CHILD TEACHER RELATIONSHIP TRAINING AS A HEAD START EARLY MENTAL HEALTH INTERVENTION FOR CHILDREN EXHIBITING DISRUPTIVE BEHAVIOR

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This exploratory study examined the effectiveness of child teacher relationship training (CTRT) with at-risk preschool children exhibiting disruptive behavior. The participants included a total of 23 Head Start teachers and their aides, and children identified by their teachers as exhibiting clinical or borderline levels of externalizing behavior problems. Teacher participants included 22 females and 1 male; demographics were reported as 56% Hispanic ethnicity, 17% Black American, and 22% European American. Child participants included 15 males and 5 females; demographics were reported as 60% Hispanic, 30% Black American, and 10% European American. A 2 by 3 (Group x Repeated Measures) split plot ANOVA was used to analyze the data. According to teacher reports using the Teacher Report Form (C-TRF) and blinded raters' reports using the Direct Observation Form (DOF) to assess disruptive behaviors, children whose teachers received the CTRT intervention demonstrated statistically significant decreases ($p < .05$) in externalizing behaviors on the C-TRF and total problems on the DOF from pre- to mid- to post-test, compared to children whose teachers participated in the active control group. The CTRT intervention demonstrated large treatment effects on both measures (C-TRF: $\eta_p^2 = .173$; DOF: $\eta_p^2 = .164$) when compared to CD, revealing the practical significance of the findings on reducing disruptive behaviors. According to independent raters on the DOF, 90% of children receiving the CTRT intervention moved from clinical levels of behavioral concern to more normative levels of functioning following treatment, establishing the clinical significance of CTRT as an early mental health intervention for preschool children in Head start exhibiting disruptive behavior.

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CHILD TEACHER RELATIONSHIP TRAINING AS A HEAD START EARLY MENTAL HEALTH INTERVENTION FOR CHILDREN EXHIBITING DISRUPTIVE BEHAVIOR

The number of young children suffering from unmet mental health needs remains a critical problem in the United States despite government reports over the past decade calling for more action to remedy this situation (National Center for Children in Poverty, 2011; New Freedom Commission on Mental Health, 2003; U. S. Department of Health and Human Services, 2010). A more serious concern is the lack of services for young children living in poverty. The National Center for Children in Poverty (NCCP, 2011) reported that 14.2% of low-income children develop serious social-emotional problems that impact their school readiness, social-emotional development, and everyday functioning. Researchers have shown that children growing up in poverty-stricken and disadvantaged families are at a higher risk for more difficulties later on in life, including conduct problems, antisocial behaviors, mental health problems, delinquency, and academic problems (Duncan, Ziol-Guest, & Kalil, 2010; Cauthen & Fass, 2009).

Head Start, the nation's largest early intervention and prevention program, was created to foster optimal social, emotional, behavioral, and cognitive development for children from low-income families including early identification of mental health concerns (Serna, Nielson, Mattern, & Forness, 2003). However, Head Start's effectiveness in addressing the early mental health needs of its young children has been challenged (Lopez, Tarullo, Forness, & Boyce, 2000). The increased rate of young children exhibiting disruptive behavior problems is particularly alarming. Head Start teachers and administrators report a noticeable increase in "out of control" behavior problems, while also noting a lack of training in how to respond effectively (Yoshikaway & Knitzer, 1997). The prevalence of these aggressive and acting-out problem behaviors in young children is about 25% for low-income children when compared to 10% for

children who are not economically disadvantaged (Webster-Stratton & Hammond, 2003). These behaviors also have a significant impact on the overall classroom environment and place more of a challenge on the teacher, peers, and administrators. Webster-Stratton and Reid (2003) also reported that without early intervention, emotional and behavioral problems in children tend to further crystallize by the age of eight. Head Start is in a unique position to early identify disruptive behavior problems and provide responsive interventions that can prevent more severe behavioral problems that can interfere with future academic and personal social success.

Disruptive Behavior in the Classroom

Disruptive behavior in the classroom creates tension in the teacher-child relationship (Abidin & Robinson, 2002; Myers & Pianta, 2008; Ray, 2007). The U.S. Department of Human Services (2010) and the President's New Freedom Commission (2003) expressed concerns in recent government reports regarding the potential negative impact of poor teacher-child interactions on children's social-emotional development. The growing number of children exhibiting disruptive behaviors in the school creates a higher level of stress among teachers, thus making it more difficult to create positive teacher-child relationships (Ray, 2007; Helker & Ray, 2009). Teachers who feel more stressed tend to respond to their students in less effective and more negative ways. This creates concerns because teachers play a significant role in the lives of young children, often spending more time with the children then even their own parents (Birch & Ladd, 1999). Thus, the school environment plays a critical role in the social-emotional development of the child and often is the only place where children are likely to receive mental health services.

Teachers' lack of training in how to respond effectively to the social-emotional needs of children exhibiting externalized behaviors is a major factor in teachers' negative response to

these children (Ray, 2007; Yoshikawa & Knitzer, 1997). Children's early school experiences establish their future behaviors, patterns, and interactions with others. Children's primary relationships help to form their view of themselves, the world, and others and are critical to their healthy development (Myers & Pianta, 2008; Birch & Ladd, 1999; Hamre & Pianta, 2001; Landreth & Bratton, 2006).

Play-Based Early Mental Health Interventions

Early childhood scholars have viewed play as the way children communicate and learn about the world. Play therapy is an early mental health intervention that utilizes the child's natural language of play, allowing them a concrete means to symbolically express their thoughts, feelings, concerns, and experiences (Landreth, 2012; Axline, 1947). In several outcome research studies, researchers have shown the effectiveness of play therapy with children in the school environment (Bratton, 2010; Ray, Blanco, Sullivan, & Holliman, 2009; Morrison & Bratton, 2010) and also demonstrated the effects of play therapy with disruptive behaviors (Ray et al., 2007; Fall, Balvanz, Johnson, & Nelson, 1999, Meany-Walen & Bratton, in review, Muro, Ray, Schottlekorb, Smith, & Blanco, 2006; Raman, & Kapur, 1999).

Caregiver Involvement

Involving caregivers in play therapy interventions has proven to be an effective early mental health intervention (Bratton & Landreth, 1995; Chau & Landreth, 1997; Jang, 2000; Tyndall-Lind, Landreth & Giordano, 2001; Landreth and Lobaugh, 2003; Smith & Landreth, 2003; Sheely, 2008; Ceballos, 2009). In the 1960s, Louise and Bernard Guerney developed filial therapy, which was designed to enhance the parent-child relationship (B.G. Guerney, 1964). Filial therapy focuses on the parent-child relationship by training and supervising parents in basic child-centered play therapy skills that are utilized in weekly special play times at home

with their child (Landreth, 2012). Parents then become a therapeutic agent for their child in place of the therapist. The parent-child relationship has more emotional significance for the child than does the relationship with a play therapist, thus meeting the child's emotional needs in a more meaningful way (L. Guerney, 2000).

Building on the work of the Guerneys, Landreth (1991, 2002), developed a more structured and condensed 10-session filial therapy training format in an effort to make filial therapy more reasonable for the lives of parents, Landreth and Bratton (2006) formalized the 10-session model in a text called *Child-Parent Relationship Training* (CPRT). The CPRT model utilizes didactic teaching, group process, at-home sessions, video-recorded or live supervision, role-playing, and demonstrations. The model was manualized by Bratton, Landreth, Kellam, and Blackard (2006) in an effort to ensure the integrity of implementing the treatment. There have been a total of 32 controlled-outcome studies involving 916 subjects investigating the effectiveness of CPRT with results reporting it as a viable early mental health intervention (Bratton, Landreth & Lin, 2010). These results were further analyzed following the meta-analysis conducted by Bratton, Ray, Rhine, and Jones (2005) in an effort to examine the overall treatment effect of filial therapy studies utilizing the CPRT methodology. Bratton et al. (2010) calculated an overall effect size (ES) of 1.25 for filial studies, and more specifically, a strong ES of 1.30 for studies only involving parents. These findings are an indication of the strength of filial therapy as an effective modality in treating children.

As these studies have shown, the involvement of parents and caregivers in play based interventions has proven to be highly effective in addressing the social-emotional needs of children. Within the low-income population, teachers often play a more prominent role in the lives of children and are seen as caregivers themselves. Thus, the involvement of teachers in play

based interventions appears to be essential in holistically meeting the needs of children.

Involving Teachers as Therapeutic Agents of Change

The role of the teacher-child relationship in the social-emotional development of the child is critical (Myers & Pianta, 2008). Teachers spend extensive amounts of time with children throughout the day, often more time than some parents do with children. Thus, the teacher-child relationship has a significant impact on the students' behavior, social-emotional development, and academic success (Thomson & Happoid, 2001; Pianta 1999; Myers & Pianta, 2008). As previously noted, teachers often do not have the skills necessary to effectively respond to children exhibiting disruptive behavior (Ray, 2007). If gone untreated, children exhibiting these disruptive behaviors are at-risk for future disruptive behaviors on into adulthood and less academic success (Hamre & Pianta, 2001; Birch & Ladd, 1998, Ray, 2007). The manners in which teachers respond to children during intense emotional reactions deeply impact the child's ability to exhibit self-control (Thomson & Happoid, 2001). Thus, it is imperative that teachers receive training in responding therapeutically to children during emotional reactions to foster stronger social-emotional development within the child.

Models utilizing the teacher-child relationship have been developed in more recent years. Kinder therapy was developed by White, Flynt, and Draper (1997) based on the filial therapy model (Guerney, 1967) and Adler's individual psychology theory (1998). Kinder therapy emphasizes the importance of teachers in the lives of children and teachers are trained to understand the child's lifestyle and social interest and to use encouragement, based on Adler's theory (White, Draper, Flynt, & Jones, 2000). Play therapy skills are also taught and supervised play sessions are utilized, as well as training in applying the skills to the general classroom environment. Edwards, Varjas, White, and Stokes (2009) utilized a qualitative approach to

understand the effects of kinder training with kindergarten, first, and second grade teachers. Using semi-structured interviews, supervision of teacher-child play sessions, and reflexive journaling, Edwards et al. (2009) found the model to be beneficial to the teacher-child relationship. Many research studies have found kinder therapy to be effective in improving teacher-child interactions and academic achievement (White, Flynt, & Jones, 1999; Peisner-Feinberg, Culkin, Howes, & Kagen, 1999; Draper, White, O'Shaughnessey, & Flynt, 2001; Post, McAllister, Sheely, & Hess, 2004).

A more recent model, developed for working with teachers is relationship enhancement for learner and teacher (RELATe; Ray, personal communication, 2010). This model is based on child-centered play therapy principles and was developed to assist teaches in increasing interpersonal skills to build positive relationships with children (Carlson & Ray, in review). The intervention includes four components: a 3-hour educational module, play sessions between teachers and children of focus, live supervision by experienced play therapists, and feedback between the teacher and the supervisor. This model was targeted for elementary schools. Ray, Muro, and Schumann (2004) and Ray and Beam (2000) conducted pilot studies revealing the effectiveness of RELATe with teachers. Carlson and Ray (in review) conducted a study integrating three models of play based teacher-consultations (PBTC): CTRT, RELATe, and kinder training and found overall positive effects, with increases in the responsiveness and positive teacher-child relationships in over half of the teacher participants and decreases in criticism with all teachers.

Child Teacher Relationship Training

Based on the significance of the teacher-child relationship, Bratton, Landreth, Morrison, and Helker (in review) developed a model involving teachers in the therapy process to enhance

their skills and allow them to meet the social-emotional as well as the developmental needs of the children in their classroom. The model, child teacher relationship training (CTRT), is based on the foundations of filial therapy and modifies the CPRT model to be utilized with teaches in the school environment.

Morrison and Bratton (2010) and, in a companion study, Helker and Ray (2009) conducted preliminary studies of CTRT with the Head Start population. Morrison & Bratton (2010) examined the effectiveness of training Head Start teachers and aides in CTRT as an early mental health intervention for disadvantaged preschool students identified with behavioral problems was examined by the researchers during this study. Analysis of pre-mid-to posttest findings revealed that compared to an active control group, CTRT demonstrated a large treatment effect on reducing children's externalizing problems and the between-group difference was statistically significant. Although the findings of the study hold promise, the study was limited by utilizing only one form of assessment, the Child-Teacher Report Form (C-TRF), used with teachers participating in the study, as the only source of measurement.

In a companion study, Helker and Ray (2009) examined the effects of CTRT training on teachers' and aides' use of relationship-building skills in the classroom and its effects on students' behavior. A statistically significant relationship was found between teachers' and aides higher use of relationship-building skills and students' decrease in externalizing behaviors.

Statement of the Problem

The mental health needs of disadvantaged children continue to increase. As shown in recent government reports, there is a major mental health "crisis" among the nation's population of young children, specifically among those that are economically disadvantaged (U.S. Public Health Service, 2010; President's New Freedom Commission, 2003). Although the numbers of

children suffering from emotional and behavioral disorders continues to rise, there is a shortage of mental health interventions that are developmentally appropriate in responding to the needs of young children (President's New Freedom Commission, 2003; U.S. Public Health Service, 2010).

Of particular concern is the growing number of children exhibiting disruptive behavior (Webster-Stratton & Hammond, 2003; Meany-Walen & Bratton, in process). Disruptive behavior has shown to be more prevalent in young children from low-income families when compared to children from families that are not economically disadvantaged, with a range of 25% compared to 10%, respectively (Webster-Stratton & Hammond, 2003). Without early intervention or treatment, these behaviors have been found to worsen overtime and create more serious academic and behavioral problems across the lifespan of the child (Webster-Stratton & Reid, 2003; Barkley, 2007).

Further, disruptive behavior impacts the classroom environment, as well as the teacher-child relationship (Abidin & Robinson, 2002; Myers & Pianta, 2008; Ray, 2007). Due to the number of hours that teachers spend with the children each week, they have more of an opportunity to get to know the children, and equally have a strong impact on not only their academic development, but also their social-emotional development (Hamre & Pianta, 2001). The quality of the teacher-child relationship has been linked to academic and social success. Disruptive behaviors inhibit this relationship, often being reported as the most challenging for teachers and the classroom environment (Myers & Pianta, 2008; Ray, 2007).

The school environment provides more of an opportunity to serve a greater amount of students who are in need of mental health interventions. Children from low-income families often utilize the Head Start Program, thus making it an ideal environment to provide early mental

health intervention for this population (Head Start Act, 1981; Morrison & Bratton, 2010). Due to the growing number of children exhibiting disruptive behavior and the significant impact that the teacher-child relationship has on the child's social-emotional development, the need to identify developmentally appropriate interventions, which emphasize the strengthening of these relationships, is imperative.

Purpose of the Study

The purpose of the pilot study was to explore the effectiveness of CTRT as a Head Start early mental health intervention for disadvantaged pre-school children identified with disruptive behavior. Specifically, this study addressed one primary research question: Was there a mean reduction in children's disruptive behavior over time for children whose teachers received training and supervision in CTRT compared to children whose teachers received the active control condition?

Methods

In conducting this study, I used a randomized repeated measures control group design and three points of measurement (pretest, midtest, and posttest) to examine the effects of child teacher relationship training (CTRT) on disruptive behavior for disadvantaged preschool children enrolled in a Head Start program. A priori power analysis using G*Power software determined that a minimum sample of 12 participants would be necessary to find a statistical difference between groups over three points of measurement (pre to mid to post). G*Power calculation was based on alpha level .05, minimum power established at .80, and a large treatment effect size (f = .40) based on Cohen's (1992) guidelines. The predictor of a large effect size was based on the previous findings of Morrison and Bratton (2010).

Instrumentation

Teacher Report Form. The Child Behavior Checklist (CBCL) has a Caregiver-Teacher Report Form (C-TRF) that is designed for the caregiver or teacher of a child within the age range of 1½ to 5 years old. The C-TRF has 99 specific problem items that respondents' rate on a Likert scale of 0-2 indicating; *not true* (0), *sometimes true* (1), or *very true* (2). An open-ended item is also included to list other problems observed by the caregivers. The entire assessment takes approximately 15 minutes to complete. Classroom teachers completed the C-TRF on each student from their classroom participating in the study. There are eight syndrome scales, six DSM-oriented scales, and composite scales on the C-TRF, which included the Internalizing Problems scale, the Externalizing Problems scale, and the Total Problems scale. The Externalizing Problems scale, the Attention Problems and Aggression Problems subscales, and the ADHD, Oppositional Defiant Problems, and Conduct Problems DSM-oriented scales were utilized as a screener to qualify children for the study. The Externalizing Problems scale was utilized for the purposes of this study to examine changes in disruptive behavior across time. A reduction in scores indicates improvement in the targeted behavior (Achenbach & Rescorla, 2001).

The C-TRF has been used in numerous research studies to evaluate the effects of play based interventions with parents (Ceballos & Bratton, 2010; Sheely-Moore & Bratton, 2010), with teachers (Morrison & Bratton, 2010; Helker & Ray, 2009), in the Head Start setting (Morrison & Bratton, 2010; Helker & Ray, 2009; Bratton, Ceballos, Sheely-Moore, Meany-Walen, & Pronchenko, in review) and in studies examining the effects of play therapy as an effective intervention for children (Meany-Walen & Bratton, in review; Schottelkorb & Ray, 2009). The overall mean test-retest reliability score was established at .81 and the scaled scores

were stable (Achenbach & Rescorla, 2000). Achenbach and Rescorla (2001) reported internal consistency for the C-TRF: an alpha of .90 for the Total Adaptive scale; for the problem scales, alphas of .72 to .95; and for the DSM-oriented scales, alphas ranging from .73 to .94. In more than 6000 studies, strong validity evidence for the C-TRF has been well established (Achenbach & Rescorla, 2000). For the purposes of this study, the C-TRF was used at pretest to qualify children, and again at midpoint and posttest to examine treatment effects.

Direct Observation Form

The Direct Observation Form (DOF) is an instrument used to assess student's disruptive behavior during a 10-minute period of time using standardized observations (McConaughy & Achenbach, 2009). An examiner, trained to use the instrument, observes an identified child within a natural setting such as the classroom, group, lunch, or recess time. In one-minute intervals, the observer tracks on-task and off-task behavior and writes a description of the child's behavior. After each observation, the examiner immediately completes an 89-item problem checklist, ranking the witnessed behavior on a scale of 0 (behavior not observed) to 3 (definite occurrence with severe intensity or occurrence lasting more than 3 minutes in duration). DOF procedures require a minimum of 2 observations within an observation set to obtain a single score on an individual child. The DOF scoring software allows for computation of a child's average scores.

The DOF provides scores in Total Problems scale, On-task scale, and six syndrome subscales: Withdrawn/Inattentive, Nervous/Obsessive, Depressed, Hyperactive, Attention/Demanding, and Aggressive. A sample of 649 children between the ages of 6-11 years who were clinically referred for evaluations based on their behavioral, emotional, or learning difficulties, were used to develop the 2009 version of the DOF (McConaughy & Achenbach,

2009). During a personal communication with Thomas Achenbach, it was verified that the use of the DOF with preschool children was appropriate (T. Achenbach, personal communication, September 20, 2010). The DOF was normed from a sample of 661 children from 4 different states (New York, Arizona, Vermont, and Pennsylvania) to represent a broad range of United States' geography.

McConaughy and Achenbach (2009) reported reasonable validity was evaluated and established. The DOF was designed to be used separately or in combination with the Child Behavior Checklist (CBCL) and/or the C-TRF (Achenbach & Rescorla, 2001; McConaughy & Achenbach, 2009). For the purposes of this study, DOF observations of children participating in the study from both the experimental group and the active control group were made by blinded observers at pre-, mid-, and post testing. Children observed by the raters consisted of participants in the study and non-participants in the study, thus ensuring the raters were not only blind to the treatment assignment of the teachers, but also to the children participating in the study.

Participant Selection

The study was conducted in a Head Start Center located in the southwestern United States. The study began with 24 teachers and 22 children. One teacher was dropped from the study due to a family crisis. Of the 22 children, one was dropped due to geographic relocation, and one was dropped due to his teacher being dropped from the study. A total of 23 teachers/aides and 20 children participated in the study. Dropouts' and completers' demographics and data were examined to determine any differences that might impact the outcomes. No differences in completers and non-completers were detected.

Teacher participants. All Head Start classroom teachers (n = 12) and their aides (n = 12)

were asked to participate in the study ($N = 24$). The teacher/aide pairs were randomly drawn and assigned to either the experimental (CTRT) or active control group (Conscious Discipline). The groups were examined to ensure equality among the groups. A total of 23 teachers and aides, consisting of 11 teachers and 12 aides in the experimental group and 12 teachers and 12 aides in the control group, participated in the research study in its entirety. Overall, the teacher participants included 22 females, 11 (Experimental) and 11 (Control), and 1 male in the control group. Overall, 56% of the teacher participants reported Hispanic ethnicity, 17% Black American, and 22% European American. All teachers participating in the study held a bachelor's degree or higher. Four teachers in the CTRT group and five in the active control group were certified in Early Childhood Education. Five teachers in the CTRT group and two in the active control group were certified Bilingual Generalists. CTRT teachers averaged seven years of experience and were, on average, 39 years old; control teachers averaged seven years of experience and were, on average, 36 years old.

Child participants. Teachers were asked to identify and refer children who exhibited disruptive behaviors such as rule breaking, conduct problems, oppositional behaviors, yelling, attention seeking, immaturity, hyperactive behaviors, swearing, aggression, fighting, or crying. Upon receiving these referrals, consent forms were sent home with the referred students. Teachers identified students whose families needed an English Version or a Spanish version of the consent form. Following the receipt of parental consent for each child, the C-TRF was administered to the classroom teachers in order to qualify children to the study. Children were then selected to participate based on the following criteria:

1. Children were enrolled in the chosen Head Start program
2. Children who were not labeled with significant cognitive delays as determined by

special classroom placement qualified for the study.

3. Children were referred for disruptive behavior by classroom teacher.

4. Teacher agreed to participate in the study by attending the CTRT or the Conscious Discipline training, completing the C-TRF, and permitting observers in the classroom.

5. Parent consented for child to participate in the study.

6. Children who scored in the borderline or clinical range on at least one of the following as an indicator of target behavior (disruptive behaviors in the classroom): the C-TRF Externalizing Problems subscale, or on one of the following C-TRF subscales: Attention Problems, Aggressive Behavior, ADHD, Oppositional Defiant Problems, or Conduct Problems.

Following the identification of the students who qualified for the study, the teachers were asked to select a "child of focus" from the group of children. Teachers were instructed to select a child whom they felt could benefit the most from individualized attention.

Children's treatment group assignment was based on their teachers' random assignment to either the experimental or active control group. The "children of focus" were chosen by either the teacher or the aide to participate in the 30-minute play sessions with the teachers in the experimental group and were the children who qualified for the study based on the above requirements. A total of 22 children qualified and were chosen as "children of focus" by the teachers and aides in the study. One student was withdrawn from the school and was dropped from the study. Due to a teacher being withdrawn from the study, the teacher's child of focus was also withdrawn from the study. A total of 20 children completed the study. Table 1 presents demographic information on the children involved in the study.

Table 1

*Demographics of Children in the Research Study (*n = *20)*

	Experimental CTRT group (n = 11)	Active Control Group (n = 9)
Gender		
Males	9	6
Females	2	3
Average Age	3.63	3.88
Ethnicity		
Hispanic	7	5
Black American	3	3
White/Caucasian	1	1

Treatment

Experimental teachers and aides (n= 11) received CTRT; the active control group (n = 12) received Conscious Discipline training (Bailey, 2000). While training was typical of what is traditionally received in Conscious Discipline (Bailey, 2000), I was unable to directly control for the frequency, intensity, or integrity of the training. Thus, a decision to designate this condition as an active control group rather than a comparison treatment was made. The programs were chosen for this study and adopted by the participating school based on the similar philosophies of promoting healthy child-teacher relationships that foster students' optimal social-emotional and cognitive development.

Experimental group treatment. The five teachers and six aides in the experimental group

(n = 11) participated in training, supervision, and coaching in CTRT protocol (Bratton et. al., in review) to learn more effective ways of responding to the behavioral and emotional needs of children. CTRT is an adapted model of CPRT (Landreth & Bratton, 2006). The *Child Parent Relationship Therapy* (CPRT) *Treatment Manual* (Bratton et al., 2006) was adapted to accommodate the teacher-child relationship and the school setting (Morrison & Bratton, 2010). The goal of CTRT is to train the teachers and aides in relationship building skills that help them to become more sensitive to, understanding of, and responsive to the needs of their students.

The CTRT treatment was conducted over two phases of training. Phase I focused on the basic CTRT skill application with one child, and Phase II focused on the integration and application of skills in the classroom environment. Two advanced doctoral students who have advanced training and supervised experience in play therapy and CPRT methodology facilitated the training, supervision, and coaching. Treatment integrity was ensured through the use of the CTRT protocol and ongoing supervision and consultation with an expert in CPRT.

During Phase I, the teachers and aides learned and practiced core CTRT principles and skills which included structuring, reflective listening and responding, recognizing and responding to children's feelings, therapeutic limit setting, building children's self-esteem, facilitating creativity/spontaneity, facilitating decision making, and returning responsibility. Phase I training content was equivalent to the material covered in the CPRT 10-session protocol (Bratton et al., 2006). The training format included 2 full days of intensive didactic instruction and experimental activities (approximately 14 hours equivalent to the content covered in the first 5 sessions in the CPRT manual), followed by 7 weeks of 1-hour group training/supervision meetings during which the remainder of CTRT material was covered. The teacher-aide pairs were divided into 2 groups of 3 pairs for the weekly meetings to promote interaction and more

individualized attention.

To further enhance the mastery of the CTRT skills, each teacher and aide selected a "child of focus" from children in their classroom who qualified for the study and conducted weekly 30-minute video-recorded play sessions over 7 weeks. These one-on-one play sessions were held in a designated room equipped with the prescribed toys and materials as described in the CPRT manual (Bratton et al., 2006). During the weekly meetings, the teachers and aides received constructive feedback during the supervision of their recorded play sessions. To ensure successful learning and application of their new skills during Phase I, teachers and aides were instructed not to practice skills outside of their 30-minute play times.

Phase II training began immediately after Phase I and included 10 weeks of in-class coaching. To provide consistency and establish a routine structure for implementing the CTRT skills, the daily *center* time (a block of time scheduled for the children's self-directed play) was designated Child Teacher Relationship (CTR)-time. The CTRT skills were modeled in the classroom during this time by the primary researchers. Didactic instruction and role-playing in more advanced skills, including skills to be used in both one-on-one situations and with small groups of children, were the focus of supervision in CTRT Phase II. The in-class coaching took place 3 times a week for 30 minutes each for a total of 90 minutes of in-class training time each week per teaching team. Teacher-aide pairs took turns (15 minutes each) participating in CTR-time during the 30-minute coaching block. This enabled one partner to focus on the CTRT skills with a small group of children while the other teacher partner focused on general classroom management. Hour long weekly supervision continued during the 10 weeks of this treatment phase. This took place once a week during the teacher's daily planning period, which occurred after the children's dismissal from school.

Active control treatment. The active control group teacher and aides received training in the Conscious Discipline approach (Bailey, 2000), a widely used early childhood teacher training program that focuses on classroom management skills designed to help teachers and aides respond to young children in more positive ways by improving the teacher-child relationship, enhancing children's social-emotional development, and building character. An expert in the field of counseling, a designated Conscious Discipline trainer, who holds a doctoral degree in counseling, conducted the training for the active control group. Teachers and aides selected for the active control group (n =12) received training in the Conscious Discipline approach. Consistent with the Conscious Discipline curriculum, the teachers and aides received training for one full day prior to school beginning (approximately 7 hours) and met periodically throughout the study to receive further training and support in implementing Conscious Discipline program into their classrooms. Conscious Discipline training included Conscious Discipline DVDs (Bailey, 2004) and readings from *Conscious Discipline: 7 Basic Skills for Brain Smart Classroom Management* (Bailey, 2000). The teachers and aides were not directly supervised or observed to ensure the skill acquisition. The curriculum is grounded in the philosophy that schools are to be viewed as school families where children and adults learn the skills necessary to be successful in life. Skills taught included forming relationships, communicating effectively, and developing the abilities to be empathetic with others, to communicate feelings directly, and resolve conflicts in constructive ways. These were the major skills of focus. Additionally, teachers were taught to be proactive rather than reactive in situations of conflict through the seven basic skills of discipline that promote inner peace for children. These skills included composure, encouragement, assertiveness, choices, positive intent and empathy (Bailey, 2000).

Data Collection

Upon IRB approval, informed consent was obtained from teacher and aide participants and from the parents of the child participants. Spanish language consent forms as well as Spanish-speaking research assistants were provided as necessary to collect the consent forms allowing the children to participate. The C-TRF was utilized as a pretest and also as a screener to qualify children to the study at the beginning of the school year based on teachers' reports. Children who scored in the borderline to clinical range on the C-TRF Externalizing Problems subscale, or on one of the following C-TRF subscales: Attention Problems, Aggressive Behavior, ADHD, Oppositional Defiant Problems, or Conduct Problems were selected to participate in the study. To ensure integrity of data collection, teachers were provided classroom substitutes while the teachers completed the C-TRF in a location free from distraction. A research assistant was available to answer any questions. The C-TRF was collected at midpoint testing at the conclusion of Phase I and again at post-testing at the conclusion of Phase II.

The DOF, a direct observation measure of children's disruptive behavior, was conducted to obtain the least-biased, objective observable data. To obtain the data, four independent raters who were pursuing a degree in the mental health field and had experience working with children, received training and practice in the use of the DOF. The inter-rater reliability was calculated with the Spearman-Brown correction. The raters were then split into two dyads and completed a minimum of 5 practice cases with randomly selected preschool children who were not involved in the study. Rater dyads achieved an acceptable level of interrater reliability (.89 and .80). The rater dyads regrouped before midpoint observations and achieved an acceptable level of interrater reliability (.90 and .83) and again before post testing (.90 and .88). The DOF pretesting observations occurred once the children of focus were identified by the teachers.

The DOF raters, who were blind to the study, were assigned study participants as well as children not participating in the study to observe for 10-minute intervals for three observational periods over the time period of a week to obtain a single score. The goal of observing children in a variety of school environments was to gather the most accurate account of student behavior (McConaughy & Achenbach, 2009). The blind raters observed each participant and non-participant 3 times at pretest, 3 times at midpoint, and 3 times at post-test. Non-participants were assigned to ensure that the raters were not only blind to the teachers' assignment in the study, but also to the children participating in the study. The computerized scoring required a minimum of 2 observations to create a single score. Therefore, each participant and non participant received a single pretest, single midpoint, and single posttest score. Because the purpose of this study was to examine treatment effects on children's classroom behavior, all observations were completed during structured, academic situations in the classroom.

Analysis of Data

A 2 (Group) by 3 (Repeated Measures) split plot ANOVA was performed on the dependent variables (C-TRF externalizing problems and DOF total behaviors) to determine if the groups performed differently across time. An alpha level of .05 was established to test for significant mean differences. Partial eta squared (η_p^2) effect sizes were calculated as an indicator of the magnitude of the difference between groups due to treatment. Effect sizes are reported and interpreted according to Cohen's (1988) guidelines. The number of children who moved from clinical or borderline levels of disruptive behaviors to more normative functioning is reported as a measure of the clinical significance of treatment on the lives of participants.

Results

Table 2 presents the pre, mid, and post test means and SD values for the experimental and

active control group on the Externalizing scale of the C-TRF. A reduction in scores on the C-TRF indicates improvement in the targeted behavior.

Table 2

Mean Scores on the Externalizing Problems Scales on the Child Behavior Checklist-Caregiver/Teacher Report Form(C-TRF)

	Experimental group n=11			*Active Control Group n=9*		
	Pretest	Midpoint	Posttest	Pretest	Midpoint	Posttest
Externalizing Behavior						
Mean	68.909	62.4545	59.3380	66.4444	66.333	66.889
SD	9.04	8.72	6.31	7.06	9.00	11.42

Note: A decrease in mean scores indicates an improvement in behavior.

Results of analysis of the dependent variable, externalizing problems, revealed statistically significant interaction effects of Time (pretest, midpoint, posttest) x Group Membership (experimental, active control) [sphericity assumed= $F(2,17) = 3.768$, $p = .03$, ($\eta_p^2 = .173$]. These results indicate that according to the teachers observation, children who participated in CTRT ($n = 11$) demonstrated a statistically significant decrease in disruptive behavior problems overtime, when compared to the children in the active control group ($n = 9$). The interaction effect sizes on the C-TRF ($\eta_p^2 = .173$) indicates that compared to the active control group, CTRT demonstrated large treatment effects on children's exhibited disruptive behaviors.

Figure 1 graphically displays the interaction effects of mean group differences for externalizing behavior over time. Group 1 represents the experimental group and Group 2

represents the active control group.

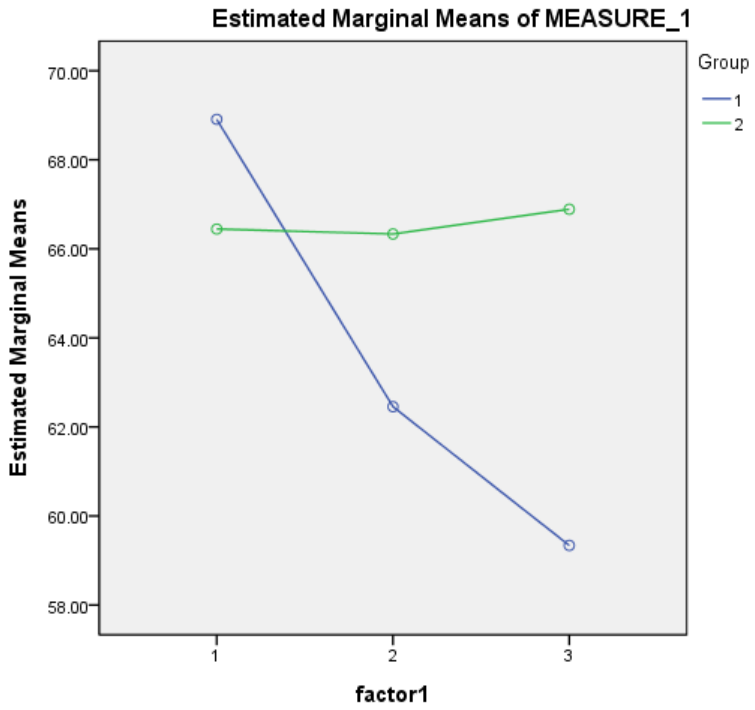

Figure 1. Estimated marginal means of externalizing problems for total group.

Table 3 presents the pre, mid, and post-test means and SD values for the experimental and active control group on the Total Behaviors scale of the DOF. A reduction in scores on the DOF indicates improvement in the targeted behavior.

Table 3

Mean Scores on the Total Behavior Scale on the Direct Observation Form (DOF)

	Experimental group N=10			*Active Control group N=9*		
	Pretest	Midpoint	Posttest	Pretest	Midpoint	Posttest
Externalizing Behavior						
Mean	69.977	50.2199	48.2516	63.5556	52.5556	54.3333
SD	7.70	10.31	5.04	7.62	8.64	7.76

Note: A decrease in mean scores indicates an improvement in behavior.

Results of analysis of the dependent variable, total behaviors, were congruent with those of the Externalizing Problems in the CTRF and revealed statistically significant interaction effects of time (pretest, midpoint, posttest) x group membership (experimental, active control); [sphericity assumed= $F(2,16) = 3.529$; $p = .04$, $\eta_p^2 = .164$]. These results indicate that according to the observations of blinded raters, children who received CTRT ($n = 11$) demonstrated a statistically significant decrease in disruptive behavior problems over time, when compared to the children in the active control group ($n = 9$). The interaction effect sizes on the DOF ($\eta_p^2 = .164$) indicates that compared to the active control group, CTRT demonstrated large treatment effects on children's disruptive behaviors.

Figure 2 graphically displays the interaction effects of mean group differences for Total Behavior over time. Group 1 represents the experimental group and group 2 represents the active control group.

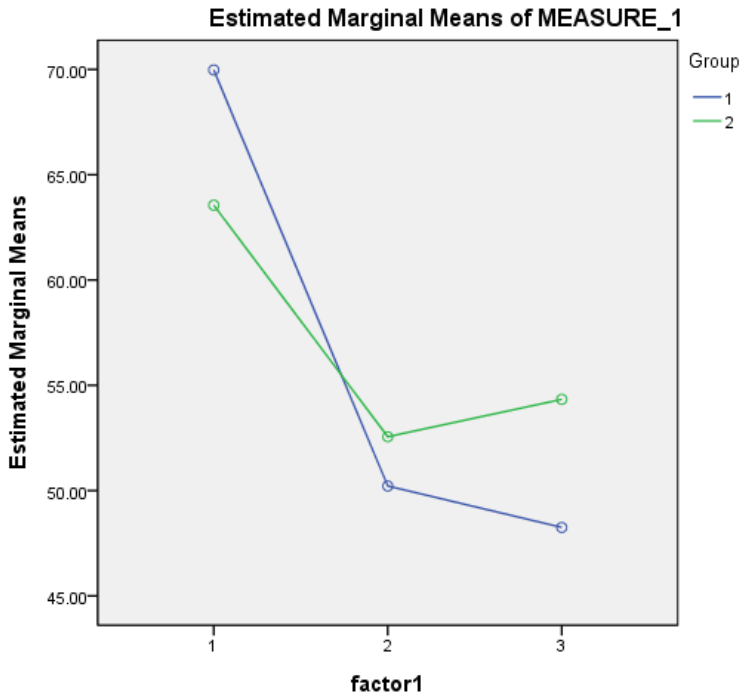

Figure 2. Estimated marginal means of Total Behavior for total group.

Clinical Significance

According to Kazdin (1999) clinical significance refers to whether the intervention being studied makes a beneficial impact in the everyday life of the participants or the people with whom the participants interact. To gain better understanding of the impact that CTRT had on children's disruptive behavior in the classroom, the individual scores of each participant's pre, mid, and post-test scores on the Total Behaviors scale of the DOF and the Externalizing behavior scale on the C-TRF were examined. Specifically, clinical significance was assessed by determining the number of children in the experimental group who moved from clinical/borderline levels of concern at pre-test to a normative range of functioning following treatment. The use of direct observations, such as the DOF, provides an unbiased assessment of the participants' behaviors based on the raters' objectivity and blindness to the study (McConaughy & Achenbach, 2009; Volpe, DiPerna, Hintze, & Shapiero, 2005).

Externalizing behavior scale. Children's t-scores on the Externalizing Behavior scale of the C-TRF were analyzed to determine clinical significance of the CTRT on the student's disruptive behavior. Out of the 11 children who received CTRT, 7 children improved from clinical or borderline disruptive behavior problems to more normative levels of functioning. Specifically, 3 children who scored in the clinical range at pretest moved to a normal range at post; 1 child who scored in the borderline range at pretest moved to a normal range at post; and 3 children who scored in the clinical range at pretest moved to a borderline range at post. Four children remained in the clinical level of concern, but demonstrated improved behavior with an average decrease in score of 2 points. On the other hand, out of the 9 children in the active control group, 2 children improved from clinical or borderline scores to more normative levels of functioning, one child remained the same, and 6 children worsened, with an average increase in score of 3.83 points.

Total behavior outcomes. Children's *t*-scores on the Total Behavior scale on the DOF were analyzed to determine the clinical significance of CTRT on the students' disruptive behavior. The total sample size of the experimental group children was 11; however, one student moved prior to the midpoint observation, thus the DOF data was dropped. Therefore, the DOF sample size for the experimental group consisted of 10 children. Of the 10 children in the CTRF group, 9 children improved from clinical or borderline disruptive behavior problems to more normative functioning. More specifically, 8 children who scored in the clinical range at pretest moved to the normal range at posttest; and 1 child who scored in the borderline range at pretest moved to the normal range at posttest. One child remained the same but decreased in score by 6 points. Conversely, out of the 9 children in the active control group, 6 children moved from clinical and borderline disruptive behavior problems to more normative functioning.

Specifically, 2 children who scored in the clinical range at pretest moved to the normal range at posttest; 3 children moved from the borderline range to normal range; and one child moved from the clinical range to the borderline range. Three children remained the same with an average decrease in scores of 1.

Discussion

The statistical, practical, and clinical significance of the present study's findings lends promising support to the effectiveness of CTRT as a Head Start early mental health intervention for children exhibiting disruptive behavior. Recent reports have shown a significant increase in the overall problematic behaviors displayed in young children, with disruptive behaviors being the primary reported behaviors (Webster-Stratton & Hammond, 2003; Webster-Stratton & Reid, 2003). These behaviors have a negative impact on adult and peer relationships and place children at risk for academic and personal difficulties.

Effects of CTRT on Disruptive Behavior

Results of this pilot study indicate that CTRT is a viable intervention for at-risk preschool children exhibiting disruptive classroom behavior. Compared to the active control group, CTRT demonstrated a statistically significant reduction and large treatment effect on children's disruptive behaviors across three points of measure. The significance of the findings is enhanced by the consistency of the results on two measures of disruptive behavior, the C-TRF Externalizing scale and the DOF Total Problems, obtained from two sources, teachers (C-TRF) and objective raters who were blinded to the study (DOF).

CTRT's effect on disruptive behavior problems is encouraging during this "mental health crisis" in our nation (NCCP, 2011). These behaviors also inhibit the degree to which children can be successful academically and socially and can cause more problems for our society at large

(Walker, Ramsey, & Gresham, 2004).

Significance of Utilizing Preschool Teachers as Early Mental Health Partners

Head Start teachers report being ill-prepared to meet the social-emotional needs of this population of children (Yoshikawa & Knitzer, 1997). The lack of training in how to respond to these types of behaviors produces a never-ending cycle where a) the child, displays disruptive behaviors which stem from emotional disturbance, b) the teacher feels challenged and ineffective, c) these feelings create a strain on the teacher-child relationship d) the teacher develops a negative view of the child, e) the teacher responds to the child in a negative way, usually through threats or punishments, f) this response creates more emotional disturbance within the child and the child then exhibits further disruptive behavior, allowing the cycle to repeat. In an effort to further emphasize this cycle and the reciprocal relationship between the teacher and the child, I have developed the reciprocal relationship cycle (RRC), illustrated in Figure 3 below.

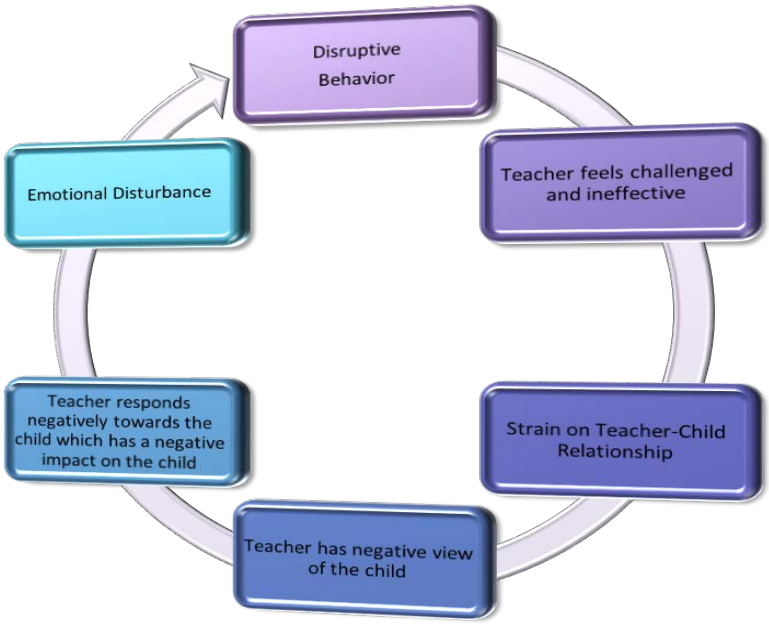

Figure 3. Reciprocal relationship cycle (RRC).

While many interventions tend to focus solely on one of two dimensions of this cycle: either the child's behavior or the teacher's modification of the child's behavior, I believe the more effective intervention utilizes the significance that the child-teacher relationship has on the social-emotional development of the child and emphasizes this dimension to create a break in the cycle. Interestingly, the results of this study further validate the importance of this dimension. Specifically, the reports on the CTRF, as based on the teacher's perspectives, showed a significant difference in the reported decreases of the exhibited disruptive behavior of the children in the CTRT group when compared to the increasing disruptive behavior reports of the active control group. Although the DOF reports received from the blinded raters also showed improvement, the difference between groups was not as great as the differences on the C-TRF. This appears to indicate that the teachers' perspectives of the children in the CTRT group were changing over time while the teachers' perspectives in the active control group were not. The importance of this finding signifies that the teachers' perspective and view of the child has a deep impact on the cycle as a whole.

Thus, interventions such as CTRT that focus on training teachers to understand and respond to the needs of at-risk children and equipping them with specific skills to respond more effectively to behavioral difficulties in their classroom are particularly needed in programs such as Head Start (Morrison & Bratton, 2010). Teachers who feel empowered and capable when encountered with disruptive behavioral problems are able to respond more effectively to these behaviors while maintaining the teacher-child relationship and ultimately, better meeting the needs of the child.

Similar to the study done by Morrison and Bratton (2010), the present findings support the effectiveness of the CTRT model within the Head Start population. The CTRT model

utilizes preschool teachers and aides by training them in specific skills to promote healthy functioning and development amongst their students. The children identified with disruptive behavior problems on both scales showed significant improvements based on their interactions with their teachers and aides in the play room and in the classroom. Although the teachers worked one on one with one child of focus during Phase I, they implemented their newly learned skills during Phase II with the entire classroom. By using teachers and aides as effective partners, more students can be reached, thus providing for the social and emotional needs of a greater number of students.

CTRT as an Effective Early Mental Health Intervention

Another interesting finding within the results of this study is the difference between the CTRT intervention and the active control intervention, Conscious Discipline. Particularly on the DOF instrument, the results indicated that the children's disruptive behavior in both groups was decreasing, although the CTRT group showed a statically significant difference between the groups. Due to the similarities in the philosophy which emphasizes strong teacher-child relationship within both interventions, it is believed this is the reason both groups were improving. However, the skills were further enhanced and utilized within the larger classroom setting, thus allowing the teachers in the CTRT group to generalize their skills to the entire class. This phase in the treatment appeared to have a strong impact on the teachers and the students in the classroom.

As intended, the present study adds to the research supporting the use of teachers and caregivers as therapeutic agents for young children (Morrison & Bratton, 2010; Helker & Ray, 2009; Post, McAllister, Sheely, & Hess, 2004; Edwards et. al, 2009). The CTRT model takes advantage of the prime opportunity presented in the school system to serve a greater number of

children that can be reached through community mental health agencies. Throughout this study, the teachers and aides were required to devote and commit to spending a significant amount of time, which was met at first with some resistance. As the training went on and the teachers became more comfortable and confident with the use of their skills, they began to report positive changes in the classroom environment and with the students exhibiting disruptive behavior. By the end of the study, the teachers and aides were reporting that they were able to better understand their students and felt more confident when dealing with disruptive or problematic behaviors. Therefore, although CTRT requires a large time commitment, the overall results show the value and effectiveness that this intervention has with at-risk population.

Limitations of the Study

Although the real-world setting of this study allows it to be replicated by a mental health professional or a school counselor, there are limitations to the study. The small sample size obtained from only one school in the southwestern region of the United States limits the generalizability of the results beyond the participating school's population of students exhibiting disruptive behaviors in the classroom. Using teachers who were involved in the training as a source of child data was an obvious limitation. The possibility exists that teachers' may have altered their perceptions of their students as a result of CTRT and their ratings on the C-TRF of the children's behavior may have been biased. However, the teachers and aides trained in Conscious Discipline were also exposed to a similar philosophy of child teacher relationship and did not report the positive degree of changes that the experimental group reported. Further, the use of the Direct Observation Form (DOF) with blind raters allowed for a more objective source of child data to be utilized and the results of these observations were similar to the findings of the C-TRF results. In a preliminary investigation, Morrison and Bratton (2010) listed the use of only

the C-TRF as one of the primary limitations of the study. The use of the DOF in this study was an answer to that limitation. An additional concern is the possibility of researcher's bias, as the CTRT training was conducted by the primary researcher, who was more invested in the study, compared to the Conscious Discipline trainer, who was not a member of the research team.

Recommendations for Future Research

Based on the results and the limitations of this study, recommendations for future research include a follow-up study to determine if children maintained the behavioral improvements and the continued utilization of the CTRT skills by the teachers and the aides in the classroom. Replicating this study with a larger sample size from multiple sites using the same protocol would add confidence to the findings and the generalizability of the study. Although the use of different sources of measurements from both the teachers on the C-TRF and blind raters on the DOF were a definite strength of the study, the use of another assessment utilizing parents would also increase the rigor of the study.

Conclusion

Throughout the past several decades, the number of children in need of early mental health interventions has grown at a continuous pace (U.S Department of Human Services, 2010; President's New Freedom Commission, 2003). The number of children exhibiting problematic behaviors that reduce their chances of success academically and socially increases at an alarming rate (Abidin & Robinson, 2002; Myers & Pianta, 2008). This contributes to the development of negative teacher child relationships, which are vital to the social and emotional development of children (Myers & Pianta, 2008; Birch & Ladd, 1999). Head Start teachers report a lack of training in skills to effectively respond to children exhibiting problematic behaviors (Yoshikawa & Knitzer, 1997). CTRT provides an effective solution through the use of extensive training,

equipping the teachers with responsive skills that are not only effective in reducing disruptive behavior, but also in strengthening the teacher child relationship. The results of this study are encouraging and provide support for CTRT as an effective early mental health intervention for Head Start children exhibiting disruptive behavioral problems.

References

Abidin, R. R., & Robinson, L. L. (2002). Stress, biases, or professionalism: What drives teachers' referral judgments of students with challenging behaviors? *Journal of Emotional and Behavioral Disorders, 10*(4)*,* 294-212.

Achenbach, T. M., & Rescorla, L. A. (2001). *Manual for the ASEBA school-age forms & profiles.* Burlington: University of Vermont, Research Center for Children, Youth, & Families.

Adler, A. (1998). *Understanding human nature.* England: Oneworld Oxford. (Original work published in 1927).

Axline, V. (1974). *Play therapy*. New York, NY: Ballantine Books.

Bailey, B. A. (2000). *Conscious discipline*. Oviedo, Fl: Loving Guidance.

Bailey, B. A. (2004). *Conscious discipline*. Oviedo, Fl: Loving Guidance.

Barkley, R. (2007). School interventions for attention deficit hyperactivity disorder: Where to from here? *School Psychology Review, 36*(2)*,* 279-286.

Birch, S. H., & Ladd, G. W. (1999). Children's interpersonal behaviors and the teacher-child relationship. *Developmental Psychology, 34(*5*),* 934-946. doi: 0012-1649/98

Bratton, S. (2010). Meeting the early mental health needs of children through school-based play therapy: A review of outcome research. In A. A. Drewes & C. E. Schaefer (Eds.), *School-based play therapy* (2nd ed., pp. 17-59). Hoboken, NJ: Wiley

Bratton, S., & Landreth, G. L. (1995). Filial therapy with single parents: Effects on parental acceptance, empathy, and stress. *International Journal of Play Therapy, 4,* 61-80.

Bratton, S. C., Landreth, G. L., Kellam, T., and Blackard, (2006). *Child parent relationship therapy (CPRT) treatment manual.* New York: Routledge.

Bratton, S., Landreth, G., & Lin, Y. (2010). Child parent relationship therapy: A review of controlled outcome research. In J. N. Baggerly, D. C. Ray, & S. C. Bratton (Eds.), *Child centered play therapy research: The evidence base for effective practice* (pp. 267-293). NY: Wiley.

Bratton, S. C., Landreth, G. L., Morrison, M., & Helker,W. (2010). *Child teacher relationship training (CTRT) treatment manual*. New York: Routledge. In review.

Bratton, S. C., Ray, D., Rhine, T., & Jones, L. (2005). The efficacy of play therapy with children: A meta-analytic review of treatment outcomes. *Professional Psychology: Research and Practice, 36*(4)*,* 376-390. Doi: 10.1037/0735-7028.36.4.376

Bratton, S., Ceballos, P., Sheely-Moore, A., Meany-Walen, K., & Pronchenko, Y. (2011). *Head Start early mental health intervention: Effects of CCPT on disruptive behaviors*. Manuscript submitted for publication.

Carlson, S.E., & Ray, D. (2011). *Effects of play-based teacher consultation (PBTC) program on interpersonal skills of elementary school teachers in the classroom*. In review.

Cauthen, N. K., & Fass, S. (2009). *10 important questions about child poverty and family economic hardship*. National Center for Children in Poverty, Columbia University Mailman School of Public Health. Retrieved from http://http://www.nccp.org/publications/pub_829.html

Ceballos, P. (2009). *School-based child parent relationship therapy (CPRT) with low income*

first generation immigrant Hispanic parents: Effects on child behavior and parent-child relationship stress (Doctoral dissertation). Retrieved from ProQuest Dissertations and Theses database. (UMI No. 3326785).

Ceballos, P., & Bratton, S. (2010). Empowering Latin families: Effects of a culturally responsive intervention for low-income immigrant Latin parents on children's behaviors and parental stress. *Psychology in the Schools, 47(*8*),* 761-775.

Chau,I., & Landreth, G. L. (1997). Filial therapy with Chinese parents: Effects on parental empathic interactions, parental acceptance of child and parental stress. *International Journal of Play Therapy, 6*, 75-92.

Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2nd ed.). New York, NY: Academic Press.

Cohen, J. (1992). A power primer. *Psychological Bulletin, 112*, 155-159.

Duncan, G. J., Ziol-Guest, K. M. and Kalil, A. (2010), Early-childhood poverty and adult attainment, behavior, and health. *Child Development*, *81*, 306–325. doi: 10.1111/j.1467 8624.2009.01396.

Draper, K., White, J., O'Shaughnessy, T. E., Flynt, M., & Jones, N. (2001). Kinder training: Play-based consultation to improve the school adjustment of discouraged kindergarten and first grade students. *International Journal of Play Therapy, 10,* 1-30.

Edwards, N. A., Varjas, K. M., White, J. F., & Stokes, S. A. (2009). Teachers' perceptions of kinder training: Acceptability, integrity, and effectiveness. *International Journal of Play Therapy*, *18*(3), 129-146. doi: 10.1037/a0015170

Fall, M., Navelski, L. F., & Welch, K. K. (2002). Outcomes of a play intervention for children identified for special education services. *International Journal of Play Therapy, 11*(2),

91-106.

Guerney, B. G. (1964). Filial therapy: Description and rationale. *Journal of Consulting Psychology, 28,* 303-310.

Guerney, L. (1991). Parents as partners in treating behavior problems in early childhood settings. *Early Childhood Special Education, 11(2),* 74-90.

.Hamre, B. K., & Pianta, R. C. (2001). Early teacher-child relationships and the trajectory of children's school outcomes through eighth grade. *Child Development, 72*, 625-638.

Helker, W., & Ray, D. (2009). The impact child-teacher relationship training on teachers' and aides' use of relationship-building skills and the effect on student classroom behavior. *International Journal of Play Therapy, 18(2)*, 70-83.

Jang, M. (2000). Effectiveness of filial therapy for Korean parents. *International Journal of Play Therapy, 9(2)*, 39–56.

Kazdin, A. E. (1999). The meanings and measurement of clinical significance. *Journal of Counseling and Clinical Psychology, 67*, 332-339.

Landreth, G. L. (2002). *Play therapy: The art of the relationship* (2nd ed.). New York, NY: Brunner Routledge.

Landreth, G. L. (2012). *Play therapy: The art of the relationship* (3rd ed.). New York, NY: Brunner Routledge.

Landreth, G. L., & Bratton, S. C. (2006). *Child-parent relationship therapy: A 10-week filial therapy model*. Springfield, IL: Thomas Books.

Lopez, M.L., Tarullo, L.B., Forness, S.R., & Boyce, C.A. (2000). Early identification and intervention: Head Start's response to mental health challenges. *Early Education & Development, 11(3)*, 265-282.

McConaughy, S. H., & Achenbach, T. M. (2009). *Manual for the ASEBA Direct Observation Form*. Burlington,VT: University of Vermont, Research Center for Children, Youth, & Families.

Meany-Walen, K. K., & Bratton, S. C. (2011). Adlerian play therapy: Effectiveness on disruptive behaviors of early elementary-aged children. In review.

Morrison, M. O., & Bratton, S. C. (2010). Preliminary investigation of an early mental health intervention for Head Start programs: Effects of child teacher relationship training on children's behavior problems. *Psychology in the Schools, 47(*10*)*, 1003–1017.

Muro, J., Ray, D., Schottelkorb, A., Smith, M. R., & Blanco, P. J. (2006). Quantitative analysis of long-term child-centered play therapy. *International Journal of Play Therapy, 15(*2*),* 35-58. doi:10.1037/h0088914

Myers, S. S., & Pianta, R. C. (2008). Development commentary: Individual and contextual influences on student-teacher relationships and children's early problem behaviors. *Journal of Clinical Child & Adolescent Psychology, 17*(3)*,* 600-608. doi: 10.1080/15374410802148160

National Center for Children in Poverty (2011). *United States early childhood profile*. Retrieved from http://www.nccp.org/profiles/US_profile_16.html

National Center of Children in Poverty (2012). *Basic facts about low-income children: Children under age 6*. Retrieved from http://nccp.org/publications/pub_896.html.

Peisner-Feinberg, E. S., Burchinal, M. R., Clifford, R. M., Yazejian, N., Culkin, M. L., Zelazo, J., Howes, C., Byler, P., Kagen, S.L., & Rustici, J. (1999). The children of the cost, quality, and outcomes study go to school technical report: Executive Summary. Chapel Hill: University of North Carolina at Chapel Hill, Frank Porter Child Development

Center.

Pianta, R.C. (1999). *Enhancing relationships between children and teachers*. Washington, DC: American Psychological Association.

Post, P., McAllister, M., Sheely, A., Hess, K., & Flowers, C. (2004). Child-centered kinder training for teachers of pre-school children deemed at-risk. *International Journal of Play Therapy, 13*, 53-74.

President's New Freedom Commission on Mental Health. (2003). *Achieving the promise: Transforming mental health care in America final report* (DHHS Publication N. SMA-03-3832). Rockville, MD: Department of Health and Human Services.

Ray, D. (2007). Two counseling interventions to reduce teacher-child relationship stress. *Professional School Counseling, 10*(4)*,* 428-440.

Ray, D., & Beam, K. (2000, April). *RELATe: Relationship enhancement for learner and teacher.* Texas Association for Play Therapy 7th annual conference. Austin, Texas.

Ray, D. C., Blanco, P. J., Sullivan, J. M., & Holliman, R. (2009). An exploratory study of child centered play therapy with aggressive children. *International Journal of Play Therapy, 18(*3*)*, 162-175.

Ray, D., Muro, J., & Schumann, B. (2004). Play therapy in the schools: Lessons learned. *International Journal of Play Therapy, 13*, 79-100.

Ray, D., Schottelkorb, A., & Tsai, M. (2007). Play therapy with children exhibiting symptoms of attention deficit hyperactivity disorder. *International Journal of Play Therapy, 16*(2)*,* 95-111. doi: 1555-6824/07

Schottelkorb, A. A. & Ray, D. (2009). ADHD symptom reduction in elementary students: A single-case effectiveness design. *Professional School Counseling*, *13*(1), 11-22.

Serna, L. A., Nielsen, E., Mattern, N., & Forness, S. (2003). Primary prevention in mental health for Head Start classrooms: Partial replication with teachers as interventions. *Behavioral Disorders, 28(2)*, 124-129.

Sheely, A. (2008). *School based child parent relationship therapy (CPRT) with low income Black American parents: Effects on children's behaviors and parent-child relationship stress, a pilot study* (Doctoral dissertation). Retrieved from ProQuest Dissertations and Theses database. (UMI No. 3326822).

Sheely-Moore, A., & Bratton, S. (2010). A strengths-based parenting intervention with low income African American families. *Professional School Counseling, 13(3)*, 175-183.

Tyndall-Lind, A., Landreth, G., & Giordano, M. (2001). Intensive group play therapy with children witness of domestic violence. *International Journal of Play Therapy, 10*(1), 53-83.

Thompson, R. A., & Happoid, C. A. (2002). *The roots of school readiness in social and emotional development* (Rep. No. 1). Kansas City, MO: The Ewing Marion Kauffman Foundation.

U.S. Public Health Service. (2010). *Report of the surgeon general's conference on children's mental health: A national action agenda.* Washington, DC: U.S. Department of Health and Human Services.

Volpe, R. J., DiPerna, J. C., Hintze, J. M., & Shapiro, E. S. (2009). Observing students in classroom settings: A review of seven coding schemes. *School Psychology Review, 34*(4), 454-474.

Walker, H. M., Ramsey, E. & Gresham, R. M. (2005). *Antisocial behavior in school: Evidence based practices* (2nd ed.). Belmont,CA: Wadsworth/Thomson Learning.

Webster-Stratton, C., & Hammond, M. (1997).Treating children with early-onset conduct problems: A comparison of child and parent training interventions. *Journal of Consulting and Clinical Psychology, 65*, 93–109.

Webster-Stratton, C., & Ried, M. J. (2003). The incredible years parents, teachers, and children training services: A multifaceted treatment approach for young children with conduct problems. In A. E. Kazdin & J. R. Weisz (Eds.), *Evidence-based psychotherapies for children and adolescents* (pp. 224-240). New York, NY: Guilford.

Webster-Stratton, C., Reid, M. J., & Hammond, M. (2004). Treating children with early-onset conduct problems: Intervention outcomes for parent, child, and teacher training. *Journal of Clinical Child and Adolescent Psychology, 33(*1*)*, 105-124.

White, J., Flynt, M., & Draper, K. (1997). Kinder therapy: Teachers as therapeutic agents. *International Journal of Play Therapy, 6*, 33-49.

White, J., Flynt, M., & Jones, N. P. (1999). Kinder therapy: An Adlerian approach for training teachers to be therapeutic agents through play. *Journal of Individual Psychology, 55*, 365-382.

United States Department of Health and Human Services (2010). *Head Start impact study final report.* Retrieved from http://www.acf.hhs.gov/programs/opre/hs/impact_study/reports.pdf

Yoshikawa, H., & Knitzer, J. (1997*). Lessons from the field: Head Start mental health strategies to meet changing needs*. NY: National Center for Children in Poverty, Columbia University School of Public Health.

APPENDIX A

EXTENDED LITERATURE REVIEW

The review of literature focuses on the Head Start program and the needs of disadvantaged children, disruptive behavior, a rationale for using play therapy and filial therapy, and the importance of the teacher-child relationship.

Head Start Program

The Head Start program first began in 1965 as an initiative to provide preschool children of low-income families with a comprehensive program designed to address their social, health, emotional, nutritional, and psychological needs (Head Start Act, 1981). The overall goal was to break the cycle of poverty in American families by improving the outcomes for low-income children so they may begin school in equal standing with others from higher-income households (Lee, 2010). In 2007, the program was reauthorized by President George Bush. An addition was made to the purpose of the program, emphasizing not only the promotion of school readiness in low-income children by providing them with a variety of learning approaches, but also focusing on their social and emotional functioning (Head Start Act, 2007). To be eligible to attend a Head Start program, children must be 3 to 5 years of age and their family income must fall below the poverty line as defined by the United States Office of Management and Budget (Head Start Act, 2007). The United States has the highest level of child poverty of all industrialized nations, with more than 13 million (18%) children living in poor households in 2007 (NCCP, 2008). In 2011, nearly 22% of children under the age of six lived in households where the family income was below 100%-200% of the federal poverty level (NCCP, 2011). According to a recent report by the Administration for Children and Families (2010), the majority of children enrolled in Head Start are ethnic minorities, making up almost 60% of the Head Start population (Administration for Children and Families, 2010).

Many research studies have shown that children who grow up in economically

disadvantaged families are at risk for numerous difficulties later in life. Duncan and Brooks-Gunn(1997) found that poor children are often more at risk for academic failure, social-emotional difficulties, violence, and mental illnesses when compared to non-poor children due to the number of associated risk factors that affect their families. Duncan, Ziol-Guest, and Kalil (2010) also found that poverty and its accompanying stressors have the potential to shape the neurobiology of the developing child, leading to poorer outcomes later in life. As adults, these at- risk children are less successful in the labor market, have poorer health, and are more likely to commit crimes or become involved in problem behavior. (Duncan, Ziol-Guest, & Kalil, 2010).

Early Mental Health Needs of Disadvantaged Children

The number of young children exhibiting behavioral problems severe enough to impair academic success continues to increase at an alarming rate (Walker, Ramsey, & Gresham, 2004). The prevalence of these problematic behaviors in preschool children and school-age children is about 25% for low-income children when compared to 10% for children who are not economically disadvantaged (Webster-Stratton & Hammond, 2003). Miller, Gouley, Seifer, Dickstein, and Shields (2004) reported low-income children having higher levels of dysregulated behavior as well as having a more difficult time adjusting to the preschool classroom environment and the expectations of school. Webster-Stratton and Reid (2003) also reported that without early intervention, emotional and behavioral problems in children tend to crystallize by the age of 8. This is an indication of the significance in addressing the emotional needs of Head Start students to ensure future academic and social success.

Children who come from low-income families usually have the least stable care giving environments due to increased parental stress levels associated with living in poverty, unpredictable work schedules, and decreased availability of high quality childcare (Thompson,

1999). Additional family and community stressors including drugs and alcohol, violence, and an array of mental illnesses have a deep impact on the child's social-emotional development (Yoshikawa & Knitzer, 1997). Exposure to these stressors only further enhances the chances of behavioral and emotional problems in the future.

Although there are clear benefits in Head Start programs, they appear to place a greater emphasis on the academic and intellectual development of the students and not enough emphasis on the social-emotional difficulties that most children in Head Start face (Forness, Ramey, Ramey, Hus, Brezausek, & McMillan, 1998). The need for early mental health treatment and effective interventions for children suffering from emotional and behavioral disorders continues to increase (Bratton, 2010). The need is even greater for young children deemed at-risk for school achievement to prevent unnecessary suffering and long-term consequences that can result over time when these needs go unaddressed.

Serna, Nielsen, Mattern, and Forness (2003) agreed that the primary goal for Head Start programs should be the development of social-emotional skills. Further, Head Start is uniquely suited. As the earliest form of intervention provided on a nationwide level for children, Head Start has the potential to insure that disadvantaged children receive early intervention services and resources that will provide more opportunities for future academic and life-long success. Webster-Stratton and Reed (2003) supported this premise, emphasizing that early interventions can counteract the many risk factors faced by low income children and in turn, enhance their personal strengths. It appears that using child-teacher relationship training with at-risk children would be beneficial in reducing future problematic behaviors.

The number of children meeting the criteria for more severe behavioral disorders such as Oppositional Defiant Disorder (ODD), Conduct Disorder (CD), Attention Deficit Hyperactivity

Disorder (ADHD), and aggression continues to increase and are predictive not only of academic difficulties, but serious behavior and health difficulties throughout adolescents and onto adulthood (Webster-Stratton, & Hammond, 1998). These behavioral problems are considered disruptive to the classroom environment and not only have a negative impact on the child, but on the relationships in which the child engages.

Disruptive Behavior

Disruptive behaviors are reported as the most challenging for teachers and the classroom environment (Myers & Pianta, 2008; Ray, 2007). These behaviors create problems in the classroom and often take away from learning. Disruptive behaviors are defined as behaviors with outward momentum and are sometimes referred to as externalized behaviors. These behaviors can include irritability, intense negative reactions, anger, negative mood, aggression, rule breaking, distractibility, and an inability to adapt (Achenbach and Rescorla, 2001). Children exhibiting these less tolerable behaviors are often met with frustration by the teacher, thus impacting the quality of the teacher-child relationship (Ray, 2007). Disruptive behavior not only affects the child's relationship with the teachers, but also proves to create difficulties among peers and in the home. Further, Webster-Stratton and Reid (2003) found that these behaviors become more stable as time passes without intervention.

As discussed above, research links disruptive behavior patterns with many ongoing and long-term difficulties in personal and social development (Myers & Pianta, 2008; Ray et. al., 2007; Webster-Stratton & Reid, 2003). Children learn how to interact in a social setting through their relationships with their main caregivers and also through relationships with their peers (Myers & Pianta, 2008). Children exhibiting aggressive, unpredictable, irritable, and other disruptive behaviors often have trouble getting along with their caregivers, teachers, and their

peers, thus preventing the creation of positive relationships that are needed for further social development. These children often become isolated, increasing the likelihood of further disruptive behavior, which leads to more strain on their relationships, and thus, creating a never-ending cycle (Ray, 2007). For example, students with attention deficit hyperactivity disorder (ADHD) were found to be rated by teachers as more stressful to teach when compared to non-ADHD students (Greene, Beszterczey, Katzenstein, Park, & Goring, 2002). These findings were highly individualized based on the characteristics of both the teacher and the student, providing further evidence that the relationship is of a reciprocal nature (Greene, et.al, 2002; Ray, 2007). Pace, Mullins, Beesley, Hill, and Carson, (1999) also found that childhood emotional and behavioral adjustment problems are associated with less favorable interpersonal relationships with teachers. These researchers believed that many children become depressed or further behaviorally disturbed due to these impaired interpersonal relationships, leading to further disruptive behavior and further negative interactions with others.

Research has also found a correlation between disruptive behavior and decreased school readiness. Thompson and Happoid (2001) stated that kindergarten teachers reported that it was not the children's lack of cognitive abilities that caused the most difficulty in the classroom; but rather, it was the children's lack of motivation and social-emotional qualities necessary for school learning. In other words, children exhibiting disruptive behaviors are likely to have a hard time focusing on their schoolwork. Thompson and Happoid (2001) identified three qualities in young children that are necessary for school success: intellectual skills, motivation to learn, and social-emotional development. Children learn best under the guidance of an adult teacher balanced by the influence of their relationships with their peers. Therefore, it is imperative that children are able to understand the feelings and views of others, cooperate well with others, and

be able to experience both emotional and behavioral self-control (Thompson & Happoid, 2001). This places a child's social-emotional development as the critical point in the development of learning. Children must feel that they are in control of their emotions in order to feel good about school, build relationships with their peers and teachers, and be motivated to learn (Raver & Zigler, 2004).

Thus, preschool children identified with disruptive behaviors are at a critical developmental level for intervention. Although the Head Start Standards appear to emphasize the significance of addressing the social-emotional needs of at-risk children, research has shown that the majority of the mental health needs of Head Start's children are not being met (Yoshikawa & Knitzer, 1997; Pianta & Stuhlman, 2004; Bierman, Domitrovich, Nix, Gest, Welsh, Greenburg, Blair, Nelson, & Gill, 2008). As a result, interventions that foster social-emotional learning and improve behavioral self-regulation can strengthen cognitive development (Myers & Pianta, 2008).

Rationale for Play-based Early Mental Health Interventions

Play has long been viewed as the way children are able to communicate best and learn about themselves, others, and the world (Erickson, 1963; Vygotsky, 1966; Landreth, 2002, Ray, 2011). Play therapy is a developmentally appropriate intervention that utilizes the role of play in children's growth and development (Landreth, 2012). Young children, typically, cannot accurately communicate about abstract concepts verbally, and therefore, play therapy provides them with an opportunity to communicate using their natural form of expression, play. (Landreth, 2012). Play therapy allows children to bridge the gap between their experiences and understanding, giving them the means for problem solving, coping, mastery, and learning (Landreth, 2012). It also provides a sensitive adult the means to enter into and understand the

child's world through the unique perspective of the child. Furthermore, it allows the child an avenue by which they can experience a sense of being in control of their lives and their environment, which is an essential and significant part of the child's emotional development (Landreth, 2012).

Child-centered play therapy (CCPT) was developed from the work of Carl Rogers, who placed great emphasis on the therapeutic relationship in the person-centered therapy approach (Rogers, 1951). Carl Rogers believed that each individual has an innate motivation towards growth and self-actualization, and by providing a therapeutic environment that emphasizes acceptance, each is capable of meeting their own needs (Rogers, 1951). Virginia Axline (1974) applied this philosophy to working with children in play therapy. Axline (1974) identified eight principles that guide the therapist in child-centered play therapy and facilitate the child's process towards self-actualization and acceptance. These principles include: developing a warm and caring relationship with the child, accepting the child unconditionally, establishing a feeling of permissiveness in the relationship which allows the child to feel free to express self, recognizing and reflecting the feelings of the child to create understanding ,respecting the child's innate ability to solve his or her own problems and offering the opportunity to return responsibility to the child, not attempting to direct the child's actions or conversation, but allowing the child to lead the way, recognizing the nature of the child's process and not attempting to rush it in anyway, and establishing only those limitations that are necessary to anchor the child's counseling to the world of reality.

Landreth (2002) further advanced the development of child-centered play therapy, expanding on the principles of Axline and further explaining the essential skills for developing a therapeutic environment. Today, CCPT is a widely used and effective modality for working with

young children (Tsai & Ray, 2011;Dougherty & Ray, 2007; Bratton, Ray, Rhine, & Jones, 2005).

Play Therapy in the Schools

Play therapy has been successfully utilized in the school environment and recent research has attempted to demonstrate the effectiveness of school-based play therapy for children referred by teachers or parents because of disruptive behavior (Bratton, 2010; Ray, et.al ,2007). Ray et. al (2007) utilized CCPT with sixty elementary school age children who qualified as symptomatic of attention deficit/hyperactivity disorder (ADHD). The children were assigned randomly to two treatment condition groups: CCPT or reading mentoring (RM). All children participated in 16 individual 30-min sessions in the schools. The children who participated in 16 sessions of CCPT demonstrated a statistically significant decrease in ADHD and anxiety/withdrawal symptoms. Of the children participating in the CCPT group, they exhibited statistically significantly fewer problems in the areas of emotional instability, anxiety, and withdrawal, as well as overall problem student characteristics. Similar studies have also found an improvement in teacher-child relationships as reported by the teacher (Morrison & Bratton, 2010; Ray, Blanco, Sullivan, & Holliman, 2009). Several other researchers have found school based CCPT and nondirective interventions to be successful with a variety of other emotional and behavioral concerns (Garza & Bratton 2005; Fall, Navelski, & Welch, 2002; Smith & Blanco, 2006; Helker & Ray, 2009). Play therapy has also been successful with other areas of concern including anxiety (Shen, 2002), external locus of control (Post, 1999); development (Baggerly & Jenkins, 2009; Dougherty & Ray, 2007), and academic achievement (Blanco & Ray, 2010).

Play therapy has been found useful with different cultural groups as well. Garza and Bratton (2005) utilized CCPT with a group of 29 Hispanic children referred to school counseling

due to behavioral problems. The children were randomly assigned to the CCPT treatment group or a curriculum-based small group intervention. Treatment was provided by Hispanic bilingual counselors. The results showed statistically significant decreases in externalizing behavior problems in the children who received CCPT as reported by the parents.

Shen (2002) also investigated the effectiveness of short-term and long-term CCPT with child victims of 1999 Chinese earthquakes. Shen utilized a pretest-posttest control group design with 30 elementary school students. The group receiving CCPT when compared to the no-treatment group had a statistically significant reduction in anxiety levels.

Children receiving CCPT in the schools have also been found to demonstrate an increase in academic performance. Blanco and Ray (2010) reported that children identified as at-risk of academic failure were able to produce statically significant improvements on academic achievement scores and reported an increase in self-concept after receiving 14 CCPT sessions when compared to children not receiving CCPT.

In a meta-analysis of 93 play therapy outcome studies, Bratton et al. (2005) concluded that play therapy is an effective intervention for children with a range of age groups, backgrounds, and reasons for referral. The meta-analysis had a moderate to large treatment effect. However, the most interesting findings were the larger effect sizes from outcome studies utilizing parents and caregivers in the play therapy interventions (ES = 1.15) when compared to the utilization of a mental health professional (ES = .72). This indicates the significant impact that both parents and teachers have on the child's emotional development, especially when involved in the child's therapy.

Play Therapy with Caregivers

More and more research shows the impact of caregiver involvement in the social-emotional development of children. The field of play therapy has an extensive history in involving caregivers in the child's therapy. Bernard and Louise Guerney were pioneers in the concept of parent-child relationship therapy and developed a formal model for training parents in basic play therapy skills to use with their children (Guerney, 1964). Their approach was based on the principles and procedures of CCPT. This approach has a foundation in the belief that only through a caring relationship that is characterized by unconditional acceptance, empathy, and appreciation, can children truly heal. The Guerney's believed that parents could act as therapeutic agents by utilizing these beliefs with the proper knowledge and skills. They coined the approach *filial therapy*, believing that training parents in more developmentally appropriate ways in which to relate to their children would facilitate longer-lasting changes in the child.

CPRT

VanFleet (1994), a former student of the Guerneys, developed a filial therapy model which divided the process into three phases: An early phase containing assessments, a middle phase which involved training and transfer of the sessions into the home, and a closing phase, which included generalizing the skills throughout therapy and post-measures. Also building on the work of the Guerneys, Landreth (1991, 2002), developed a more structured and condensed 10-session filial therapy training format. In an effort to make filial therapy more reasonable for the lives of parents, Landreth and Bratton (2006) developed a 10-session model, utilizing didactic teaching, group process, at-home sessions, videotaped or live supervision, role-playing, and demonstrations. This model was called child-parent relationship training (CPRT; Landreth & Bratton, 2006). During child-parent relationship therapy (CPRT) the parents learn basic child-

centered play therapy skills and conduct weekly 30-minute play sessions with their children, with the goal of strengthening the parent-child relationship. The CPRT foundation is also based on the basic CCPT principles. The CPRT model was then manualized by Bratton, Landreth, Kellam, and Blackard (2006) to allow the accessibility for other mental health professionals and an ability to use it in research studies, to ensure the model's effectiveness.

There have been a total of 32 controlled-outcome studies involving 916 subjects investigating the effectiveness of all filial therapy with results reporting it as a viable early mental health intervention (Bratton, Landreth & Lin, 2010). These results were further analyzed following the meta-analysis conducted by Bratton, Ray, Rhine, and Jones (2005) in an effort to examine the overall treatment effect of filial therapy studies utilizing the CPRT methodology. Bratton et al. (2010) calculated an overall effect size of 1.25 for filial studies, and more specifically, a strong ES of 1.30 for studies only involving parents. These findings are an indication of the strength of filial therapy as an effective modality in treating children. Many other studies have found CPRT effective with multiple populations and cultures (Bratton & Landreth, 1995; Chau & Landreth; Jang, 2000; Tyndall-Lind, Landreth & Giordano, 2001; Landreth and Lobaugh, 2003; Smith & Landreth, 2003; Sheeley-Moore & Ceballos, 2011; Ceballos & Bratton, 2010).

The Significant Roles of Teachers

Teachers play an important role in the life of a child. The relationships between children and adults influence the development of a range of skills and competencies in the preschool and early school age years (Birch & Ladd, 1996; Pianta, 1997; Pianta & Walsh; 1996; Myers & Pianta, 2008). Specifically, the quality of teacher-child relationships and its effects on students' behavior, social-emotional development, and academic success has been the focus of many

recent research studies. Young children develop a sense of the world around them, of self, and other people based on the interactions they have with significant adults in their lives, such as parent, caregivers, and teachers (Thompson & Happoid, 2001). The way these adults respond to the child during times of strong emotional reactions deeply impacts the child's ability to regulate self-control. Therefore, training teachers to respond more therapeutically to the emotional reactions of the children in their classroom can be extremely beneficial to the child's social-emotional development.

Teacher-Child Relationship

Pianta (1999) discussed the effects of inadequate attachment with a significant adult in early childhood, stating these attachments can cause notable difficulties as children develop and also place children at-risk for many other difficulties. Often times, children can form strong relationships with their teachers. Nurturing teachers can meet many of the same emotional needs of children that their own parents provide and are able to function as attachment figures in the lives of children (Perry, 2001; Howes & Bowman, 2002). Due to the uniqueness of the classroom environment and the high degree of relational processes that occur, the teacher-child relationship is extremely significant (Pianta, 1999).

Birch and Ladd (1997) followed 206 kindergarten students and their 16 teachers as part of a research study evaluating the impact of the teacher-child relationship on the child's adjustment to schools and three distinct features of the teacher-child relationship (closeness, dependency, and conflict). Results indicated a correlation between dependency in the teacher-child relationship and school adjustment difficulties, which included poorer academic performance, more negative school attitudes, and less positive engagement with the school environment. Further, teacher-rated conflict was found to be associated with the teachers'

ratings of children's school liking, school avoidance, self-directedness, and cooperative participation in the classroom. On the other hand, close teacher-child relationships were associated with positive school adjustment and academic achievement.

Birch and Ladd (1998) further examined children's interpersonal behaviors and identified three types of interpersonal behaviors that children may exhibit: Moving "towards" others (e.g. social behaviors), moving "against" others (e.g. antisocial behaviors), and moving "away" from others (e.g. asocial behaviors). Children exhibiting social behaviors appeared to have relationships with the teacher that showed the child felt connected. Open communication and warmth characterized the relationship experience each child felt with his or her teacher. These children were more able to take risks and were more successful academically and emotionally. Children exhibiting antisocial behavior tended to form relationships characterized by high levels of conflict, lacks of rapport, and harsh interactions. These conflicted relationships had a low level of closeness and challenged the teachers' classroom management style. Children often did not view this relationship as a source of support and therefore had a more difficult time feeling comfortable in the learning environment. Children exhibiting asocial behaviors either had a more dependent or withdrawn relationship with their teachers. Those characterized by more dependence required more supervision and guidance from the teachers (Birch & Ladd, 1997).

Hamre and Pianta (2001) followed 179 children in kindergarten through eighth grade and found that the quality of early teacher-child relationships predicted several school outcomes including behavior problems and academic achievement. The results indicate the significance of early teacher-child relationships on children's behavior and adjustment in their later years of school.

Hughes, Cavell, and Jackson (1999) investigated the contribution of the quality of the

teacher-child relationship to changes in the child's level of aggression. The results indicated a correlation between the quality of the child-teacher relationship and the child's behavior. Further, children who were considered at-risk for relationship and attachment difficulties benefited more from a high-quality teacher-child relationship. The study demonstrates the significance of a strong-positive teacher-child relationship, specifically for students who may be more at risk for significant behavior difficulties, such as aggression.

Kinder Therapy

Further research has been developed utilizing models, which emphasize caregiver involvement, specifically with teachers. Kinder training was developed by White, Flynt, and Draper (1997) as a consultation model for training teachers using didactic skills, practice sessions, and supervisory support. The model was based on Guerney's (1964) filial therapy model and also utilized Adler's (1983) theory of individual psychology. Teachers were also taught to understand the child's lifestyle, social interest, and use encouragement, all premises of Alder's theory, to enhance the teacher-child relationship (White, Draper, Flynt, & Jones, 2000; Draper, White, O'Shaughnessey, & Flynt, 2001). Their work focused on using play therapy training helping teachers transfer play therapy skills into the classroom environment.

Edwards, Varjas, White, and Stokes (2009) utilized a qualitative approach to understand the effects of Kinder training with kindergarten, first, and second grade teachers. Using semi-structured interviews, supervision of teacher-child play sessions, and reflexive journaling, Edwards et al. (2009) found the model to be beneficial to the teacher-child relationship. Many research studies on kinder training have showed improved classroom interactions between the teachers and the students, as well as improved academic skills and student behaviors (White, Flynt, & Jones, 1999; Peisner-Feinberg, Culkin, Howes, & Kagen, 1999; Draper, White,

O'Shaughnessey, & Flynt, 2001; Post, McAllister, Sheely, & Hess, 2004). This model further emphasizes the importance of the caregivers, specifically teachers, in the lives of children and the impact they have on a child's social-emotional development.

RELATe

A more recent model, developed for working with teachers is relationship enhancement for learner and teacher (RELATe; Ray, personal communication). This model is based on child-centered play therapy principles and was developed to assist teaches in increasing interpersonal skills to build positive relationships with children (Carlson & Ray, in review). The intervention includes four components: a 3-hour educational module, play sessions between teachers and children of focus, live supervision by experienced play therapists, and feedback between the teacher and the supervisor. This model was targeted for elementary schools. Ray, Muro, and Schumann (2004) and Ray and Beam (2000) conducted pilot studies revealing the effectiveness of RELATe with teachers. Carlson and Ray (in review) conducted a study integrating three models of play based teacher-consultations (PBTC): CTRT, RELATe, and kinder training and found overall positive effects, with increases in the responsiveness and positive teacher-child relationships in over half of the teacher participants and decreases in criticism with all teachers.

CTRT

The quality of the teacher-child relationship has been linked to children's social-emotional development and academic success (Hamre & Pianta, 2001). Thus, the importance of enhancing teachers' abilities in relating to children, especially those more at-risk for future behavioral and academic problems, cannot be stressed enough. Morrison and Bratton (2010) conducted a preliminary investigation, adapting the CPRT model to train teachers to use play therapy skills in the classroom. They coined the training *Child Teacher Relationship Training*

(CTRT; Bratton, Landreth, Morrison, & Helkner, in review). The overall goal of CTRT was to train teachers and aides in relationship enhancement skills, enabling them to become more sensitive, understanding, and responsive to the needs of their children. 24 Head Start teachers and aides were randomly selected and received training in CTRT protocol, conducted seven 30-minute play sessions with a child of focus identified with behavioral problems, and received weekly supervision from a trained play therapist. The skills were then modeled in the classroom setting for 10-weeks. The results of the study yielded a statically significant relationship between the teachers' use of the CTRT skills in the classroom and a decrease in students' externalizing behavior, thus showing CTRT to be an effective intervention with the Head Start population (Morrison & Bratton, 2010).

In a companion study to Morrison and Bratton (2010), Helker and Ray (2009) also examined the impact of CTRT on educators' use of relationship-building skills in the classroom and the effect on student behavior with 24 teacher-aide dyads and 32 children identified by teachers as having behavioral problems. Children receiving CTRT demonstrated a significant decrease in externalizing behaviors when compared to the active control group. A statistically significant relationship was also found between educators' higher use of relationship building skills and the students' decrease in externalizing behaviors.

Summary of Literature

Head Start is the largest intervention program in the United States for at-risk, disadvantaged children. The number of children with unmet, mental health issues continues to grow. The home environments of the children attending head can have a negative impact on the child's social-emotional development as well as school readiness. A high number of children exhibiting disruptive behaviors are being reported by this population and create problems within

the classroom environment. These behaviors make it difficult to form strong, positive, teacher-child relationships, which are detrimental to the future academic and social success for these children. Teachers often do not have the resources to deal with these issues in the classroom and often do not know how to respond efficiently to children exhibiting these behaviors. If untreated, these behaviors will persist and increase throughout the years, placing a continuous strain on future teacher-child relationship, thus perpetuating a never-ending cycle. Training teachers to respond more appropriately and attend to the emotional needs of the children can be beneficial to both the child and the teacher. Play therapy and filial therapy have both been proven to be developmentally appropriate interventions for responding to the social-emotional needs of children. CTRT has also been found in preliminary investigations, to enhance the teacher-child relationship and decrease externalizing behaviors. Further investigation of the effectiveness of CTRT on disruptive behaviors offers many significant benefits to disadvantaged children exhibiting disruptive behaviors.

APPENDIX B

DETAILED METHODOLOGY

Using a repeated measures active control group design and 3 points of measurement (pretest, midtest, and posttest), this experimental study examined the effects of child teacher relationship training (CTRT) on disruptive behavior for disadvantaged preschool children enrolled in a Head Start program. CTRT is based on the principles and procedures of child parent relationship therapy (CPRT, Landreth & Bratton, 2006), which is a time-limited filial therapy model based on the principles and procedures of child-centered play therapy (CCPT). The CPRT protocol and manual (Bratton, Landreth, Kellam, & Blackard, 2006) was modified by Bratton, Landreth, Morrison, and Helker (in progress) and named child teacher relationship training for the use with teachers. Definition of terms, hypothesis, instrumentation, participant selection, treatment, and analysis of the data are included in this chapter.

Definition of Terms

For the purpose of this study, the following terms have been operationally defined below.

Child-centered play therapy (CCPT): Child-centered play therapy is defined as "a dynamic interpersonal relationship between a child (or person of any age) and a therapist trained in play therapy procedures who provides selected play materials and facilitates the development of a safe relationship for the child (or person of any age) to fully express and explore self (feelings, thoughts, experiences, and behaviors) through play, the child's natural medium of communication, for optimal growth and development " (Landreth, 2002, p. 16).

Child parent relationship therapy (CPRT): Parents are taught the basic child-centered play therapy (CCPT) skills, principles, and techniques which include reflective listening, recognizing and responding to children's feelings, therapeutic limit setting, self-esteem building and encouragement, and structuring weekly play sessions with their children using a special kit of selected toys (Landreth & Bratton, 2006, p. 11).

Child Teacher Relationship Training (CTRT): This treatment was utilized as the experimental group treatment and was adapted from the CPRT structure and curriculum using the protocol and training materials included in the *Child Parent Relationship Therapy* (CPRT) *Treatment Manual* (Bratton, Landreth, Kellan, & Blackard, 2006). The protocol was modified to accommodate the teacher/child relationship, the classroom environment, and the school schedule. In the adapted model, the teachers and aides were trained and supervised in Child Teacher Relationship Therapy during two phases of training. During the first phase of treatment, the teachers and aides participated in 7-training/supervision play sessions consistent with the principles and procedures of CTRT, which included 7 weeks of supervised one-on-one play sessions with a teacher-selected child of focus. The second phase of treatment consisted of the teachers and aides participating in 10 weeks of coaching/modeling in their classrooms to incorporate CTRT skills into the classroom environment, along with weekly training/supervision group sessions.

Child of focus: The child chosen by the teacher or the aide with whom to conduct seven weekly 30-minute recorded play sessions. This child was chosen by the teacher or aide from the group of children who qualified for participation in the study based on the Borderline or Clinical range scores on the C-TRF Externalizing. Teachers and aides were instructed to select a child that they believed would benefit the most from the training. The child of focus was chosen based on the teacher's perception of the child as exhibiting disruptive behavior in the classroom and behavioral or emotional difficulties.

Head Start program: A federally funded early childhood program for children ages 3 to 5 years of age who come from low-income families that are at or below the poverty line. The program is designed to provide health, education, social services, and parent-community

involvement for children and their families (Head Start Act, 1981).

Head Start teacher: Educators who are degreed and certified by the Texas Education Agency in Early Childhood Education.

Head Start aide: Educators hired to assist certified teachers in classroom instruction.

Disruptive behavior: Disruptive behaviors are outward manifestations of an inner conflict, including rule breaking behaviors, aggressive behaviors, conduct problems, oppositional behaviors, inattention, hyperactivity, immaturity, and attention seeking (Achenbach & Rescorla, 2001; McConaughy & Achenbach, 2009). For the purposes of this study, disruptive behavior in the classroom was of specific interest and was operationally defined by children's scores on (a) the Externalizing Problems subscale score of the Caregiver-Teacher Report Form (CTRF) as reported by teachers (Achenbach & Rescorla, 2001), and (b) the Total Problems scores on the Direct Observation Form (DOF) as rated by independent observers (McConaughy & Achenbach, 2009).

Research Questions

For the purpose of this study, the following research questions were formulated to investigate the effects of (a) the experimental treatment (CTRT) on Head Start students identified with disruptive behavior in the classroom, when compared to the active control treatment, Conscious Discipline.

1. Will children in the experimental treatment group demonstrate a significant decrease in disruptive behaviors in pre- to mid- to post-test mean scores on the CTRF Externalizing Problems scale compared to the students in the active control group, as reported by teachers?

2. Will children in the experimental treatment group demonstrate a significant

decrease in disruptive behaviors in pre- to mid- to post-test mean scores on the DOF Total Behaviors scale compared to students in the active control group, as reported by independent raters blinded to the study?

Instrumentation

Two instruments were used to obtain data for the purposes of this study: The Caregiver-Teacher Report Form (C-TRF) and the Direct Observation Form (DOF). Both of these instruments measure the same types of disruptive behavior but utilize two different sources of measurements. Teachers' observations of behavioral changes were utilized with the C-TRF and the observations of blinded raters, whom were both blinded to the teachers and the children in the study, were utilized with the DOF.

Teacher Report Form

The Child Behavior Checklist (CBCL) has a Caregiver-Teacher Report Form (C-TRF) that is designed for the caregiver or teacher of a child within the age range of 1½ to 5 years old. The C-TRF has 99 specific problem items that respondents' rate on a Likert scale of 0-2 indicating; *not true* (0), *sometimes true* (1), or *very true* (2). An open-ended item is also included to list other problems observed by the caregivers. The entire assessment takes approximately 15 minutes to complete. Classroom teachers completed the C-TRF on each student from their classroom participating in the study. There are eight syndrome scales, six DSM-oriented scales, and composite scales on the C-TRF, which included the Internalizing Problems scale, the Externalizing Problems scale, and the Total Problems scale. A reduction in scores indicates improvement in the targeted behavior (Achenbach & Rescorla, 2000). The Externalizing Problems scale was utilized for the purposes of this study.

The C-TRF has been used in numerous research studies to evaluate the effects of play

based interventions with parents (Ceballos & Bratton, 2010; Sheely-Moore & Bratton, 2010), with teachers (Morrison & Bratton, 2010; Helker & Ray, 2009), in the Head Start setting (Morrison & Bratton, 2010; Helker & Ray, 2009; Bratton, Ceballos, Sheely-Moore, Meany-Walen, & Pronchenko, in review) and in studies examining the effects of play therapy as an effective intervention for children (Meany-Walen &Bratton, in review; Schottelkorb & Ray, 2009). The overall mean test-retest reliability score was established at .81 and the scaled scores were stable (Achenbach & Rescorla, 2000). Achenbach and Rescorla (2001) reported internal consistency for the C-TRF: an alpha of .90 for the Total Adaptive scale; for the problem scales, alphas of .72 to .95; and for the DSM-oriented scales, alphas ranging from .73 to .94. In more than 6000 studies, strong validity evidence for the C-TRF has been well established (Achenbach & Rescorla, 2000). For the purposes of this study, the C-TRF was used at pretest to qualify children, and again at midpoint and posttest to examine treatment effects.

Direct Observation Form.

The Direct Observation Form (DOF) is an instrument used to assess student's behavior during a 10-minute period of time using standardized observations (McConaughy & Achenbach, 2009). An examiner, trained to use the instrument, observes an identified child within a natural setting such as the classroom, group, lunch, or recess time. In one-minute intervals, the observer tracks on-task and off-task behavior and writes a description of the child's behavior. After each observation, the examiner immediately completes an 89-item problem checklist, ranking the witnessed behavior on a scale of 0 (*behavior not observed*) to 3 (*definite occurrence with severe intensity or occurrence lasting more than 3 minutes in duration*). DOF procedures require a minimum of 2 observations and within an observation set to obtain a single score on an individual child. The DOF scoring software allows for computation of a child's average scores.

The DOF provides scores in Total Problems scale, On-task scale, and six syndrome subscales: Withdrawn/Inattentive, Nervous/Obsessive, Depressed, Hyperactive/Attention, Demanding, and Aggressive. A sample of 649 children between the ages of 6-11 years who were clinically referred for evaluations based on their behavioral, emotional, or learning difficulties, were used to develop the 2009 version of the DOF (McConaughy & Achenbach, 2009). During a personal communication with Thomas Achenbach, it was verified that the use of the DOF with preschool children was appropriate (T. Achenbach, personal communication, September 20, 2010). The DOF was normed from a sample of 661 children from 4 different states (New York, Arizona, Vermont, and Pennsylvania) to represent a broad range of United States' geography.

McConaughy and Achenbach (2009) reported that validity of the DOF was evaluated and established. The DOF was designed to be used separately or in combination with the Child Behavior Checklist (CBCL) and/or the C-TRF (Achenbach & Rescorla, 2001; McConaughy & Achenbach, 2009). For the purposes of this study, DOF observations of children participating in the study from both the experimental group and the active control group were made by blind observers at pre-, mid-, and post testing. Observed children consisted of children participating in the study and non-participants in the study, thus the raters were blind not only to the teachers but also to the children.

Participant Selection

The study was conducted in a Head Start Center located in the southwestern United States. Prior to the start of the school year, meetings were held with the school staff and the principal of the Head Start center to discuss the benefits of improving the child-teacher relationship and how this will potentially have a positive affect on the behavior, specifically

disruptive behavior, of the children in the classroom. The principal and all the teachers/classroom aides of the Head Start Center expressed interest in participating in the project and the teachers participated in one of two teacher development programs designed to improve the teacher-child relationship. Human subjects approval was obtained from the University of North Texas Internal Review Board (IRB) before potential child subjects were contacted. Ethical research responsibilities included in the American Counseling Association Code of Ethics (2005), Section G, was followed including informed consent, confidentiality, and reporting results. No participant was excluded from the study based on race, ethnicity, gender, religious beliefs, or social class.

A priori power analysis using G*Power software determined that a minimum sample of 12 participants would be necessary to find a statistical difference between groups over three points of measurement (pre to mid to post). G*Power calculation was based on alpha level .05, minimum power established at .80, and a large treatment effect size (f = .40) based on Cohen's (1992) guidelines.

The study began with 24 teachers and 22 children. One teacher was dropped from the study due to a family crisis. Of the 22 children, one was dropped due to geographic relocation, and one was dropped due to his teacher being dropped from the study. A total of 23 teachers/aides and 20 children participated in the study. Dropouts' and completers' demographics and data were examined to determine any differences that might impact the outcomes. No differences in completers and non-completers were detected.

Teacher Participants

All Head Start classroom teachers (n = 12) and their aides (n = 12) consented to participate in the study (N = 24). The teacher/aide pairs were randomly drawn and assigned to

either the experimental or active control group. The groups were examined to ensure equality among the groups. One teacher from the experimental group was dropped from the study due to an unexpected family crisis that resulted in excessive absences. A total of 23 teachers and aides, consisting of 11 teachers and 12 aides in the experimental group and 12 teachers and 12 aides in the control group, participated in the research study in its entirety. Tables B.1 and B.2 presents demographic information and the amount of teaching experience and education of the participating teachers and classroom aides. Information in Tables 1 and 2 was obtained from a demographic information sheet completed by each teacher.

Table B.1

Demographics of Teachers and Aides in the Research Study (n = 23)

	Experimental CTRT group (n = 11)		Control Conscious Discipline Group (n = 12)	
	Teachers	Aides	Teachers	Aides
Gender				
Males	0	0	1	0
Females	5	6	5	6
Average Age	37	41.8	29	42.5
Ethnicity				
Hispanic	3	4	3	3
Black American	0	2	1	2
White/Caucasian	2	0	2	1

Table B.2

Education and Certification and Years of Teaching Experience for Teachers and Aides in the Research Study (n = 23)

	Experimental CTRT group (n = 11)		Control Conscious Discipline group (n = 12)	
	Teachers	Aides	Teachers	Aides
Average years of teaching in Head Start	6.4	8.3	4.5	9.3
Education				
High school diploma only	0	2	0	1
Some college	0	3	0	4
Bachelor's degree	2	0	5	1
Graduate degree or higher	3	0	1	0
Certification level				
Early Childhood Education EC_4	4	0	5	0
Bilingual Generalist	3	2	2	0
EC-4 Child Development Associate	1	4	0	4

Child Participants

Teachers were asked to identify and refer children who exhibited disruptive behaviors such as rule breaking, conduct problems, oppositional behaviors, yelling, attention seeking, immaturity, hyperactive behaviors, swearing, aggression, fighting, or crying. Upon receiving these referrals, consent forms were sent home with the referred students. Teachers identified students whose families needed an English Version or a Spanish version of the consent form. Following the receipt of parental consent for each child, the C-TRF was administered to the

classroom teachers in order to qualify children to the study. Children were then selected to participate based on the following criteria:

1. Children enrolled in the chosen Head Start program

2. Children who are not labeled with significant cognitive delay as determined by special classroom placement.

3. Children referred for disruptive behavior by classroom teacher.

4. Teacher agreed to participate in the study by attending the CTRT or the Conscious Discipline training, completing the C-TRF, and permitting observers in the classroom.

5. Parent consented for child to participate in the study.

6. Children who score in the borderline or clinical range on at least one of the following as an indicator of target behavior (disruptive behaviors in the classroom): the C-TRF Externalizing Problems subscale, or on one of the following C-TRF subscales: Attention Problems, Aggressive Behavior, ADHD, Oppositional Defiant Problems, or Conduct Problems.

Following the identification of the students who qualified for the study, the teachers were asked to select a "child of focus" from the group of children. Teachers were instructed to select a child whom they felt could benefit the most from the intervention.

Children's treatment group assignment was based on their teachers' assignment to the experimental or active control group. The "children of focus" are the children who qualified for the study based on the above requirements and were chosen by either the teacher or the aide to participate in the 30-minute play sessions with those in the experimental group. A total of 22 children qualified and were chosen as "children of focus" by the teachers and aides in the study. One student was withdrawn from the school and was dropped from the study. Due to a teacher being withdrawn from the study, the teacher's child of focus was also withdrawn from the study.

Due to one child moving before midpoint DOF data could be obtained, DOF data for this child was not used in the study, limiting the DOF data to 19 children (10 experimental, 9 control). A total of 20 children completed the study. Table B.3 presents demographic information on the children involved in the study.

Table B.3

Demographics of Children in the Research Study (n = 20)

		Experimental CTRT group (n = 11)	Control Conscious Discipline Group (n = 9)
Gender			
Males		9	6
Females		2	3
Average Age	3-5	3.63	3.88
Ethnicity			
Hispanic		7	5
Black American		3	3
White/Caucasian		1	1

Treatment

Experimental teachers and aides (n = 11) received CTRT; the active control group (n = 12) received Conscious Discipline training (Bailey, 2000). The programs were chosen for this study and adopted by the participating school based on the similar philosophies of promoting healthy child-teacher relationships that foster students' optimal social-emotional and cognitive development.

Experimental Group Treatment

The 5 teachers and 6 aides in the experimental group (n = 11) participated in training, supervision, and coaching the CTRT protocol (Bratton et. al., in press) to learn more effective ways of responding to the behavioral and emotional needs of children. CTRT is an adapted model of CPRT (Landreth & Bratton, 2006). The *Child Parent Relationship Therapy* (CPRT) *Treatment Manual* (Bratton et al., 2006) was adapted to accommodate the teacher-child relationship and the school setting (Morrison & Bratton, 2010). The goal of CTRT is to train the teachers and aides in relationship building skills that help them to become more sensitive to, understanding of, and responsive to the needs of their students.

The CTRT treatment was conducted over two phases of training. Phase I focused on the basic CTRT skill application with one child, and Phase II focused on the integration and application of skills in the classroom environment. Two advanced doctoral students who have advanced training and supervised experience in play therapy and CPRT methodology facilitated the training, supervision, and coaching. Treatment integrity was ensured through the use of the CTRT protocol and ongoing supervision and consultation with an expert in CPRT.

During Phase I, the teachers and aides learned and practiced core CTRT principles and skills which include structuring, reflective listening and responding, which included recognizing and responding to children's feelings, therapeutic limit setting, building children's self-esteem, facilitating creativity/spontaneity, facilitating decision making, and returning responsibility. Phase I training content was equivalent to the material covered in the CPRT 10-session protocol (Bratton et al., 2006). The training format included 2 full days of intensive didactic instruction and experimental activities (approximately 14 hours equivalent to the content covered in the first five sessions in the CPRT manual), followed by 7 weeks of 1-hour group training/supervision

meetings during which the remainder of CTRT material was covered. The teacher-aide pairs were divided into two groups of three pairs for the weekly meetings to promote interaction and more individualized attention.

To further enhance the mastery of the CTRT skills, each teacher and aide selected a "child of focus" from their classroom and conducted weekly 30-minute recorded play sessions over 7 weeks. These one-on-one play sessions were held in a designated room equipped with the prescribed toys and materials as described in the CPRT manual (Bratton et al., 2006). During the weekly meetings, the teachers and aides received constructive feedback during the supervision of their recorded play sessions. To ensure successful learning and application of their new skills during Phase I, teachers and aides were instructed not to practice skills outside of their 30-minute play times.

Phase II training began immediately after Phase I and included 10 weeks of in-class coaching. To provide consistency and establish a routine structure for implementing the CTRT skills, the daily *center* time (a block of time scheduled for the children's self-directed play) was designated child teacher relationship (CTR)-time. I and the other advanced doctoral student who provided the training during Phase I modeled the CTRT skills in the classroom during this time. Didactic instruction and role-playing in more advanced skills, including skills to be used in both one-on-one situations and with small groups of children, were the focus of supervision in CTRT Phase II. The in-class coaching took place 3 times a week for 30 minutes each for a total of 90 minutes of in-class training time each week per teaching team. Teacher-aide pairs took turns (15 minutes each) participating in CTR-time during the 30-minute coaching block. This enabled one partner to focus on the CTRT skills with a small group of children while the other teacher partner focused on general classroom management. Hour long weekly supervision continued during the

10 weeks of this treatment phase. This took place once a week during the teacher's daily planning period, which occurred after the children's dismissal from school.

Active Control Treatment

Conscious Discipline (Bailey, 2000) is a widely used early childhood teacher training program that focuses on classroom management skills designed to help teachers and aides respond to young children in more positive ways by improving the teacher-child relationship, enhancing children's social-emotional development, and building character. An expert in the field of counseling, a designated Conscious Discipline trainer, who holds a doctoral degree in counseling, conducted the training for the active control group. Teachers and aides selected for the active control group (n = 12) received training in the Conscious Discipline approach. Consistent with Conscious Discipline curriculum, the teachers and aides received training for one full day prior to school beginning (approximately 7 hours) and met periodically throughout the study to receive further training and support in implementing Conscious Discipline program into their classrooms. Conscious Discipline training included Conscious Discipline DVDs (Bailey, 2004) and readings from *Conscious Discipline: 7 Basic Skills for Brain Smart Classroom Management* (Bailey, 2000). The teachers and aides were not directly supervised or observed to ensure the skill acquisition. The curriculum is grounded in the philosophy that schools are to be viewed as school families where children and adults learn the skills necessary to be successful in life: forming relationships, communicating effectively, and developing the abilities to be empathetic with others, to communicate feelings directly, and resolve conflicts in constructive ways. These were the major skills of focus. Additionally, teachers were taught to be proactive rather than reactive in situations of conflict through the seven basic skills of discipline that promote inner peace for children. These skills included composure, encouragement,

assertiveness, choices, positive intent and empathy (Bailey, 2000).

While training was typical of what is traditionally received in the Conscious Discipline approach (Bailey, 2000), researchers were unable to directly control for the frequency, intensity, or integrity of the training. Thus, a decision to designate this condition as an active control group rather than a comparison treatment was made.

Data Collection

Upon receiving IRB approval, informed consent was obtained from teacher and aide subjects and from the parents of the child subjects. Spanish consent forms as well as Spanish-speaking research assistants were provided as necessary to collect the consent forms allowing the children to participate. The C-TRF was completed by the teachers for pretesting at the beginning of the school year, and children who scored in the borderline to clinical range on the C-TRF Externalizing Problems subscale, or on one of the following C-TRF subscales: Attention Problems, Aggressive Behavior, ADHD, Oppositional Defiant Problems, or Conduct Problems were selected to participate in the study. To ensure integrity of data collection, teachers were provided classroom substitutes while the teachers completed the C-TRF in a location free from distraction. A research assistant was available to answer any questions. The C-TRF was collected at midpoint testing at the conclusion of Phase I and again at post-testing at the conclusion of Phase II.

The DOF, a direct observation measure of children's disruptive behavior, was conducted to obtain the least-biased, objective observable data. To obtain the data, 4 independent raters who were undergraduate or graduate-level students who were pursuing a degree in the mental health field and had experience working with children, received training and practice in the use of the DOF until they reached an acceptable level of inter-rater reliability (.82). The inter-rater

reliability was calculated with the Spearman-Brown correction. The raters were then split into dyads and completed a minimum of 5 practice cases with randomly selected local preschool children who were not involved in the study. Rater dyads achieved an acceptable level of interrater reliability (.89 and .80)

The blinded raters were assigned study participants to observe for 10-minute intervals for three observational periods at different times of the day over a three day period to obtain a single score. The goal of observing children in a variety of school environments was to gather the most accurate account of student behavior (McConaughy & Achenbach, 2009). The blinded raters observed each participant 3 times at pretest, 3 times at midpoint, and 3 times at post-test. The computerized scoring required a minimum of 2 observations to create a single score. Therefore, each participant received a single pretest, single midpoint, and single posttest score. Because the purpose of this study was to examine treatment effects on children's classroom behavior, all observations were completed during structured, academic situations in the classroom.

Analysis of Data

Results obtained from pretest, midpoint, and posttest data were analyzed in order to examine the effects of the CTRT intervention on disruptive behavior. To ensure accuracy, the C-TRF and DOF assessments were scored using the assessment scoring computer software, which requires all data to be entered twice. For each dependent variable (C-TRF Externalizing Problems and DOF Total Behaviors) a 2(Group) by 3 (Repeated Measures) split plot ANOVA was performed in to analyze group differences, changes across times, and the possible interaction effect of group membership with change across time, which is of particular interest in this study. A repeated-measures ANOVA model is found to be one of the most effective

frameworks in which to evaluate intervention impact on individuals across time (Brown, Costigan, & Kendziora, 2008). An alpha level of .05 was established to test for statistical significance (Armstrong & Henson, 2005).

SPSS was utilized to analyze data, using a two-factor (Treatment Group x Time) repeated measures multivariate analysis on each dependent variable to determine whether the child teacher relationship training (CTRT) group and the active control group obtained different results across time (3 points of measure). The dependent variables included the C-TRF rating from the Externalizing Problem Scale and the DOF Total Behavior Scale. A reduction in scores on the C-TRF and the DOF indicated improvement in the targeted behavior.

Researchers reported on statistical, practical, and clinical significance. Therefore, with the alpha level set at .05, the researchers accepted a 5% probability that the results were because of chance and not the intervention (Rubin, 2008; Thompson, 2002). Practical significance indicates the magnitude of the treatment effect (Thompson, 2002). Effect sizes were calculated using partial eta squared (η_p^2) to determine practical significance. Effect sizes were interpreted as .01 small, .06 medium, and .14 indicating a large effect size (Cohen, 1988). Clinical significance refers to the practicality of an intervention when applied to the life of a client, or whether the intervention made a real impact in participants' lives (Thompson, 2002). The researchers reported clinical significance by reporting changes in mean externalizing behavior scores from the C-TRF, and mean Total behavior scores from the DOF for individual participants, indicating how many participants in the CTRF group went from the clinical range or borderline range of these behavior scores to a normal range, as reported by their teachers and as observed by the blinded raters.

APPENDIX C

UNABRIDGED RESULTS

This section includes the results of the study. A two-factor (Treatment Group x Time) repeated measures split plot ANOVA was performed in SPSS for each dependent variable (Caregiver-Teacher Report Form (C-TRF) Externalizing Problems, and the Direct Observation Form (DOF) Total Behavior) to determine whether the child teacher relationship training (CTRT) group and the active control group performed differently across time (3 points of measure). Prior to conducting the analysis, the dependent variables were analyzed to screen for homogeneity of variance/covariance matrices, normality, and sphericity. Assumptions for performing repeated measures ANOVA were met.

The C-TRF and the DOF were administered prior to treatment, at the conclusion of CTRT Phase I (pre-to midpoint), and at the end of CTRT Phase II (midpoint to post-test) to assess treatment effects on disruptive behavior. The dependent variables included the scores on the C-TRF Externalizing scale and the DOF Total Behavior scale. A reduction in scores on the Total Behavior scale on the DOF and the Externalizing Scale on the C-TRF indicated an improvement in the targeted behavior. Partial eta squared effect sizes (η_p^2) were calculated to assess practical significance. Cohen's (1988) guidelines were used to interpret η_p^2 effect size: .01 = small,.06 = medium, and .14 = large.

Results for Research Question 1

Children in the experimental treatment group will demonstrate a statistically significant decrease in scores on the Externalizing Problems subscale as compared to children in the active control group over time, as reported by the teachers on the C-TRF. Table C.1 presents the pre-test, midpoint, and post-test means and standard deviations for the experimental (n = 11) and active control group on the Externalizing Problems scales of the C-TRF.

Table C.1

Mean Scores on the Externalizing Problems Scales on the Child Behavior Checklist-Caregiver/Teacher Report Form(C-TRF)

	Experimental Group n=11			*Active Control Group n=9*		
	Pretest	Midpoint	Posttest	Pretest	Midpoint	Posttest
Externalizing Behavior Mean	68.909	62.4545	59.3380	66.4444	66.333	66.889
SD	9.04	8.72	6.31	7.06	9.00	11.42

Note: A decrease in mean scores indicates an improvement in behavior.

Results of analysis of the dependent variable, Externalizing Problems, revealed a statistically significant interaction effect of time (pretest, midpoint, posttest) x group membership (experimental, active control); [sphericity assumed = $F(2,17) = 3.768$, $p = .03$, $\eta_p^2 = .173$]. These results indicate that according to the teachers observation, children who received CTRT ($n = 11$) demonstrated a statistically significant decrease in disruptive behavior problems overtime, when compared to the children in the active control group ($n = 9$). The interaction effect size ($\eta_p^2 = .173$) indicates that compared to the active control group, CTRT demonstrated a large treatment effect on children's disruptive behaviors

Figure C.1 graphically displays the interaction effect of mean group differences for Externalizing Behavior over time. Group 1 represents the experimental group and Group 2 represents the active control group.

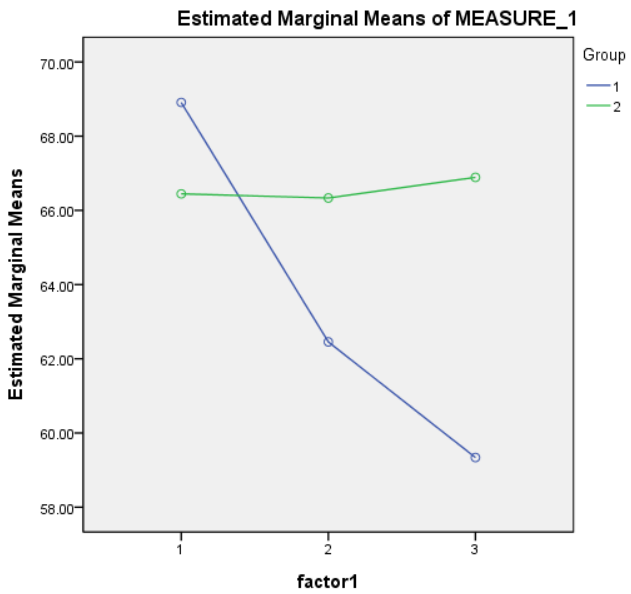

Figure C.1. Estimated marginal means of Externalizing Problems for total group.

Results for Research Question 2

Children in the experimental group will demonstrate a statistically significant decrease in scores on Total Behaviors when compared to children in the active control group on the DOF as reported by independent raters blinded to the study. Table C.1 presents the pre-test, midpoint, and post-test means and standard deviations for the experimental (n = 10) and the active control group (n = 9) on the Total Behavior scale of the DOF.

Table C.1

Mean Scores on the Total Behavior Scale on the Direct Observation Form (DOF)

	Experimental group N=10			*Active Control group N=9*		
	Pretest	Midpoint	Posttest	Pretest	Midpoint	Posttest
Externalizing Behavior Mean	69.977	50.2199	48.2516	63.5556	52.5556	54.3333
SD	7.70	10.31	5.04	7.62	8.64	7.76

Note: A decrease in mean scores indicates an improvement in behavior.

Results of analysis of the dependent variable, Total Behaviors scale, revealed a statistically significant interaction effect of time (pre-test, midpoint, post-test) x group membership (experimental, active control); [sphericity assumed= $F(2,16) = 3.529$; $p = .04$, $\eta_p^2 = .164$]. These results indicate that according to raters who were blinded to the study, children who participated in the experimental group demonstrated a statistically significant decrease in observable externalizing behavior overtime when compared to children who were in the active control group. Results further indicate that the CTRT demonstrated a large treatment effect ($\eta_p^2 = .164$) on children's total behaviors when compared to the active control group.

Figure C.1 graphically displays the interaction effect of mean group differences for total behavior over time. Group 1 represents the experimental group and Group 2 represents the active control group.

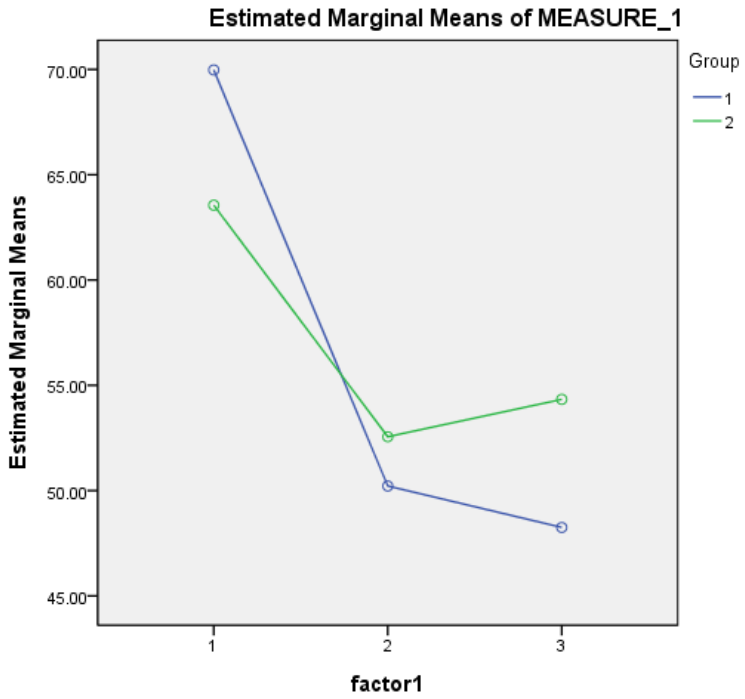

Figure C.1. Estimated marginal means of Total Behavior for total group.

Clinical Significance

According to Kazdin (1999) clinical significance refers to whether the intervention being studied makes a beneficial impact in the everyday life of the participants or the people with whom the participants interact. To gain better understanding of the impact that CTRT had on children's disruptive behavior in the classroom, the pre to post change scores for each participant on the Total Problems scale of the DOF and the Externalizing Behavior scale on the C-TRF were examined. Specifically, clinical significance was assessed by determining the number of children in the experimental group who moved from clinical/borderline levels of concern at pre-test to a more normative range of functioning following treatment. The use of direct observations such as the DOF provides an unbiased assessment of the participant's behavior due to rater's objectivity and blindness to the study (McConaughy & Achenbach, 2009; Volpe, DiPerna, Hintze, & Shapiero, 2005).

Total Behavior Outcomes

Children's pre and post *t*-scores on the Total Behavior scale on the DOF were analyzed to determine the clinical significance of CTRT on the students' disruptive behavior. Total behavior t-scores above 64 are considered in the clinical range, *t*-scores between 60 and 63 are considered in the borderline range, and *t*-scores below 60 are considered in the normal range.

The total sample size of the experimental group children was 11; however, one student moved prior to the midpoint observation and the DOF data for that student was dropped. Therefore, the DOF sample size for the experimental group consisted of 10 children. Of the 10 children who received CTRF, 9 children improved from clinical or borderline disruptive behavior problems to more normative functioning. More specifically, 8 children who scored in the clinical range at pretest moved to the normal range at posttest; and 1 child who scored in the

borderline range at pretest moved to the normal range at posttest. One child remained the same but decreased in score by 6 points. Conversely, out of the 9 children in the active control group, 6 children moved from clinical and borderline disruptive behavior problems to more normative functioning. Specifically, 2 children who scored in the clinical range at pretest moved to the normal range at posttest; 3 children moved from the borderline range to normal range; and one child moved from the clinical range to the borderline range. Three children remained the same with an average decrease in scores of 1.

Externalizing Behavior Scale

Children's pre and post t-scores on the Externalizing Behavior scale of the C-TRF were analyzed to determine clinical significance of the CTRT on the student's disruptive behavior. Out of the 11 children who received CTRT, 7 children improved from clinical or borderline disruptive behavior problems to more normative levels of functioning. Specifically, 3 children who scored in the clinical range at pretest moved to a normal range at post; 1 child who scored in the borderline range at pretest moved to a normal range at post; and 3 children who scored in the clinical range at pretest moved to a borderline range at post. Four children remained in the clinical level of concern, but demonstrated improved behavior with an average decrease in score of 2 points. On the other hand, out of the 9 children in the active control group, 2 children improved from clinical or borderline scores to more normative levels of functioning, one child remained the same, and 6 children worsened, with an average increase in score of 3.83 points.

APPENDIX D

ADDITIONAL MATERIALS

RESEARCH CONSENT FORM FOR TEACHERS

University of North Texas Institutional Review Board

Informed Consent Form

Before agreeing to participate in this research study, it is important that you read and understand the following explanation of the purpose, benefits and risks of the study and how it will be conducted.

Title of Study: Caregivers as Therapeutic Agents: Effectiveness of Child Teacher Relationship Training on Disruptive Behavior and School Readiness.

Investigator: Dr. Sue Bratton, Assistant Professor, University of North Texas (UNT) Department of Counseling and Higher Education.

Research Project Coordinators: Terri L. Gonzales, Graduate Assistant, University of North Texas (UNT) Department of Counseling and Higher Education

Yulia Pronchenko, Graduate Assistant, University of North Texas (UNT) Department of Counseling and Higher Education

Purpose of the Study: You are being asked to participate in a research study which involves the examination of the effects of Child-Teacher-Relationship Training (CTRT) on children's disruptive behavior and school readiness at your school. Child development literature emphasizes the vital importance of the teacher-child relationship for young children's academic success. In addition, the purpose of the CTRT training is to help teachers respond more appropriately to young children's behavior and create a more positive classroom environment for learning. This study involves teachers participating in training and supervision for a period of 23 weeks.

Study Procedures: If you choose to participate, you will be placed in either the CTRT treatment group or the control group that receives Conscious Discipline training. CTRT is a model that trains teachers in skills of empathy, encouragement, limit setting and choice giving. These skills are designed to help teachers effectively manage children's behavior and maintain classroom discipline in order to maximize learning. Teachers selected for the CTRT treatment group will participate in training and supervision on a weekly basis for a total of 23 weeks. Educational activities and schedules will not be impacted as a result of this study. Participating teachers will be asked to complete the Child Behavior Checklist (Caregiver-Teacher version- C-TRF) three times this school year, at the beginning, middle and end of the training, to evaluate the effects of teacher training on student behavior. The C-TRF will take approximately 20 minutes to complete. In addition teachers will be video taped during one-on-one play-based interactions with the child, as well as directly observed during classroom interactions in order to provide supervision of skills. The researcher is also interested in interaction between teacher and child specifically the teacher's ability to communicate empathy and acceptance as well as execute the skills taught. Therefore, videotapes will be utilized to examine the effects of CTRT on the teacher-child relationship. Training and supervision will be provided by counseling professionals with advanced training in play therapy and the CTRT model. The Principal Investigator and Research Project Coordinators will ensure that all information will be kept confidential.

Child Teacher Relationship Training (CTRT)
CTRT is a developmentally appropriate teacher training model that uses play based intervention skills to train teachers in skills of empathy, encouragement, limit setting and choice giving. These skills are designed to help teachers effectively manage children's behavior and maintain classroom discipline in order to maximize learning. This training focuses on the development of a positive teacher-child relationship based on the philosophy that children who feel more connected to their teacher are more successful in school. This training also utilizes developmentally appropriate culturally responsive play-based activities and skills to help teachers more effectively communicate with and manage behavior of young children. Teachers will be trained and closely supervised by counseling professionals who have advanced training in play therapy and the CTRT model. CTRT training consists of 2 days of intensive training in skills followed by 22 weeks of 1 hour per week training and supervision of the skills.

Conscious Discipline
Conscious Discipline is a developmentally appropriate teacher training program that fosters the emotional intelligence of teachers to empower both the teachers and the students. The training focuses on the basic skills of discipline, self-control, character building, and social skills. Teachers will be trained and closely supervised by counseling professionals who have advanced training in child development and Conscious Discipline.

Foreseeable Risks: There is no personal risk of discomfort directly involved with this study other than those associated with your normal daily teaching activities. You may choose to withdraw at any time without penalty or prejudice. There are no foreseeable risks involved with this study other than those associated with normal daily activities.

Benefits to the Subjects or Others: The teacher-child relationship is significant to the development of young children. Due to this significant relationship, teachers have the potential to make a considerable difference in a child's development. Therefore, training teachers to respond to children in a more encouraging and developmentally appropriate way can benefit aspects of your students' development, including cognitive, behavioral, social and emotional. Research suggests that children who feel more connected to their teacher have more positive attitudes towards school and demonstrate higher levels of academic achievement.

Teacher-child relationship training can benefit you by: increasing your ability to effectively respond to students' emotional and behavioral needs, enhance your ability in providing effective classroom management and discipline. Literature suggests that teachers who feel more confident of their ability to respond effectively to students' needs have reported more satisfaction in their careers.

Compensation for Participants: None
Procedures for Maintaining Confidentiality of Research Records: The information you provide when you answer the questionnaire will be kept confidential and will not be disclosed in any publication or discussion of this material. All data including assessments and video tapes will be assigned a code number and kept in a locked filing cabinet in order to preserve

confidentiality. Only the Principle Investigator and research assistants will review the video tapes for coding teacher-child interactions. For research purposes, only the Principle Investigator and the Research Project Coordinators will have access to the list of participants' names and code numbers. At the end of this study the list of names will be destroyed.

The only exceptions to confidentiality are if the parent or legal guardian requests release information on C-TRF results.

Questions about the Study: If you have any questions about the study, you may contact Dr. Sue Bratton at 940-565-3864.

Review for the Protection of Participants: This research study has been reviewed and approved by the UNT Institutional Review Board (IRB). The UNT IRB can be contacted at (940) 565-3940 with any questions regarding the rights of research subjects.

Research Participants' Rights:

Your signature below indicates that you have read or have had read to you all of the above and that you confirm all of the following:

- Dr. Sue Bratton has explained the study to you and answered all of your questions. You have been told the possible benefits and the potential risks and/or discomforts of the study.
- You understand that you do not have to take part in this study, and your refusal to participate or your decision to withdraw will involve no penalty or loss of rights or benefits. The study personnel may choose to stop your participation at any time.
- You understand why the study is being conducted and how it will be performed.
- You understand your rights as a research participant and you voluntarily consent to participate in this study.
- You have been told you will receive a copy of this form.

_____
Printed Name of Participant

_____ _____
Signature of Participant Date

For the Investigator or Designee:

I certify that I have reviewed the contents of this form with the subject signing above. I have explained the possible benefits and the potential risks and/or discomforts of the study. It is my opinion that the participant understood the explanation.

_____ _____

Signature of Investigator or Designee Date

University of North Texas Institutional Review Board
Informed Consent Form

Before agreeing to your child's participation in this research study, it is important that you read and understand the following explanation of the purpose, benefits and risks of the study and how it will be conducted.

Title of Study: Caregivers as Therapeutic Agents: Effectiveness of Child Teacher Relationship Training on Disruptive Behavior and School Readiness

Investigator: Dr. Sue Bratton, Assistant Professor, University of North Texas (UNT) Department of Counseling and Higher Education.

Research Project Coordinators: Terri Gonzales, Graduate Assistant, University of North Texas (UNT) Department of Counseling and Higher Education

Yulia Pronchenko, Graduate Assistant, University of North Texas (UNT) Department of Counseling and Higher Education

Purpose of the Study: You are being asked to allow your child to participate in a research study which involves your child participating in school-based play therapy services. The purpose of the study is to help children who have behavior difficulties such as aggression, fighting, attention problems, hyperactivity, problems with following directions, rule-breaking, etc to reduce their behavior problems. Experts in child development suggest that children who have less behavioral problems at school do better academically

Study Procedures: Your child will be asked to participate in approximately16 individual play therapy sessions that will take about 30 minutes, one time each week. All sessions will take place during regular school hours at a time determined by the teacher. Sessions will be video-recorded to make sure your child is receiving helpful services from the counselors.

Foreseeable Risks: The potential risks involved in this study are minimal. As with any counseling intervention, children may become more aware of emotional difficulties. In the event a child has a difficult time adjusting to new emotions, the parent will be contacted and a referral will be made to a local counseling center.

Benefits to the Subjects or Others: We expect the project to benefit your child by allowing him or her an opportunity to learn self-control and socially acceptable behaviors which can then be transferred to the classroom.

Compensation for Participants: None

Procedures for Maintaining Confidentiality of Research Records: Your child's name will be removed from all identifying materials related to this research and replaced with a random code number. Consent forms will be stored in a location separate from coded materials. All research records including video recordings will be kept in a locked cabinet in the researcher's office, and accessible only to the researchers. Research records will be kept for a period of 3 years following

the conclusion of this study. At that time, all records will be properly destroyed. The confidentiality of your child's individual information will be maintained in any professional publications or presentations regarding this study.

Questions about the Study: If you have any questions about the study, you may contact Dr. Sue Bratton at 940-565-3864.

Review for the Protection of Participants: This research study has been reviewed and approved by the UNT Institutional Review Board (IRB). The UNT IRB can be contacted at (940) 565-3940 with any questions regarding the rights of research subjects.

Research Participants' Rights: Your signature below indicates that you have read or have had read to you all of the above and that you confirm all of the following:

- Dr. Bratton has explained the study to you and answered all of your questions. You have been told the possible benefits and the potential risks and/or discomforts of the study.
- You understand that you do not have to allow your child to take part in this study, and your refusal to allow your child to participate or your decision to withdraw him/her from the study will involve no penalty or loss of rights or benefits. The study personnel may choose to stop your child's participation at any time.
- You understand why the study is being conducted and how it will be performed.
- You understand your rights as the parent/guardian of a research participant and you voluntarily consent to your child's participation in this study.
- You have been told you will receive a copy of this form.

_____ _____

Printed Name of Parent or Guardian Printed Name of the Student

_____ _____

Signature of Parent or Guardian Date

For the Investigator or Designee: I certify that I have reviewed the contents of this form with the parent or guardian signing above. I have explained the possible benefits and the potential risks and/or discomforts of the study. It is my opinion that the parent or guardian understood the explanation.

_____ _____

Signature of Investigator or Designee Date

Child Assent Form

You are being asked to be part of a research project being done by the University Of North Texas Department Of Counseling.

This project hopes you will take part in a special play time. Your teacher or teacher aide will be asking you to go to the special play room for your special play time.

Your special play time will be videotaped to make sure that your teacher or teacher aide is helpful to you during your time together.

If you decide to be part of this study, you can stop participating any time you want to.

If you would like to be part of this study, please sign your name below.

_____

Printed Name of Child

_____ _____

Signature of Child Date

_____ _____

Signature of Principal Investigator Date

Waiver of Assent

The assent of (_____) was waived due to:

_____ Age

_____ Maturity

_____ Psychological State

_____

Printed Name of Parent/Guardian

_____ _____

Signature of Parent/Guardian Date

University of North Texas Institutional Review Board

FORMA DE CONSENTIMIENTO PARA LA INVESTIGACION

Antes de que usted decida participar en éste estudio de investigación, es muy importante que usted lea y entienda las siguientes explicaciones de los procedimientos propuestos. Ésto le describe los procedimientos, beneficios, riesgos, e incomodidades de este estudio. Es muy importante que usted entienda que no hay garantía ni tampoco seguridad de los resultados que puedan tenerse con este estudio.

Título del Estudio: Investigando la Efectividad de la Terapia de Juego usando los myestras que son agentes terapéuticos con las Bases-de Juegos y el Riesgo que Implica para los Ninos que tienen problemas de portando y en preparándolos para escuela.

Investigadora Principal: Sue Bratton, Profesora Asociada de la Universidad del Norte de Texas

Coordinadors del Proyecto: Terri Gonzales, Asistente Graduado, de la Universidad del Norte de Texas

Yulia Pronchenko, Asistente Graduado de la Universidad del Norte de Texas

El propósito de este estudio y por cuánto tiempo durará:
Este proyecto está designado para examinar los efectos de la consejería escolar basada en el juego, también llamada terapia de juego. Este proyecto también está basada en el juego con el maestro o mentor para ayudar a los niños de descendencia hispana que hablan el español y que están asistiendo las escuelas primarias de Denton, Texas pero están en un alto riesgo de no alcanzar el éxito en sus estudios escolares. Al ser el grupo minoritario de crecimiento más grande en el estado de Texas, los niños hispanos frecuentemente no reciben la ayuda que ellos necesitan porque se encuentran con las barreras del idioma al ser diferente y por la falta de consejeros entrenados para trabajar con los niños hispanos. Si ofrecemos los servicios de consejería en las escuelas para niños hispános a la edad más temprano posible, estaremos ayudando esta situación crítica, para así poder confrontar los problemas a una edad temprano y ayudarlos a obtener el mayor de los éxitos en su vida estudiantil.

Este estudio conlleva 30 minutos de sesiones de consejería para su niño o niña, una vez por semana por aproximadamente 10 semanas. A el (la) maestro (a) de su niño (a) se les pedirá que completen dos cuestionarios al comienzo y al final de la sesión de consejería de su niño o niña. Cada cuestionario tomará aproximadamente 20 minutos para completarlo.

Descripción del estudio incluyendo los procedimientos usados:
Si su niño califica y usted decide que quiere que su niño o niña particípe, su niño (a) será asignado (a) a recibir uno de los siguientes servicios de consejería escolar terapia de juego. Los consejeros que ofrecen estos servicios están especialmente entrenados para trabajar con niños y estarán supervisados directamente por la Dra. Bratton, la coordinadora del proyecto, para asegurar la máxima calidad de los servicios.

<u>Terapia de juego:</u>

En la terapia de juego, también llamada consejería con niños a través de los juegos y los juguetes, un consejero que tiene entrenamiento avanzado en juegos de terapia llevará a su niño (a) al área de juego de la escuela, que está equipada con una variedad de juguetes debidamente desarrollados y creados para este popósito, también tiene materiales como artes plásticas, objetos para construir, plastilina, juegos, muñecos y animales, carros y camiones, peluches, títeres, ropa para disfrazarse o fingir ser alguien, un área de cocina, arena y agua.

Usando los juguetes y los juegos en las terapias de consejería para ayudar a los niños que están teniendo problemas en la escuela, se basa en la realidad de que los niños se comunican más facilmente a través del juego, mientras que los adultos generalmente se comunican a través de las palabras. Los niños de la edad primaria piensan en un nivel muy concreto, de manera que es más fácil para ellos usar figuras de juguetes y otros materiales para mostrarle al consejero lo que ellos están pensando o sintiendo. Tratando de explicar como usted se está sintiendo y porque se siente de esa manera, puede ser muy difícil inclusive para un adulto--¡especialmente cuando uno está enojado! Esto es sobretodo cierto para los niños que están pasando por problemas de aprendizaje de un idioma segundo.

El mentor o maestro del aprendizaje del juego:
En este programa de asesoría, un estudiante del primer año o último año de la universidad con entrenamiento especial en consejería y juegos terapéuticos, juega con varios procedimientos para ayudar a los niños mientras interactúan con ellos por 45 minutos cada semana. Los maestros ofrecen un juguete especial o varios, con diferentes tipos de juegos y juguetes para ayudar a que los niños expresen como se están sintiendo y que están pensando.

Consejería de grupo:
En los grupos de consejería, que también se llaman grupos de guía escolar, la idea se basa en que el consejero oferecerá a los niños una variedad de actividades a través de un currículo aprobado por la escuela, incluyendo: 1) leyendo historias y haciendo preguntas a los niños acerca de la historia o pidiéndoles a ellos que dibujen algo relacionado con la historia, 2) mostrando a los niños fotos de diferentes emociones como el estar bravo y el estar felíz y preguntándoles si pueden identificar que tipo de emoción es, y 3) pidiéndoles que practiquen normas de relaciones sociales básicas, por ejemplo: como resolver un desacuerdo con otros niños y como saber elegir de una manera amigable.

Descripción de los procedimientos/elementos que están asociados con riesgos previsibles:
No existen riesgos que puedan prevenirse envueltos con este estudio más que los que están asociados con las actividades normales de vida.

Beneficios para los sujetos:
La escuela primaria es una época muy importante en el desarrollo de su niño o niña, es la época en que los niños desarrollan las actitudes o comportamientos que van a durarle toda la vida en cuanto a la escuela, en las relaciones con otros niños, con ellos mismos, con grupos sociales y la familia. Muchos niños tienen dificultades para ajustarse a las demandas de la escuela, en particular los niños que están teniendo problemas para aprender un idioma segundo y adaptarse a una nueva cultura. Con frecuencia, los problemas de estos niños no son atendidos hasta que ellos

han crecido lo suficiente para poder comunicar sus problemas con palabras. Los servicios de consejería basados en el juego ofrecen la oportunidad a través de este proyecto de investigación, de ayudarlos con actividades de juego apropiadas para esa edad temprano de estos niños-- antes de que los problemas se conviertan en algo más serio, por ejemplo: a) un mejor entendimiento de sus propios pensamientos e ideas y como pueden expresar éstas en muchas diferentes maneras; b) empezando a desarrollar seguridad en sus propias habilidades; y c) llegando a ser más responsable, en la manera en que aprenden a controlarse a ellos mismos y resolver sus propios problemas. Los consejeros estarán también disponibles para los padres para poder discutir como sus niños están progresando, ayudarlos con útiles consejos parentales, o compartiendo ideas acerca de cómo usted puede ayudar, de una manera mejor a que su niño triunfe.

Compensarson Para los Participantes: Nada

Privacidad de los datos del estudio:
Los cuestionarios que tanto usted como el (la) maestro (a) de su niño o niña completen antes y después del estudio estarán guardados confidencialmente. Ellos no estarán identificados con su nombre o con el nombre del niño; un numero de código especial será usado en vez del nombre del niño (a). Los cuestionarios ofrecen información muy importante acerca del comportamiento de su niño o niña y ofrecen también información acerca de la efectividad de los servicos de consejería que su niño (a) recibió. Sin embargo, ninguna información acerca de su niño (a) o suya será compartida con los maestros de su niño (a), los directivos de la escuela, o cualquier otra persona. Las únicas excepciones a la privacidad son si 1) el niño (a) declara ser abusado, abandonado o explotado 2) el niño (a) está en una situación peligrosa por si mismo o por otra persona, 3) un orden judicial ordena la exposición de esta información, o 4) los padres o guardianes legales solicitan que la información sea publicada.
La Dra. Sue Bratton, Investigadora Principal, guardará y firmará todos los resultados y le puede dar cualquier información si usted está interesado. Al final del estudio, todas las formas serán destruidas.

La investigadora también está interesada en que tipo de juguetes el niño o niña usa, que tipos de juegos le gustan, y en el uso del idioma (si es español o inglés) durante las sesiones de consejería. Por esta razón la investigadora usará una cámara de video para grabar las sesiones de juego individuales. Los videos no identificarán el nombre del niño o niña, al contrario, se usará un numero especial para codificar las cintas y sólo la investigadora sabrá a quien le pertenece el video. Las cintas de video serán guardadas en una caja especial con candado en la oficina de la investigadora. Solo la investigadora y los empleados asociados a ella, revisarán las cintas de video para poder codificar los juegos y los patrones de lenguaje. En adición a ésto, las sesiones serán grabadas para propósitos de supervisión y serán vistos por la Dra. Sue Bratton, investigadora principal del estudio, para asegurar que su niño (a) está recibiendo la mejor calidad de servicios de consejería. Al final de este estudio, todas las cintas de video serán destruidas a menos que los padres den un consentimiento por escrito que permita usar los videos para entrenamiento y propósitos educativos.

Preguntas de el studio: En caso de que existan problemas o preguntas, se me ha dicho que puedo llamar a la Dra. Sue Bratton, (940) 565-3864.

Revisión para la protección de los participantes:
Este estudio investigativo ha sido revisado y aprobado por el Comité para la Protección de los Derechos Humanos de la UNT (940) 565-3940.

Los derechos de los participantes de la investigación:
Yo he leído o he hecho que me lean todo lo expresado arriba. Este estudio me ha sido explicado y todas las preguntas que he tenido han sido contestadas. Se me ha informado de todos los riesgos o molestias y posibles beneficios de este estudio.

Yo entiendo que mi niño o niña y yo no tenemos que tomar parte de este estudio, y que mi negación a participar o mi decisión de salirme no conllevará ninguna pena o perdida de los derechos o los beneficios o los recursos legales a los cuales tengo derechos. También entiendo que la investigadora puede decidir interrumpir la participación de mi niño o niña en cualquier momento.

En caso de que existan problemas o preguntas, se me ha dicho que puedo llamar a la Dra. Sue Bratton, (940) 565-3864.

Yo entiendo mis derechos como participante o parte de este estudio investigativo, y yo voluntariamente estoy dando mi consentimiento para participar en este estudio. Yo entiendo a lo que se refiere este estudio y como y porque se está haciendo. Se me ha explicado que yo recibiré una copia firmada de esta forma de consentimiento.

_____ _____
Firma del Padre o Madre o Guardian Fecha

_____
Nombre de Nino(a)

Para la Investigadora o el (la) Designada (o):

Yo certifico que he recibido el contenido de esta forma con la persona que firmó más arriba, quien, en mi opinión, entendió la explicación. Yo he explicado los beneficios y riesgos conocidos de esta investigación**.**

_____ _____
Firma de la Investigadora Principal Fecha

COMPREHENSIVE REFERENCE LIST

Abidin, R. R., & Robinson, L. L. (2002). Stress, biases, or professionalism: What drives teachers' referral judgments of students with challenging behaviors? *Journal of Emotional and Behavioral Disorders, 10*(4)*,* 294-212.

Achenbach, T. M., & Rescorla, L. A. (2001). *Manual for the ASEBA school-age forms & profiles.* Burlington: University of Vermont, Research Center for Children, Youth, & Families.

Adler, A. (1998). *Understanding human nature.* England: Oneworld Oxford. (Original work published in 1927).

American Counseling Association. (2005). *ACA code of ethics.* Alexandria, VA: American Counseling Association.

Armstrong, S. A., & Henson, R. K. (2005). Statistical practices of IJPT researchers: A review from 1993 to 2003. *International Journal of Play Therapy*, 14(1), 7-26.

Axline, V. (1974). *Play therapy*. New York, NY: Ballantine Books.

Baggerly, J., & Jenkins, W. W. (2009). The effectiveness of child-centered play therapy on developmental and diagnostic factors in children who are homeless. *International Journal of Play Therapy, 18*(1)*,* 45-55. doi: 10.1037/a0013878

Bailey, B. A. (2000). *Conscious discipline*. Oviedo, Fl: Loving Guidance.

Bailey, B. A. (2004). *Conscious discipline*. Oviedo, Fl: Loving Guidance.

Barkley, R. (2007). School interventions for attention deficit hyperactivity disorder: Where to from here? *School Psychology Review, 36*(2)*,* 279-286.

Bierman, K.L., Domitrovich, C.E., Nix, R.L., Gest, S.D., Welsh, J.A., Greenberg, M.T., Blair, C Nelson, K. E., & Gill, S. (2008). *Child Development*, *79(6)*, 1802-1817.

Birch, S. H., & Ladd, G. W. (1997). The teacher-child relationship and children's early school adjustment. *Journal of School Psychology*, 35, 61-79.

Birch, S. H., & Ladd, G. W. (1999). Children's interpersonal behaviors and the teacher-child relationship. *Developmental Psychology*, 34(5), 934-946. doi: 0012-1649/98

Blanco, P. J. & Ray, D. C. (2011). Play therapy in elementary schools: A best practice for improving academic achievement. *Journal of Counseling and Development, 18*(2), 235-243.

Bratton, S. (2010). Meeting the early mental health needs of children through school-based play therapy: A review of outcome research. In A. A. Drewes & C. E. Schaefer (Eds.), *School-based play therapy* (2nd ed., pp. 17-59). Hoboken, NJ: Wiley

Bratton, S. C., Landreth, G. L., Kellam, T., and Blackard, (2006). *Child parent relationship therapy (CPRT) treatment manual*. New York: Routledge.

Bratton, S. C., Ray, D., Rhine, T., & Jones, L. (2005). The efficacy of play therapy with children: A meta-analytic review of treatment outcomes. *Professional Psychology: Research and Practice, 36*(4)*,* 376-390. Doi: 10.1037/*0735*-7028.36.4.376

Bratton, S., Ceballos, P., Sheely-Moore, A., Meany-Walen, K., & Pronchenko, Y. (2011). *Head Start early mental health intervention: Effects of CCPT on disruptive behaviors*. Manuscript submitted for publication.

Bratton, S., & Landreth, G. L. (1995). Filial therapy with single parents: Effects on parental acceptance, empathy, and stress. *International Journal of Play Therapy*, 4, 61-80.

Bratton, S., Landreth, G., & Lin, Y. (2010). Child parent relationship therapy: A review of controlled outcome research. In J. N. Baggerly, D. C. Ray, & S. C. Bratton (Eds.), *Child centered play therapy research: The evidence base for effective practice* (pp. 267-293).

NY: Wiley.

Bratton, S. C., Landreth, G. L., Morrison, M., & Helker,W. (2010). *Child teacher relationship training (CTRT) treatment manual*. New York: Routledge. In review.

Brown, C.H., Costigan, T.E., & Kendziora, K. (2008). Data analytic frameworks: Analysis of variance, latent growth, and hierarchichal models. In Nezu & Nezu (Eds.), *Evidence-based outcome research: A practical guide to conducting randomized clinical trials for psychosocial interventions* (pp. 285-313). London: Oxford University Press.

Cauthen, N. K., & Fass, S. (2009). *10 important questions about child poverty and family economic hardship*. National Center for Children in Poverty, Columbia University Mailman School of Public Health. Retrieved from http://http://www.nccp.org/publications/pub_829.html

Ceballos, P. (2008). *School-based child parent relationship therapy (CPRT) with low income first generation immigrant Hispanic parents: Effects on child behavior and parent-child relationship stress* (Doctoral dissertation). Retrieved from ProQuest Dissertations and Theses database. (UMI No. 3326785).

Ceballos, P., & Bratton, S. (2010). Empowering Latin families: Effects of a culturally responsive intervention for low-income immigrant Lation parents on children's behaviors and parental stress. *Psychology in the Schools*, 47(8), 761-775.

Chau,I., & Landreth, G. L. (1997). Filial therapy with Chinese parents: Effects on parental empathic interactions, parental acceptance of child and parental stress. *International Journal of Play Therapy*, 6, 75-92.

Cochran, J. L., Cochran, N. H.; Nordling, W. J.; McAdam, A.; Miller, D. T. (2010). Two case studies of child-centered play therapy for children referred with highly disruptive

behavior. *International Journal of Play Therapy*, 19(3), 130-143.

Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2nd ed.). New York, NY: Academic Press.

Cohen, J. (1992). A power primer. Psychological Bulletin, 112, 155-159.

Draper, K., White, J., O'Shaughnessy, T. E., Flynt, M., & Jones, N. (2001). Kinder training: Play-based consultation to improve the school adjustment of discouraged kindergarten and first grade students. *International Journal of Play Therapy*, 10, 1-30.

Dougherty, J., & Ray, D. (2007). Differential impact of play therapy on developmental levels of children. *International Journal of Play Therapy*, 16(1), 2-19. doi:10.1037/1555-6824.16.1.2

Duncan, G. J., Brooks-Gunn, J., & Klebanov, P.K. (1994). Economic deprivation and early childhood development. *Child Development, 65(*2), 296-318.

Duncan, G. J., Ziol-Guest, K. M. and Kalil, A. (2010), Early-childhood poverty and adult attainment, behavior, and health. *Child Development*, *81*, 306–325. doi: 10.1111/j.1467 8624.2009.01396.

Edwards, N. A., Varjas, K. M., White, J. F., & Stokes, S. A. (2009). Teachers' perceptions of Kinder Training: Acceptability, integrity, and effectiveness. *International Journal of Play Therapy*, 18(3), 129-146. doi: 10.1037/a0015170

Erikson, E. H. (1963). *Childhood and society*. New York, NY: W W Norton & Company, Inc.

Fall, M. (1999). A play therapy intervention and its relationship to self-efficacy and learning behaviors. *Professional School Counseling, 2(*3*),* 194.

Fall, M., Navelski, L. F., & Welch, K. K. (2002). Outcomes of a play intervention for children identified for special education services. *International Journal of Play Therapy, 11*(2),

91-106.

Forness, S.R., Ramey, S.L., Ramey, C.T., Hsu, C., Brezausek, C.M., MacMillan, D.L., Kavale, K.A. (I998a). Head Stan children finishing first grade: Preliminary data on school identification of children at risk for special education. *Behavioral Disorders, 23,* 99- 111.

Garza, Y., & Bratton, S. C. (2005). School-based child-centered play therapy with Hispanic children: Outcomes and cultural considerations. *International Journal of Play Therapy, 14*(1)*,* 51-79.

Greene, R. W., Beszterczey, S.K.B., Katzenstein,T., Park, K., & Goring, J. (2002). Are Students with ADHD more stressful to teach? Patterns of teacher stress in an elementary school sample. *Journal of Emotional and Behavioral Disorders, 10(*2*)*, 79-89.

Guerney, B. G. (1964). Filial therapy: Description and rationale. *Journal of Consulting Psychology*, 28, 303-310.

Guerney, L. (1991). Parents as partners in treating behavior problems in early childhood settings. *Early Childhood Special Education, 11(*2*),* 74-90.

.Hamre, B. K., & Pianta, R. C. (2001). Early teacher-child relationships and the trajectory of children's school outcomes through eighth grade. *Child Development*, 72, 625-638.

Hamre, B. K., Pianta, R. C., Downer, J. T., & Mashburn, A. J. (2007). Teachers' perceptions of conflict with young students: Looking beyond problem behaviors. *Social Development, 17*(1)*,* 115-136. doi: 10.1111/j.1467-9507.2007.00418.x

Head Start Act. (1981). Pub. L. No. 97-35, 635-645.

Head Start Act. (2007). Pub. L. No. 110-134.

Helker, W., & Ray, D. (2009). The impact child-teacher relationship training on teachers' and aides' use of relationship-building skills and the effect on student classroom behavior.

International Journal of Play Therapy, 18(2), 70-83.

Hess, B. A., Post, P., & Flowers, C. (2005). Follow up study of kinder training for preschool teachers of children deemed at-risk. *International Journal of Play Therapy*, 14, 103-115.

Hughes, J.N. & Cavell, T.A., Jackson, T (1999). *Journal of Clinical Child Psychology 28(2),* 173-184.

Jang, M. (2000). Effectiveness of filial therapy for Korean parents. *International Journal of Play Therapy, 9(2)*, 39–56.

Kazdin, A. E. (1999). The meanings and measurement of clinical significance. *Journal of Counseling and Clinical Psychology, 67*, 332-339.

Kazdin, A. (2003). Clinical significance: Measuring whether interventions make a difference. In A. Nezu & C. Nezu (Eds.), *Evidence-based outcome research* (3rd ed., pp. 601-719). New York: Oxford University Press.

Landreth, G. L. (2002). *Play therapy: The art of the relationship* (2nd ed.). New York, NY: Brunner Routledge.

Landreth, G. L. (2012). Play therapy: The art of the relationship (3rd ed.). NY: Routledge.

Landreth, G. L., & Bratton, S. C. (2006). *Child-parent relationship therapy: A 10-week filial therapy model*. Springfield, IL: Thomas Books.

Landreth, G. L., & Lobaugh, A. F. (1998). Filial therapy with incarcerated fathers: Effects on parental acceptance of child, parental stress and child adjustment. *Journal of Counseling and Development*, 76, 157-165.

LeBlanc, M., & Ritchie, M. (1999). Predictors of play therapy outcomes. *International Journal of Play Therapy, 8*(2), 19-34.

Lopez, M.L., Tarullo, L.B., Forness, S.R., & Boyce, C.A. (2000). Early identification and intervention: Head Start's response to mental health challenges. *Early Education & Development, 11(*3*)*, 265-282.

McConaughy, S. H., & Achenbach, T. M. (2009). *Manual for the ASEBA direct observation form*. Burlington,VT: University of Vermont, Research Center for Children, Youth, & Families.

Meany-Walen, K. K., & Bratton, S. C. (2011). *Adlerian play therapy: Effectiveness on disruptive behaviors of early elementary-aged children.* In review.

Miller, A.L., Gouley, K.K., Seifer, R., Dickstein, S., & Shields, A. (2004). Emotions and behaviors in the Head Start classroom: Associations among observed dysregulation, social competence, and preschool adjustment. *Early Education and Development, 15(*2*)*, 147-166.

Myers, S. S., & Pianta, R. C. (2008). Development commentary: Individual and contextual influences on student-teacher relationships and children's early problem behaviors. *Journal of Clinical Child & Adolescent Psychology, 17*(3)*,* 600-608. doi: 10.1080/15374410802148160

Morrison, M. O., & Bratton, S. C. (2010). Preliminary investigation of an early mental health intervention for Head Start programs: Effects of Child Teacher Relationship Training on children's behavior problems. *Psychology in the Schools*, 47(10), 1003–1017.

Muro, J., Ray, D., Schottelkorb, A., Smith, M. R., & Blanco, P. J. (2006). Quantitative analysis of long-term child-centered play therapy. *International Journal of Play Therapy*, 15(2), 35-58. doi:10.1037/h0088914

National Center for Children in Poverty (2011). United States early childhood profile. Retrieved

from http://www.nccp.org/profiles/US_profile_16.html

National Center of Children in Poverty (2012). *Basic facts about low-income children: Children under age 6*. Retrieved from http://nccp.org/publications/pub_896.html.

New Freedom Commission on Mental Health (2003). *Achieving the promise: Transforming mental health care in America. Final Report*. DHHD Pub. No. SMA-03-3832. Rockville, MD: Department of Health and Human Services.

Pace, T.M., Mullins, L.L., Beesley, D., Hill, J.S., & Carson, K. (1999). *Contemporary Educational Psychology, 24*, 140-155.

Peisner-Feinberg, E. S., Burchinal, M. R., Clifford, R. M., Yazejian, N., Culkin, M. L., Zelazo, J., Howes, C., Byler, P., Kagen, S.L., & Rustici, J. (1999). *The children of the cost, quality, and outcomes study go to school technical report*: *Executive summary*. Chapel Hill: University of North Carolina at Chapel Hill, Frank Porter Child Development Center.

Perry, B. D. (2001). Promoting nonviolent behavior in children. *Early Childhood Today, 16*(1), 26-29.

Pianta, R.C. (1999). *Enhancing relationships between children and teachers*. Washington, DC: American Psychological Association.

Pianta, R. C., & Walsh, D. J. (1996). *High-Risk Children in Schools: Constructing Sustaining Relationships*. New York, NY: Routledge

Post, P., McAllister, M., Sheely, A., Hess, K., & Flowers, C. (2004). Child-centered kinder training for teachers of pre-school children deemed at-risk. *International Journal of Play Therapy*, 13, 53-74.

President's New Freedom Commission on Mental Health. (2003). *Achieving the promise:*

Transforming mental health care in America final report (DHHS Publication N. SMA 03-3832). Rockville, MD: Department of Health and Human Services.

Post, P. (1999). Impact of child-centered play therapy on the self-esteem, locus of control, and anxiety of at-risk 4th, 5th, and 6th grade students. *International Journal of Play Therapy*, 8(2), 1-18. doi:10.1037/h0089428

Ray, D. (2007). Two counseling interventions to reduce teacher-child relationship stress. *Professional School Counseling, 10*(4), 428-440.

Ray, D. C. (2011). *Advanced play therapy: Essential conditions, knowledge, and skills for child practice.* New York, NY US: Routledge/Taylor & Francis Group

Ray, D., & Beam, K. (2000, April). *RELATe: Relationship enhancement for learner and teacher.* Texas Association for Play Therapy 7th Annual Conference. Austin, Texas.

Ray, D. C., Blanco, P. J., Sullivan, J. M., & Holliman, R. (2009). An exploratory study of child centered play therapy with aggressive children. *International Journal of Play Therapy*, 18(3), 162-175.

Ray, D., Muro, J., & Schumann, B. (2004). Play therapy in the schools: Lessons learned. *International Journal of Play Therapy, 13*, 79-100.

Ray, D., Schottelkorb, A., & Tsai, M. (2007). Play therapy with children exhibiting symptoms of attention deficit hyperactivity disorder. *International Journal of Play Therapy, 16*(2), 95 111. doi: 1555-6824/07

Raver, C. & Zigler, E., (2004). *Another step back? Assessing readiness in Head Start. Beyond the Journal: Young Children on the Web*, 1-5. Retrieved from http://www.journal.naeyc.org/btj/200401/Raver.pdf.

Rogers, C. R. (1951). *Client centered therapy*. London: Constable.

Rubin, A. (2008). *Practitioner's guide to using research for evidence-based practice*. Somerset, NJ: John Wiley & Sons.

Schottelkorb, A. A. & Ray, D. (2009). ADHD symptom reduction in elementary students: A single-case effectiveness design. *Professional School Counseling*, *13*(1), 11-22.

Serna, L. A., Nielsen, E., Mattern, N., & Forness, S. (2003). Primary prevention in mental health for Head Start classrooms: Partial replication with teachers as interventions. *Behavioral Disorders*, 28(2), 124-129.

Sheely, A. (2008*). School based child parent relationship therapy (CPRT) with low income Black American parents: Effects on children's behaviors and parent-child relationship stress, a pilot study* (Doctoral dissertation). Retrieved from ProQuest Dissertations and Theses database. (UMI No. 3326822).

Sheely-Moore, A., & Bratton, S. (2010). A strengths-based parenting intervention with low income African American families. *Professional School Counseling*, 13(3), 175-183.

Sheely-Moore, A. I., & Ceballos, P. L. (2011). *Empowering Head Start African American and Latino Families: Promoting Strengths-Based Parenting Characteristics through Child Parent Relationship Training--An Evidence-Based Group Parenting Program*. NHSA Dialog, 14(1), 41-53.

Shen, Y. (2002). Short-term group play therapy with Chinese earthquake victims: Effects on anxiety, depression, and adjustment. *International Journal of Play Therapy, 11*(1)*,* 43-63.

Smith, N., & Landreth, G. (2003). Intensive filial therapy with child witnesses of domestic violence: A comparison with individual and sibling group play therapy. *International Journal of Play Therapy*, 12(1), 67-88. doi:10.1037/h0088872

Thompson, B. (2002). "Statistical," "practical," and "clinical": How many kinds of significance

do counselors need to consider? *Journal of Counseling and Development, 80,* 64-71.

Thompson, R. A., & Happoid, C. A. (2002). *The roots of school readiness in social and emotional development (Rep. No. 1)*. Kansas City, MO: The Ewing Marion Kauffman Foundation.

Tsai, M., & Ray, D. C. (2011). Play therapy outcome prediction: An exploratory study at a university-based clinic. *International Journal of Play Therapy, 20(2),* 94-108. doi:10.1037/a0023441

Tyndall-Lind, A., Landreth, G., & Giordano, M. (2001). Intensive group play therapy with children witness of domestic violence. *International Journal of Play Therapy, 10*(1), 53-83.

United States Public Health Service. (2010). *Report of the surgeon general's conference on children's mental health: A national action agenda.* Washington, DC: U.S. Department of Health and Human Services.

United States Department of Health and Human Services (2010). *Head Start impact study final result.* Washington, D.C. Retrieved from http://www.acf.hhs.gov/programs/opre/hs/impact_study/reports/impact_study/executive_summary_final.pdf

Volpe, R. J., DiPerna, J. C., Hintze, J. M., & Shapiro, E. S. (2009). Observing students in classroom settings: A review of seven coding schemes. *School Psychology Review, 34*(4), 454-474.

Vygotsky, L.S. (1966) Development of higher mental functions. In A.N. Leontyev, A.R. Luria and A. Smirnov (Eds.) *Psychological research in the USSR*. Moscow: Progress Publishers.

Walker, H. M., Ramsey, E. & Gresham, R. M. (2005). *Antisocial behavior in school: Evidence*

based practices (2nd ed.). Belmont,CA: Wadsworth/Thomson Learning.

White, J., Flynt, M., & Draper, K. (1997). Kinder therapy: Teachers as therapeutic agents. *International Journal of Play Therapy*, 6, 33-49.

White, J., Flynt, M., & Jones, N. P. (1999). Kinder therapy: An Adlerian approach for training teachers to be therapeutic agents through play. *The Journal of Individual Psychology*, 55, 365-382.

Webster-Stratton, C., & Ried, M. J. (2003). The incredible years parents, teachers, and children training services: A multifaceted treatment approach for young children with conduct problems. In A. E. Kazdin & J. R. Weisz (Eds.), *Evidence-based psychotherapies for children and adolescents* (pp. 224-240). New York, NY: Guilford.

Webster-Stratton, C., Reid, M. J., & Hammond, M. (2004). Treating children with early-onset conduct problems: Intervention outcomes for parent, child, and teacher training. *Journal of Clinical Child and Adolescent Psychology, 33(*1*)*, 105-124.

White, J., Flynt, M., & Jones, N. P. (1999). Kinder therapy: An Adlerian approach for training teachers to be therapeutic agents through play. *The Journal of Individual Psychology*, 55, 365-382.

Yoshikawa, H., & Knitzer, J. (1997). *Lessons from the field: Head start mental health strategies to meet changing needs*. NY: National Center for Children in Poverty, Columbia University School of Public Health.