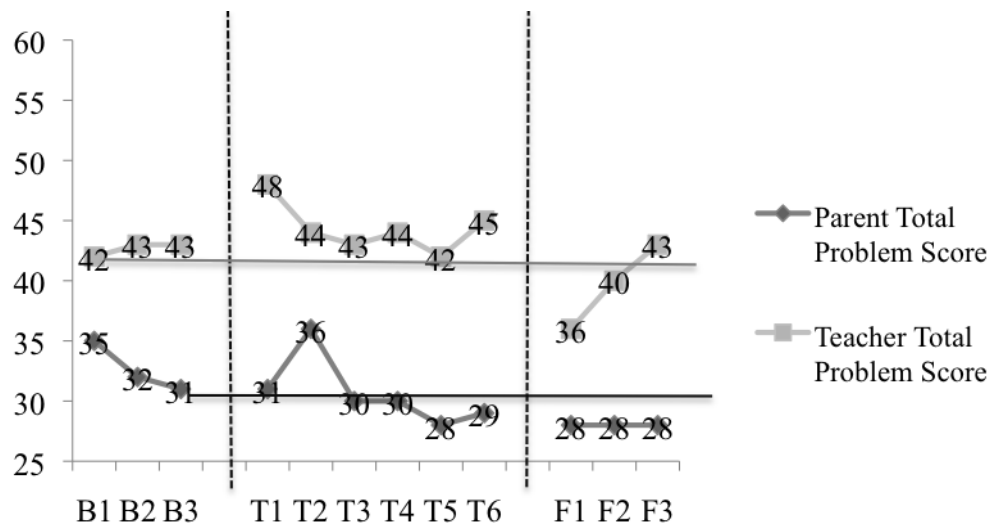


Figure 27. Student 9: Total problem score as rated by parent and teachers during the three phases of the study (3 weeks of baseline, the lowest baseline score was used, 6 weeks of treatment, and 3 weeks of withdraw phase).

Table 11.

Overlap of the Data between Phases (% Lower than the Lowest) – Student 9 Franklin

		Intervention	Withdrawal	Combined
Internalizing	Parent	83.33	100.00	88.88
	Teacher	50.00	100.00	55.55
Externalizing	Parent	100.00	100.00	100.00
	Teacher	00.00	66.66	22.22
Total problem score	Parent	66.66	100.00	77.77
	Teacher	16.66	100.00	44.44

Note: Combined phases refer to both treatment and withdraw scores added together to equal the combined score.

Both Figures 25, 26 and 27, and Table 11, indicate that the teacher ratings were lower for in all three areas of Internalizing, externalizing, total problem score, in the intervention and combined phase.

Parent treatment effect sizes for PND was moderately effective for the internalizing score. Very effective for the externalizing score and moderately effective for the total problem score. According to the parent rating there was change in behavior for all three behaviors.

Teacher treatment effect size for PND was debatably effective for the internalizing scores; ineffective for the externalizing scores and ineffective for the total problem score. According to the teachers rating there was no change in externalizing behavior and total problem score, whereas internalizing behavior was somewhat improved.

Student 10: Julian

Julian is a 5 years old, Hispanic, Spanish speaking male, in prekindergarten-4. Julian's mother was the parent that was responsible for filling out the CBCL weekly and identified herself as Hispanic, Spanish speaking.

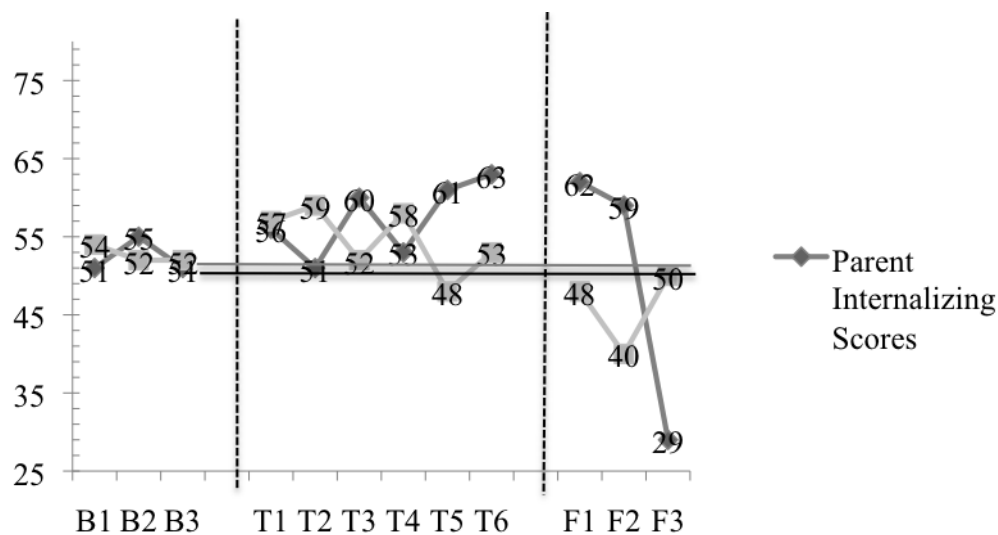


Figure 28. Student 10: Internalizing scores as rated by parent and teachers during the three phases of the study (3 weeks of baseline, the lowest baseline score was used, 6 weeks of treatment, and 3 weeks of withdraw phase).

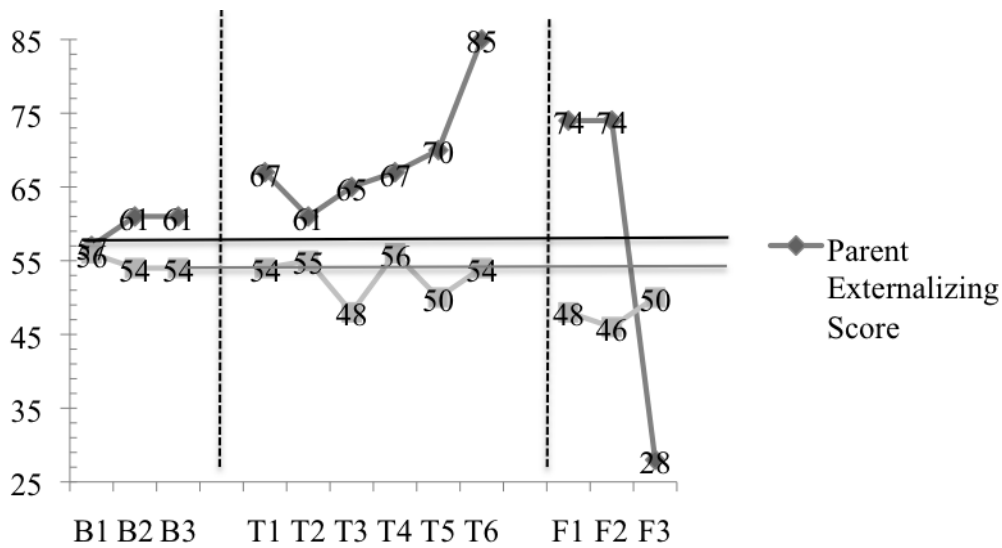


Figure 29. Student 10: Externalizing scores as rated by parent and teachers during the three phases of the study (3 weeks of baseline, the lowest baseline score was used, 6 weeks of treatment, and 3 weeks of withdraw phase).

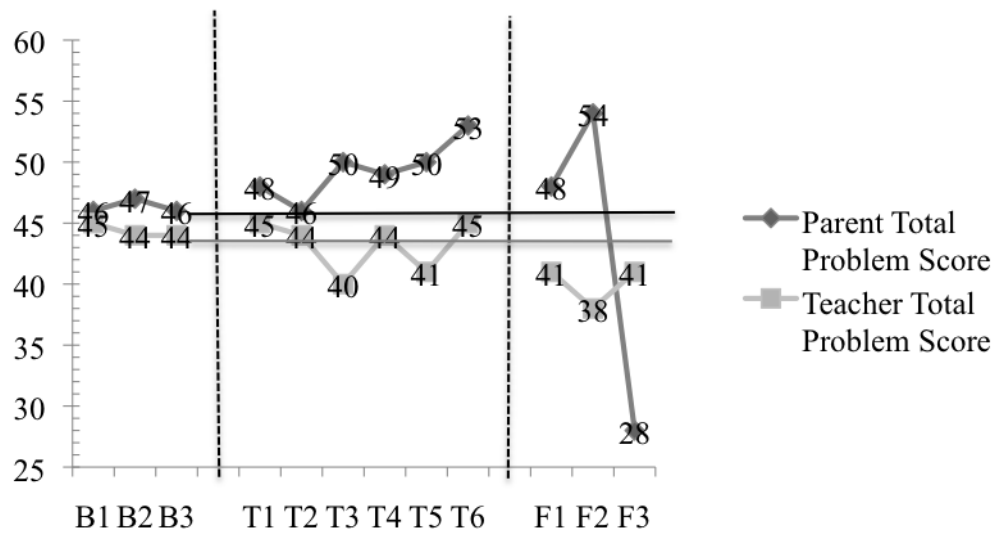


Figure 30. Student 10: Total number scores as rated by parent and teachers during the three phases of the study (3 weeks of baseline, the lowest baseline score was used, 6 weeks of treatment, and 3 weeks of withdraw phase).

Table 12.

Overlap of the Data between Phases (% Lower than the Lowest) – Student 10 Julian

		Intervention	Withdrawal	Combined
Internalizing	Parent	00.00	33.33	11.11
	Teacher	16.66	100.00	44.44
Externalizing	Parent	00.00	33.33	11.11
	Teacher	33.33	100.00	55.55
Total problem score	Parent	00.00	33.33	11.11
	Teacher	33.33	100.00	55.55

Note: Combined phases refer to both treatment and withdraw scores added together to equal the combined score.

Both Figures 28, 29 and 30, and Table 12, indicate that the parent ratings were much lower for all three areas (Internalizing, externalizing, and total problem score) in all three phases (intervention, withdrawal, and combined phase.

Parent treatment effect sizes for PND was ineffective for the internalizing score. Ineffective for the externalizing score and ineffective for the total problem score. According to the parent rating there was no change in behavior for all three behaviors.

Teacher treatment effect size for PND was ineffective for the internalizing scores; debatably effective for the externalizing scores and debatably effective for the total problem score. According to the teachers rating there was no change in internalizing behavior, whereas externalizing and total problem behavior scores was somewhat improved.

Student 11: Freddie

Freddie is a 5 years old, Hispanic, Spanish speaking male in kindergarten. Mother was the parent that was responsible for filling out the CBCL weekly and identified herself as Hispanic, Spanish speaking.

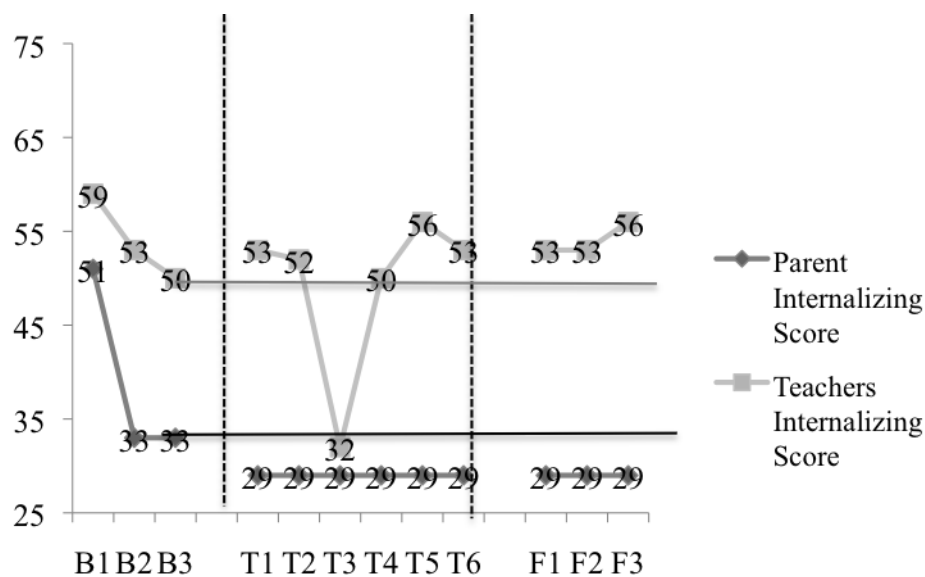


Figure 31. Student 11: Internalizing scores as rated by parent and teachers during the three phases of the study (3 weeks of baseline, the lowest baseline score was used, 6 weeks of treatment, and 3 weeks of withdraw phase).

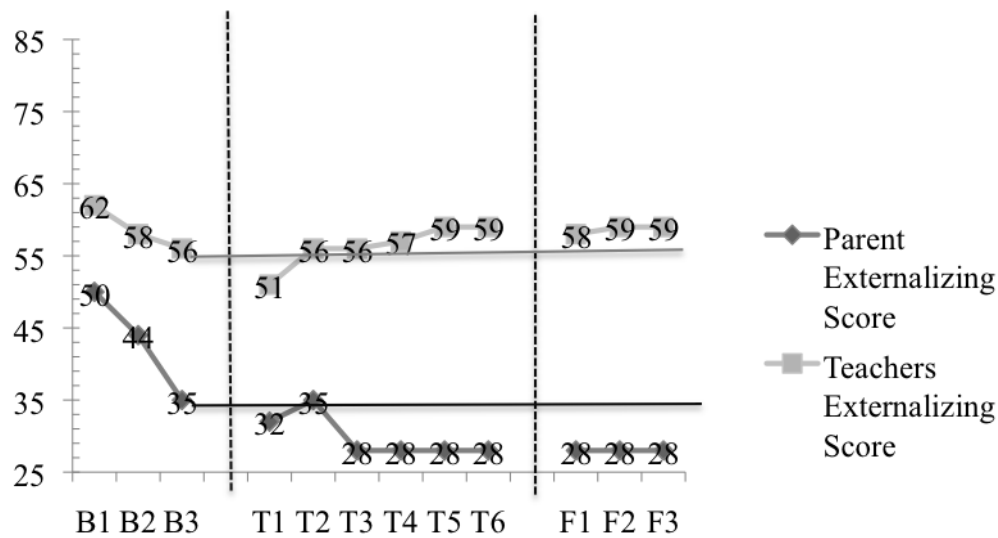


Figure 32. Student 11: Externalizing scores as rated by parent and teachers during the three phases of the study (3 weeks of baseline, the lowest baseline score was used, 6 weeks of treatment, and 3 weeks of withdraw phase).

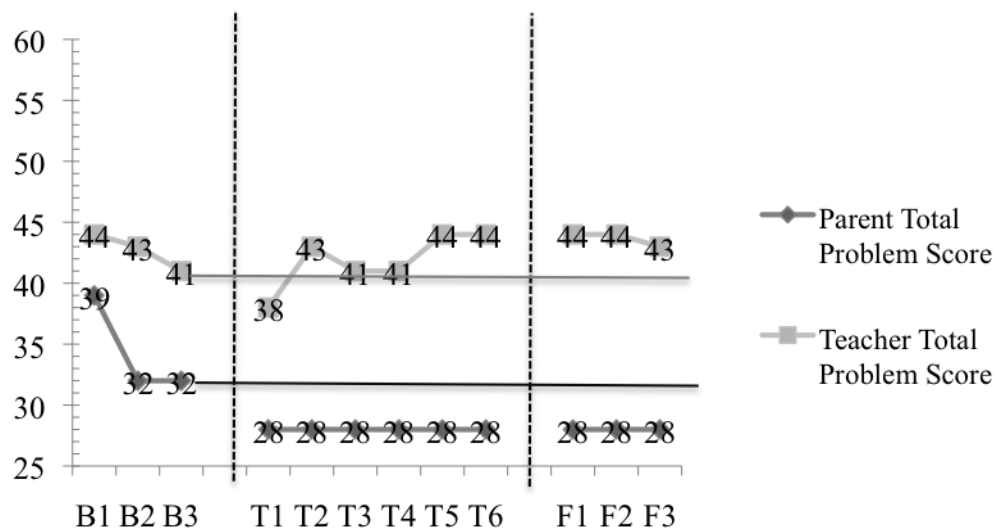


Figure 33. Student 11: Total problem score as rated by parent and teachers during the three phases of the study (3 weeks of baseline, the lowest baseline score was used, 6 weeks of treatment, and 3 weeks of withdraw phase).

Table 13.

Overlap of the Data between Phases (% Lower than the Lowest) – Student 11 Freddie

		Intervention	Withdrawal	Combined
Internalizing	Parent	100.00	100.00	100.00
	Teacher	16.66	00.00	11.11
Externalizing	Parent	83.33	100.00	88.88
	Teacher	16.66	00.00	11.11
Total problem score	Parent	100.00	100.00	100.00
	Teacher	16.66	00.00	11.11

Note: Combined phases refer to both treatment and withdraw scores added together to equal the combined score.

Both Figures 31, 32 and 33, and Table 13, indicate that the teacher ratings were lower for internalizing, externalizing, and total problem score areas in the intervention and combined phase. Conversely, in the withdrawal phase the teacher ratings were lower when compared to the parent ratings in only the externalizing and total problem score.

Parent treatment effect sizes for PND was very effective for the internalizing score. Moderately effective for the externalizing score and very effective for the total problem score.

According to the parent rating there was change in behavior for all three behaviors, with internalizing and total problem behavior score reporting the most change.

Teacher treatment effect size for PND was ineffective for the internalizing scores; ineffective for the externalizing scores and ineffective for the total problem score. According to the teachers rating there was no change in all three behaviors areas.

Student 12: Sebastian

Sebastian is a 6 years old, Hispanic, English speaking male in kindergarten. Sebastian's grandmother was the guardian that was responsible for filling out the CBCL for 6-18 years of age, weekly and identified herself as Hispanic, English speaking.

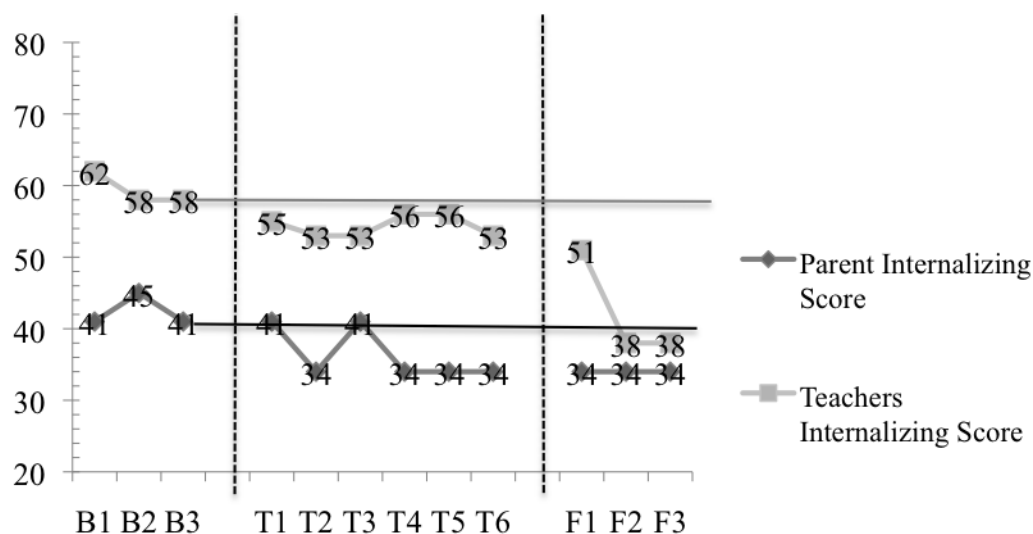


Figure 34. Student 12: Internalizing scores as rated by parent and teachers during the three phases of the study (3 weeks of baseline, the lowest baseline score was used, 6 weeks of treatment, and 3 weeks of withdraw phase).

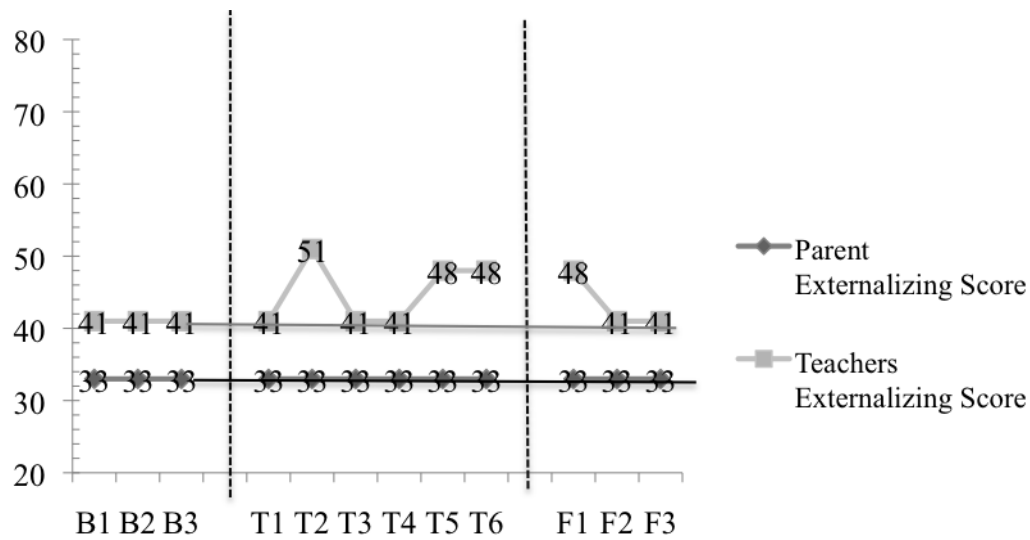


Figure 35. Student 12: Externalizing scores as rated by parent and teachers during the three phases of the study (3 weeks of baseline, the lowest baseline score was used, 6 weeks of treatment, and 3 weeks of withdraw phase).

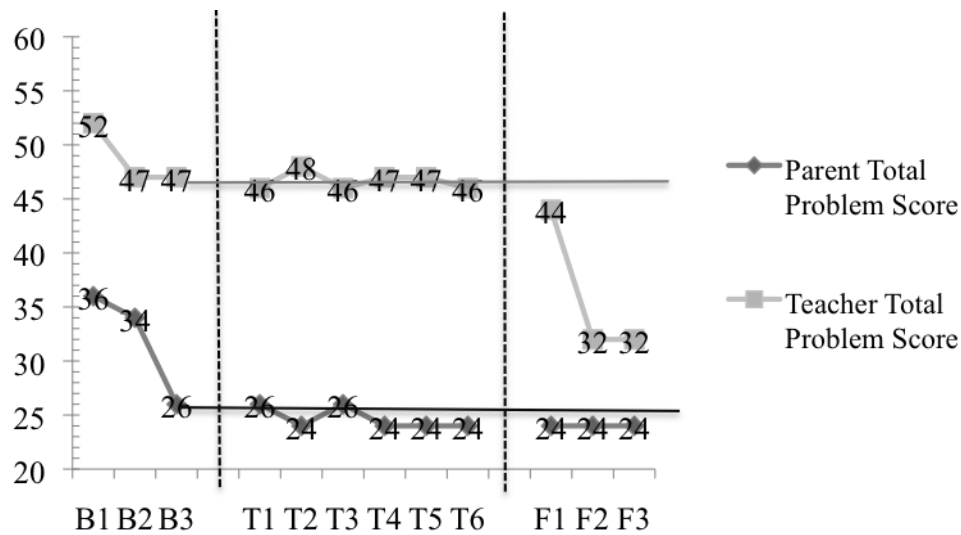


Figure 36. Student 12: Total problem score as rated by parent and teachers during the three phases of the study (3 weeks of baseline, the lowest baseline score was used, 6 weeks of treatment, and 3 weeks of withdraw phase).

Table 14.

Overlap of the Data between Phases (% Lower than the Lowest) – Student 12 Sebastian

		Intervention	Withdrawal	Combined
Internalizing	Parent	66.66	100.00	77.77
	Teacher	100.00	100.00	100.00
Externalizing	Parent	66.66	100.00	77.77
	Teacher	00.00	00.00	00.00
Total problem score	Parent	100.00	100.00	100.00
	Teacher	66.66	100.00	77.77

Note: Combined phases refer to both treatment and withdraw scores added together to equal the combined score.

Both Figures 34, 35 and 36, and Table 14, indicate that the parent ratings were lower for Internalizing behaviors area in the intervention and combined phase. Conversely, in the externalizing and total problem score areas the teacher ratings were lower when compared to the parent ratings. Ratings in the withdrawal phase were mostly 100%.

Parent treatment effect sizes for PND was moderately effective for the internalizing score. Moderately effective for the externalizing score and very effective for the total problem score. According to the parent rating there was change in behavior for all three behaviors.

Teacher treatment effect size for PND was very effective for the internalizing scores; ineffective for the externalizing scores and moderately effective for the total problem score. According to the teachers rating there was no change in externalizing behavior, whereas internalizing behavior score reported the most about of change and total problem score showed some change.

Table 15. Summary of PND Results

	Internal		External		Total		Total %	
	Parent	Teacher	Parent	Teacher	Parent	Teacher	Parent	Teacher
Ineffective	1	6	2	7	1	5	11.10%	50.00%
Debatably								
Effective	1	3	0	4	1	3	5.50%	27.70%
Moderately								
Effective	8	2	7	0	5	2	55.50%	11.10%
Very								
Effective	2	1	3	1	5	2	27.80%	11.10%

Table 16. Mean T-Scores for Internalizing Behaviors Scores

	Baseline		Treatment		Follow-up	
	Parent	Teacher	Parent	Teacher	Parent	Teacher
Student 1	54	51	47	47	29	45
Student 2	41	52	43	50	30	56
Student 3	52	52	45	46	42	55
Student 4	78	51	67	46	46	41
Student 5	59	53	51	50	33	38
Student 6	53	56	34	51	32	46
Student 7	34	56	31	58	29	49
Student 8	50	41	34	34	29	34
Student 9	41	61	32	61	29	49
Student 10	52	53	57	55	50	46
Student 11	39	54	29	49	29	54
Student 12	42	59	36	56	34	42

Table 17. Mean T-Scores for Externalizing Behaviors Scores

	Baseline		Treatment		Follow-up	
	Parent	Teacher	Parent	Teacher	Parent	Teacher
Student 1	48	46	43	50	29	50
Student 2	46	46	50	36	50	32
Student 3	58	54	52	54	45	56
Student 4	78	54	70	53	51	56
Student 5	61	64	60	56	35	43
Student 6	34	58	40	40	40	40
Student 7	44	58	36	40	28	38
Student 8	61	47	39	40	29	38
Student 9	43	54	32	55	28	53
Student 10	60	55	55	53	50	48
Student 11	43	59	30	56	28	59
Student 12	33	41	33	45	34	43

Table 18. Mean T-Scores for Total Problem Behaviors Scores

	Baseline		Treatment		Follow-up	
	Parent	Teacher	Parent	Teacher	Parent	Teacher
Student 1	41	94	36	38	28	36
Student 2	31	44	56	37	28	50
Student 3	32	39	30	34	29	39
Student 4	49	44	44	38	35	39
Student 5	42	49	51	45	33	39
Student 6	37	46	29	41	28	37
Student 7	35	46	31	46	28	39
Student 8	40	41	31	33	28	32
Student 9	33	43	31	44	28	40
Student 10	46	44	49	43	43	40
Student 11	34	43	28	42	28	44
Student 12	32	49	25	47	24	36

Summary

In this chapter, visual and descriptive results were presented regarding the effects of CCPT with students that were identified to have behavioral difficulties in the classroom. This research focused on students that were identified to have behavioral difficulties in the classroom with in the ages of 3-6 from a strictly CCPT perspective. This study answers the following research questions regarding students that have behavioral difficulties between the ages of 3-6.

1. To what extent will play therapy help to change students' behavior in the classroom?
2. What are the differences in respondents' ratings (i.e. Parent (s)/guardian(s), teacher) in the students' behavior change?

An examination the effects of child-centered play therapy of 12 students with behavioral difficulties in early elementary was conducted. The PND method was used. The PND was measured using the data points lower than the lowest baseline data point. Lundervold and Belwood (2000) state that the lower the PND the stronger the functional effects of the intervention. Results indicated that for nine of the twelve students, the teacher ratings were lower when compared to the parent ratings for all three behavior areas (Internalizing , externalizing , and total problem score). Also the meant-scores for each behavioral area is presented in table 16, 17, and 18. values are prsented In chapter 5, these findings will be interpreted in light of the literature revie

Chapter 5

Discussion

The purpose of this study was to examine the effects of CCPT on students exhibiting behavioral difficulties in the classroom. The Achenbach System of Empirically Based Assessment (Achenbach & Rescorla, 2000) preschool forms and profiles, which are the Child Behavior Checklist (CBCL) for ages 1 ½ to 5 and the Caregiver-Teacher Report Form (C-TRF), were used. In addition, the ASEBA school-age forms and profiles, which are the Child Behavior Checklist for ages 6 to 18 and the Teacher Report Forms (TRF), were used. The behaviors of students were categorized into three areas: Internalizing, Externalizing and Total problem score. Results indicate the majority of students experienced a decrease in behavioral problems during and after participating in CCPT intervention. In this chapter, the specific findings of this study are organized as follows: summary of (a) effects for Internalizing scores for parent and teachers, (b) effects of externalizing scores for parents and teachers, (c) effects for total problem score for parents and teachers, (d) overall effects for ineffective scores, (e) overall effects for debatably effective scores, (f) overall effects of moderately effective scores, (g) overall effects of very effective scores, (h) implications of research, (i) suggestions for further research, (j) limitations, and (k) conclusion.

Direct Findings

A single subject, A-B-A design was used to examine changes in behaviors of students, or the lack thereof, across pre-intervention, intervention, and post-intervention phases. Overall, visual analysis and descriptive statistics revealed that play therapy was a highly effective treatment for reducing negative behavior in most students. Table 13 interprets the treatment effect size for each student's PND in all three areas of behavior (Internalizing, Externalizing, and

Total problem score). Sluggs and Mastropieri (1998) determined the effect size as follows: .90 and greater are indicative of very effective treatment; those ranging from .70 to .89 represent moderate effectiveness of treatment; those between .50 to .69 are debatably effective and score less than .50 are regarded as ineffective (not effective) treatment.

Effects for Internalizing Scores for Parents and Teachers

Parents' ratings showed one out of twelve to be ineffective, and teachers' ratings showed six out of twelve to be ineffective. Parents' ratings for internalizing behavior showed one score out of twelve, and teachers' ratings score showed three out of twelve to be debatably effective. Parents' ratings for internalizing behavior showed eight score out of twelve, and teachers' ratings score showed two out of twelve to be moderately effective. Parents' ratings for internalizing behavior showed two out of twelve, and teachers' ratings score showed two out of twelve to be very effective.

Effects for Externalizing Scores for Parents and Teachers

Parents' ratings for externalizing behavior showed one out of twelve, and teachers ratings showed seven out of twelve to be ineffective. Parents' ratings for externalizing behavior show one score out of twelve, and teachers' ratings showed four out of twelve to be debatably effective. Parents' ratings for externalizing behavior show seven score out of twelve, and teachers' rating score showed zero out of twelve to be moderately effective. Parents' ratings for externalizing behavior showed one out of twelve, and teachers' ratings score showed two out of twelve to be very effective.

Effects for Total problem score for Parents and Teachers

Parents' ratings for total problem score show one out of twelve, and teachers' ratings score for total problem score showed five out of twelve to be ineffective. Parents' ratings for

total problem score show one out of twelve, and teachers' ratings showed three out of twelve to be debatably effective. Parents' ratings for total problem score show five out of twelve, and teachers' ratings score showed two out of twelve to be moderately effective. Parents' ratings for total problem score show five out of twelve, and teachers' ratings score for total problem score showed two out of twelve to be very effective.

Ineffective

Parents' ratings for ineffective treatment in all three areas showed a total of 4 scores out of 36 scores (3 behavior sections x 12 students) to be ineffective. This shows that less than 11.10 % of overall parents' scores were considered to be ineffective by the treatment. Teachers' ratings for ineffective treatment in all three areas showed a total of 18 out of 36 scores to be ineffective. This shows that 50% of overall teachers' scores were considered to be ineffective by the treatment. The combined total for ineffective treatment for both parent and teacher ratings were 22 out of 72 scores. Parents' ratings for Internalizing behavior showed two out of twelve and teachers' ratings score showed two out of twelve to be ineffective.

Debatably Effective

Parents' ratings for debatably effective treatment in all three areas showed a total of 2 scores out of 36 scores (3 behavior sections x 12 students) to be debatably effective. This shows that about 5.50 % of overall parents' scores were considered to be debatably effective by the treatment. Teachers' ratings for debatably effective treatment in all three areas showed a total of 12 out of 36 scores to be debatably effective, this shows that 27.7% of overall teachers' scores were considered to be debatably effected by the treatment. The combined total for debatably effective treatment for both parent and teacher ratings were 12 out of 72 scores.

Moderately Effective

Parents' ratings for moderately effective treatment in all three areas showed a total of 20 scores out of 36 scores (3 behavior sections x 12 students) to be moderately effective, this shows that 55.50 % of parents' scores were considered to be moderately effected by the treatment.

Teachers' ratings for moderately effective treatment in all three areas showed a total of four out of 36 scores to be moderately effective; hence, 11.10% of overall teachers' scores were considered to be moderately effected by the treatment. The combined total for moderately effective treatment for both parent and teacher ratings combined were 24 out of 72 scores.

Very Effective

Parents' ratings for very effective treatment in all three areas showed a total of 10 scores out of 36 scores (3 behavior sections x 12 students) to be very effective. This shows that 27.80% of parents' scores were considered to be very effective by the treatment. Teachers' ratings for very effective treatment in all three areas showed a total of 4 out of 36 scores to be very effective, which shows that 11.10 % of overall teachers' scores were considered to be very effective. The combined total for very effective treatment for both parent and teacher ratings were 14 out of 72 scores.

Results during Follow-up

This 12-week study included three weeks of base line observation, six weeks of treatment and three weeks of withdrawing the treatment. During the withdraw stage of the study, results show that over 90 percent of parents' ratings of student behaviors were very effective. Over 80 percent of teachers' ratings were also very effective after treatment. During the withdraw stage of the study, 11.10 % of parents' ratings of student behaviors were ineffective after treatment,

and 10% of teachers' ratings of student behaviors were ineffective. Student behavior during the withdraw stage of the study continued to improve after treatment.

The overall combined rating for both parents' and teachers' scores show that 50 % of scores were not affected by treatment, where as the other 50 % of scores showed there was some change made in the behavior of the students with CCPT treatment.

Table 14. Summary of PND Results

	Internal		External		Total		Total %	
	Parent	Teacher	Parent	Teacher	Parent	Teacher	Parent	Teacher
Ineffective	1	6	2	7	1	5	11.10%	50.00%
Debatably								
Effective	1	3	0	4	1	3	5.50%	27.70%
Moderately								
Effective	8	2	7	0	5	2	55.50%	11.10%
Very								
Effective	2	1	3	1	5	2	27.80%	11.10%

Implications

Throughout this study, implications for the success of using CCPT with students identified to have behavioral difficulties in the classroom were noted. Overall, more change was reported by parents in the internalizing behaviors of students, whereas the most amount of change reported by teachers was shown in the total problem score. Additionally, the data shows

that 50% of teachers' overall ratings were not affected by the treatment, while 10% of parents' were not affected. Between both the parents' and teachers' ratings, there is a 40% difference in scores. This large difference may be attributed to several reasons, one of which may be due to teachers being too busy with teaching a full class of students to allow for opportunities to observe large or small changes in an individual student. This difference in ratings may also be due to teachers being more critical of changes in a student's behavior. Although teachers' ratings showed less improvement in behaviors in this study, Ray and Dougherty (2007) showed great improvement in behavioral ratings that helped decrease children scores from the clinical range to the normal range of behavior. Muro et al. (2006) showed statistically significant improvement of scores in numerous areas, such as teacher stress and student improvement in related ADHD domains. Also these changes in rating scores may also be due to the hegemony of teachers view and labeling of students behaviors with in the first semester of the school year. This study was done in the Second semester of the school year when it has been shown for teachers to have a strong and established perception of the students.

Suggestions for further research

The promising findings of this study advance the need for further research into the effectiveness of CCPT as an intervention for reducing behaviors in the classroom with students that have been identified to have difficulties. A dearth of empirical literature exists on the effects of CCPT with behavioral difficulties in the classroom with students between 3- 6 years of age. The following recommendations are suggested for future research. Studies should further explore the teacher student relationship prior to teachers rating the student. Studies should further examine the interpersonal stress level of parents as they rate the student's behavior in the home setting. In addition, a follow-up study should be conducted one year after treatment to examine

the long-term effects of CCPT with the students that were identified to have behavioral difficulties in the classroom. The effects of CCPT should also be examined with students aged 3-6 whose parents have identified them as having behavior difficulties in the home.

Limitations

Readers are cautioned to interpret the findings of this study within the context of the following limitations. In this study, the Child Behavior Checklist (CBCL), a behavioral rating assessment, served as the sole method of data analysis. Results of this study could have been strengthened by the utilization of multiple instruments and by the inclusion of independent observations. In this study, the parent(s)/ guardian(s) as well as the teacher(s) had knowledge of the intervention that the participants were receiving; therefore their ratings of participants' behaviors may have been biased. Findings of this study are confined to problem behaviors as assessed by the CBCL. Because CCPT is a holistic intervention, important information regarding the effect(s) of treatment may not have been detected. Also out of the twelve students that were a part of the study only one student scored in the clinical range of behavior, whereas the other students behaviors were not with in the clinical rage. Although behaviors were not with in the clinical range of behaviors, minor behavioral problems were still decreased through he uses of CCPT. An additional limitation was the use of one school and three teachers in this study.

Conclusion

Overall, CCPT has been shown to decrease negative behaviors in children/students in different settings and with different types of behavioral issues. In this study, one south Texas elementary school was used to conduct this study. Students were selected by the teacher to have behavioral difficulties in the classroom for grades pre-kinder 3, 4 and Kindergarten, for a total of twelve students. These twelve students' parent(s)/ guardian(s) allowed their child to participate

in the study and filled out the CBCL forms weekly for the 12-week duration of the study. This study included three weeks of baseline observation, followed by six week of CCPT treatment twice a week, and three weeks of post baseline with a total of 864 total data points. The researcher administrated a total of 144 therapeutic hours for this study.

Overall, the study showed 71% of scores showed change in behavior, while 29% showed that there was no change in behavior after the students received six week of CCPT. This study not only showed change and improving in behavioral overall but also showed a significant difference in rating between parent and teacher rating of the student's behavior.

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