EFFECTS OF CULTURALLY RESPONSIVE CHILD-CENTERED PLAY THERAPY COMPARED TO CURRICULUM-BASED SMALL GROUP COUNSELING WITH ELEMENTARY-AGE HISPANIC CHILDREN EXPERIENCING EXTERNALIZING AND INTERNALIZING BEHAVIOR PROBLEMS: A PRELIMINARY STUDY

Yvonne Garza, LMSW, LPCI, RPT

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APPROVED:

Sue C. Bratton, Co-Major Professor
Dee Ray, Co-Major Professor
Dennis Engels, Committee Member
Jan Holden, Program Coordinator
Michael Altekruse, Chair of the Department of Counseling, Development, and Higher Education
M. Jean Keller, Dean of the College of Education
Sandra L. Terrell, Dean of the Robert B. Toulouse School of Graduate Studies
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This study was designed to determine the effectiveness of culturally responsive child-centered play therapy when compared to a curriculum-based small group counseling intervention as a school-based intervention for Hispanic children experiencing behavioral problems that place them at risk for academic failure. Specifically, this study measured the effects of the experimental play therapy treatment, compared to Kids’ Connection, on reducing Externalizing and Internalizing behavior problems of elementary school-age Hispanic children.

Twenty-nine volunteer Hispanic children were randomized to the experimental group ($n=15$) or the comparison group ($n=14$). Subjects participated in a weekly 30 minute intervention for a period of 15 weeks. Pre- and posttest data were collected from parent and teachers using the Behavior Assessment Scale for Children (BASC).

A two factor mixed repeated measures analysis of variance was computed for each hypothesis, to determine the statistical and practical significance of the difference in the pretest to posttest behavior scores of children in the two groups. According to parents’ reports, the children receiving play therapy showed statistically significant decreases in externalizing behaviors problems, specifically conduct problems, and moderate improvements in their internalizing behavior problems, specifically anxiety. Teacher BASC results showed no statistical significance and negligible-to- small practical significance between the two groups at posttest as a result of treatment; however, problems with integrity of data collection of teacher BASCs were noted.
This study determined that, according to parents’ reports, culturally responsive child-centered play therapy is an effective intervention for school-aged, Hispanic children referred for behavioral problems that have been shown to place them at risk for both academic failure and future, more serious mental health problems. Additionally, culturally responsive considerations regarding counseling Hispanic children and families were explored. This was a progressive research study that, according to a review of the literature, is the first of its kind to focus on the effects of culturally responsive child-centered play therapy treatment with Hispanic, Spanish-speaking children.
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CHAPTER 1

INTRODUCTION

The importance of an individual’s culture is recognized among counselors as significant to the counseling relationship. Experts in the field have urged counselors to identify issues in cultural diversity and research the effectiveness of culturally specific treatment modalities (Baruth & Manning, 1992; Cochran, 1996; Kottman, 2001; Santiago-Rivera, 1995). Regardless of this cogent push, there remains minimal information on the treatment of culturally diverse populations, particularly as related to children.

Current trends in population demographics suggest that Hispanics will soon be the majority minority group in the United States (Kitchen, 2002; U.S. Bureau of Census, 2000a). There are differing opinions, even within groups, regarding the appropriate term of identification for groups with ancestry from Mexico and Latin American countries. The term Hispanic, employed in this paper, includes persons who refer to themselves as Chicano, Hispanic, Latino, Mexican, and Mexican American. Statistics have indicated that Hispanic children represent 35% of the population in U.S. public schools (Nieto, 2000). One influence in the growth of Hispanic children in the schools may be that, according to Gonzalez (1997), Hispanic households are composed of four or more people 54% of the time versus the rest of the country as a whole, whose households are composed of four or more members only 28% of the time. Regardless of the reasoning behind the growth, D’Andrea and Bradley (1995) suggested that the increased numbers of Hispanic children leave schools faced with overcrowding and few resources, particularly bilingual counselors. These statistics may bring a sense of urgency to the concept of identifying culturally sensitive modalities to remediate the social and emotional problems of Hispanic children (Cochran, 1996; Gibbs, Huang, & Associates, 1998; Santiago-Rivera, 1995).
Meeting the mental health needs of Hispanics is challenging. Suggested cultural barriers to treatment include the following:

1. Hispanics are reluctant to disclose or discuss family problems outside the family or culture because of past negative experiences with people outside of their culture.

2. Hispanics’ limited English-speaking skills hinder access to information on resources.

3. Pressure to assimilate, creates a natural tension among cultures.

4. Mental health services are viewed as irrelevant or oppressive.

5. Illegal immigrants fear deportation.

6. Families lack an understanding of mental illness.

7. Hispanics are mainly somatic in their descriptions of problems and customarily utilize traditional or spiritual methods of healing (Altarriba & Bauer, 1998; Cochran, 1996; Preciado & Henry, 1997; Santiago-Rivera, 1995). Although this list does not go into detail regarding the profoundness of the barriers, it illustrates the difficulty of the task at hand. As a result of these barriers, Hispanic children are often underserved or misdiagnosed (Kottman, 2001). Frequently, counselors attend workshops on cultural diversity in attempts to understand the barriers that affect treatment, but the need exists for further study that applies knowledge and explores effectiveness (Cochran, 1996). Durodoye (2002) recommended that counselors need to become more culturally responsive to the clients they serve. This means that counselors should take a “culturally responsive” rather than a “culturally sensitive” approach, stressing the importance of an active stance instead of a passive understanding of the therapeutic task (Koss-Chioino & Vargas, 1992). Sue and Sue (2003) suggested that counselors who are culturally responsive are aware of variables such as race, ethnicity, and culture that may influence how a group identifies mental illness and defines a helping relationship. More importantly, this awareness is put into action as the therapist
facilitates discussion that is indicative of an understanding of the cultural and environmental issues that may influence the individual.

The National Center for Education Statistics (NCES, 2003) reported that students who speak English as a second language, as well as children who come from poor economic backgrounds are at risk for dropping out. The NCES also found that Hispanics lead the dropout rates (7.8%), with Black, non-Hispanics, second (6.5%), and White, non-Hispanic students last (4.0%). In states where the Hispanic population is significant, dropout rates are high. Texas ranked 45th in the nation in the percentage of dropouts, with Hispanics leading attrition rates and accounting for 64% of all Texas dropouts (Dallas Commission on Children and Youth [DCCY], 2000). According to the Intercultural Development Research Association (IDRA), as cited in DCCY (2000), youth who drop out are more likely than those who stay in school to experience problematic social and economic issues. These include, but are not limited to, poverty, unemployment, teen parenthood, and delinquency. These factors become significant problems for society, especially since there is a relationship between poverty and criminal behavior. The National Association for the Education of Young People (NAEYC, 1996) documented that children living in high-risk environments are susceptible to impaired attachments, behavior disorders, violence, substance abuse, and academic failure. Nationally, Hispanic children are overrepresented in high-risk environments. The NCES (2003) reported that the percentage of kindergartners with two or more risk factors is five times greater among Hispanic children than among their American peers.

In the 1930s Anna Freud warned that socioeconomic factors contributed to neglect of children and urged parents and teachers to be responsible, take action, and make efforts to understand the child (Freud, 1954). Five decades later, similar recommendations are being made.
The U.S. Department of Education (2001), the U.S. Surgeon General’s Report (U.S. Public Health Service, 2001), and the University of Texas System task force (1995) urged schools to identify ways to expand services to at-risk children, particularly minorities, to include the mental health, social, and personal needs of students in addition to addressing academic development. One way to meet this expectation might be to employ the expertise of trained therapists who have an understanding of the Hispanic culture, can speak the child’s language, and who specialize in early intervention techniques such as play therapy, to provide school-based prevention and intervention services to elementary-aged children. Play therapy, as a school-based intervention, may be a feasible solution for populations who generally do not seek outside services due to lack of resources.

According to a recent meta-analysis, play therapy has gained widespread acceptance and is seen as a viable therapeutic intervention for abused, developmentally delayed, and behaviorally maladapted children (Bratton, Ray, Rhines, & Jones, in press; LeBlanc & Ritchie, 2001). A recent meta-analysis of over 5 decades of play therapy outcome research revealed a treatment effect of 0.80 standard deviations compared to nontreatment groups, concluding that play therapy was an effective treatment for a wide array of presenting issues (Ray, Bratton, Rhines, & Jones, in press). The authors noted a lack of ethnic diversity in the populations studied and called for play therapy research targeting culturally diverse children. Schaefer (1993) stressed that play is more than just a pleasurable activity for children; it is also a diagnostic tool that offers valuable clues about each child’s psychological world. Landreth (2002) indicated that play is the “native language” of children, an innate and universal method of communication through which children converse in an open and direct way. Through play and fantasy, the child may work through difficult situations, traumatic experiences, or emotional problems. In child-centered play therapy (Landreth, 2002),
based on the approaches of Carl Rogers and Virginia Axline, the child is free to direct the course of the play session. Several authors have suggested that, for these reasons, child-centered play therapy is the modality of choice for treating culturally diverse populations (Cochran, 1996; L. Ramirez, 1999). According to L. Ramirez (1999), the qualities of the child-centered play therapist, such as respect, caring, and empathy, make this modality a potential fit for treating Hispanic children. A review of the literature found little reference to the cultural adaptations of toys used in a traditional playroom, and no research studies in this area could be located. Experts in the field suggested that play therapy is less limited by cultural differences between the counselors and the client than are other forms of interventions. However, an exhaustive review of the literature revealed that few studies examined the effects of play therapy with Hispanic children in the United States.

Statement of the Problem

The problem investigated was the effectiveness of culturally responsive child-centered play therapy as a school-based intervention for Hispanic children experiencing behavioral problems that place them at risk for academic failure. Specifically, this study examined the effects of play therapy in (a) reducing externalizing behavioral problems of Hispanic, elementary school-aged children; (b) reducing internalizing behavioral problems of Hispanic, elementary school-aged children. The intent of this study was to provide preliminary results regarding the effectiveness of culturally responsive child-centered play therapy as a school-based treatment modality for Hispanic children and to spur ideas for further study.
Review of Related Literature

The review of the literature concentrated on the following elements: (a) issues related to counseling Hispanic children; (b) history and principles of child-centered play therapy; (c) rationales for using play therapy; and (d) school-based counseling.

Issues Related to Counseling Hispanic Children

The U.S. Census Bureau predicted that, due to continuing immigration and high birth rates, Hispanics may soon become the nation’s largest minority group (U.S. Bureau of Census, 2000a). In Census 2000, people of Spanish/Hispanic/Latino origin made up 35.3 million of the 281.4 million residents in the United States. The majority of Hispanics live in California and Texas, and the number of Hispanics has increased 50% since 1990 (U.S. Bureau of Census, 2000b). According to Nieto (2000), Hispanics represent 35% of the student body in public schools. Baruth and Manning (1992) predicted that this estimated growth in population is evidence that counselors will increasingly be challenged to provide culturally appropriate counseling interventions, particularly with school-age children from many different ethnicities. School counselors are faced with treating a population that reportedly has the highest poverty rate and the lowest educational attainment among all ethnic minorities in America (Bender & Ruiz, 1974; Garcia, 1999).

Hispanics and School Concerns

It has been documented that Hispanics are confronted with socioeconomic barriers with more frequency than are Anglo-Americans. Nearly 40% of Hispanic children live in poverty, compared to only 28% for Anglo-American children (D’Andrea & Bradley, 1995; U.S. Bureau of Census, 2000b). More specifically, Hispanic children are overrepresented in the areas of school dropout rates, poverty, criminal activity, and teen pregnancy (NCES, 2003; Sue & Sue, 2003). The negative impact of these life circumstances has made many Hispanic children susceptible to a
variety of mental health issues. For example, Hispanic students (11%) are at a greater risk for depression (Tortolero & Roberts, 2001). The Centers for Disease Control, Office of Minority Health (CDC, 2004) listed susto (fright), nervios (nerves), mal de ojo (evil eye), and ataque de nervios (anxiety attack) as culture-bound syndromes common in Hispanics. These might be demonstrated in symptoms of screaming, crying, trembling, verbal or physical aggression, dissociative experiences, fainting spells, and suicidal gestures.

School systems are already overburdened with referrals, indicating the need to expand service delivery. Children are typically referred to school counselors, currently making the schools the primary providers of mental health services. Many of those referrals, some with severe needs, never reach the mental health system (U.S. Public Health Service, 2001). The Centers for Disease Control, Office of Minority Health (CDC, 2004) reported that, although Hispanic youth proportionately experience more internal and external behavioral problems than do non-Hispanic American youth, fewer than 1 in 20 actually utilize mental health specialists. Counseling professionals need to be prepared to cope with these large numbers of referrals with an understanding that they will frequently counsel children from cultures different from their own (Chaloner, 2002; Kottler, 2004). Therefore, counselors need to learn as much as possible about the culture of their diverse clients. In addition, they are encouraged to identify heterogeneity in counseling Hispanic children in order to identify specific needs, rather than limiting knowledge to the similarities of the Hispanic population (Kerl, 1998a, 1998b; Ruiz & Padilla, 1977).

As early as 1969, Webb identified the struggle of Hispanic children within the school setting. She noted that when Hispanic children first enter school, they feel pulled from the warmth of their family, are given tasks in a language they do not understand, and are often punished for wrongdoings they do not know they committed. As a result, a wall of ignorance, fear, and
prejudice is built around them. Webb urged counselors to attack these walls with a caring approach and applicable knowledge about what is effective with this population. Currently, Hispanic children are overrepresented by 300% in special education programs under the classification of learning disabled. Gersten and Woodward (1994) suggested that this occurrence is due to the lack of English proficiency on the part of the child, as well as improper assessments. This implies that this population continues to be misunderstood, which supports the idea that further investigation is needed and that little progress has been made in this area.

Hispanics are at risk for school failure, poor self-concept, poor social competence, and poor assimilation into their community. Robertson, Harding, and Morrison (1998) indicated that one variable not to be overlooked is the school’s inability to align itself to the cultural norms of different groups. Often, school counselors are Caucasian and rarely speak a language other than English. The CDC (2004) reported that in 1990, although 40% of Hispanics spoke no English, in the United States there were only 29 Hispanic mental health professionals for every 100,000 Hispanics compared to 173 non-Hispanic American providers per 100,000. The number of Hispanic mental health providers for children’s services would be much lower.

The United States Department of Education (1999) reported that Hispanics have the least successful record in school, with the highest dropout rate of any major ethnic group. In addition, studies show that Hispanics enter school later and leave earlier; they are less likely to attend day care and preschool; and a large percentage is enrolled below grade level (Kantrowitz & Rosado, 1991; Lewis, 1998). D’Andrea and Bradley (1995) conducted a study to determine whether Hispanics differed in the types of worries they experienced during elementary and secondary years. Results showed that Hispanics worry more than Caucasian students in the areas of contracting AIDS; dying young; finding employment; becoming pregnant; being unfairly treated
due to race; parental use of drugs and alcohol; family violence; forced sex; poor economic status; being liked by peers; and neighborhood violence. While these results indicate a crucial need for services, they also indicate that too often counselors are limited in knowledge and resources that target diverse ethnic groups.

Cochran (1996) advocated that counselors should develop culturally sensitive therapeutic practices in order to meet the unique needs of culturally diverse populations. Counselors should have an understanding of the negative impact of community-level stressors, such as poverty, unemployment, limited resources, substandard housing, and high crime rates, which have made Hispanic children more susceptible to a variety of emotional, academic, and behavioral difficulties than children who live in more favorable conditions (Attar, Guerra, & Tolan, 1994; Derk, 2001). This occurrence may be due to the fact that Hispanics are overrepresented in urban communities with a high presence of hazardous environmental conditions. For Hispanic people, hazardous environmental factors and a history of discrimination contribute to poverty, unemployment, and emotional stressors (Aisenberg, 2001). Undoubtedly, counselors will increasingly be called upon to provide interventions with children of Spanish-speaking cultures. Unfortunately, there seem to be few Hispanics in the mental health professions who are bilingual and have an active understanding of the culture (Preciado & Henry, 1997). Based on credible evidence of current numbers of Hispanics and estimates of their population growth, counselors should first explore the differences and problems affecting Hispanic children. Secondly, they should develop competencies in treatment modalities specific to the needs and culture of Hispanic children (Baruth & Manning, 1992; Cochran, 1996; Romero, Silva, & Romero, 1989).
Hispanics and Societal Concerns

The Texas Legislative Council (2000) investigated juvenile violent crime in the United States and found that early warning signs in children included early aggression, poor supervision of children, parental drug/alcohol use, low commitment to school, and high levels of transience, poverty, and family disruption. The investigation included a survey in order to attempt to understand the factors contributing to the Hispanic dropout rate. The survey was conducted with Hispanic students to identify their rationale for leaving school. Rationales included failing, not liking school, problems with teachers, poor peer relationships, disciplinary problems, not feeling safe, and not fitting in socially. Many of the factors contributing to school dropout rates could be dealt with through early intervention and counseling.

The Sexual Information and Education Council for the U.S. (2003) reported Hispanic teenagers as one of the highest population groups for teen pregnancy, birth, and abortion. Trevino (2003) indicated that Hispanic students were 13.4% more likely than Caucasian students to attempt suicide. Cortez (1999) and the U. S. Surgeon General’s report (U. S. Public Health Service, 2001) emphasized the need for research to identify how to help children at an early age in order to improve their chance of later school success, promote adaptation, and help with social development. In Texas, a task force examining many variables related to the growing number of Hispanics in the schools identified the need to expand the role of school-based services to include the health, social, and personal needs of students in addition to addressing academic development. The task force recommended the collaboration of schools with outside resources to provide needed services to students (University of Texas System, 1995). The idea of community collaboration was also supported by the National Dropout Prevention Center (2004). One way to meet the needs of the task force and provide effective services to children may be to employ the expertise of trained
therapists who specialize in early intervention techniques such as play therapy.

*History and Principles of Child-Centered Play Therapy*

Literature examining the history of the psychology of children suggests that many theorists agree that conventional talk therapy is not appropriate for children. The rationale is that children have not yet developed the cognitive development to express themselves verbally. Instead, play is used as their mode of expression. Recognizing that play is a learning-expressive modality that provides children with an avenue for growth using their most natural language, professionals have developed therapeutic approaches that allow children to use play as a medium for expressing feelings, exploring relationships, and reaching self-potential. The opportunity to be free, creative, and self-directing is what makes the play therapy experience unique and helpful for the child (James, 1977; Krall, 1989).

The use of play therapy with children has its origins in psychotherapy dating back to 1909. Sigmund Freud was the first psychotherapist to recognize that children use play as a natural means of expression. He was also the first psychotherapist to publish a case describing a psychoanalytic approach to working with a child. Freud’s work with “Little Hans’s,” a 5-year-old boy with a phobia, is a classical child analysis case in which Freud saw Hans one time for a brief visit and subsequently advised the child’s father to gather data about the child’s play. He was able to make a diagnosis and offer therapeutic advice to Hans’ father based on this information. Freud regarded play as a “poetic creation” that is to be decoded. His work was at the forefront of the movement to investigate the use of psychotherapy with children (Reisman & Ribordy, 1993).

Before the case of “Little Hans,” children were viewed as miniature adults. Little was known about how to work with them, and a child’s difficulty was attributed to emotional causes. Analysts believed that children’s problems were a result of poor education and training. Hermine
Hug-Hellmuth followed Freud in her attempts to apply psychoanalytic therapy to children. She was one of the first therapists to provide children with play materials to express themselves during therapy, believing that children were unable to verbalize their problems as adults did. Hug-Hellmuth worked with children older than 6 years of age and formulated no specific therapeutic approach, but rather made observations of the child (James, 1977; Klein, 1984).

In 1919 Melanie Klein focused on the idea that play provided direct access to the child’s unconscious and that analysis could work by substituting play for verbalized free association. Through her direct work with children, Klein (1982) noted that children could not express what adults express using words, and she began to consider symbolic play to be the most natural form of expression for them. Klein believed that play for a child was equivalent to the free associations of adults, and she was the first to employ these techniques with children younger than 6 years of age. Around the same time, Anna Freud began using play as a way of developing the child/therapist relationship. She believed that strengthening the relationship was important before working on interpreting the anxious, unconscious, motivation of the child’s play. Anna Freud differed from Klein in that she did not believe that the therapist should view every play situation as symbolic and that some play was just play. Klein (1984) believed in gaining extensive knowledge from play observations, as well as from the parents before offering direct interpretations to the child (James, 1977, 1997).

There are four major schools in play therapy: psychoanalytic play therapy, release therapy, relationship therapy, and nondirective therapy. The first major development in play therapy was a result of ineffective efforts to apply psychoanalysis to children. Analysts realized that children did not verbalize their anxieties as adults did. The typical process of utilizing recall and recollections was inappropriate and fruitless when used with children. Sigmund Freud, Hermine Hug-Hellmuth,
Melanie Klein, and Anna Freud were all noteworthy contributors to the psychoanalytic play therapy movement. Hug-Hellmuth (1921) was one of the first therapists during this time to reject adult talk as a method of therapy for children. She believed rather that toys were essential in order for children to express thoughts and emotions in therapy.

The 1930s marked the second major development in play therapy, with the introduction of release therapy (James, 1977). David Levy (1939a) developed this structured approach for working with children based on a belief that by recalling a repressed traumatic experience the child would release emotional tension. Through this structured process, the child is able to work through issues that otherwise had presumably been blocked by fear (Levy, 1939a, 1939b). As in psychoanalysis, the therapist takes major responsibility for the experience and structures a specific experience with the intent to cause an abreaction for the child. Levy believed that the release of negative feelings becomes therapeutic for the child. In this approach, the therapist does not utilize interpretations, as with psychoanalysis, and repeating experiences through play is critical (James, 1977). In this time period parents were urged to structure play experiences, and it was believed that lack of provision would allow the child to develop irresponsible and destructive play habits (Alschuler & Heinig, 1936).

Gove Hambidge (1955) expanded on Levy’s release therapy approach, naming it *structured play therapy*. In this approach, the therapist directly recreated the event, allowing the child to play out the situation and then giving the child the opportunity to use free play to recover from the procedure. Hambidge believed that therapists must carefully select and gauge the structured activities so as not to provide an experience that is overwhelming or threatening to the child (James, 1977; Rogers, 1939).
The third significant development in play therapy took place with the emergence of relationship therapy and the work of Otto Rank (1936). Additional contributors to the principles of relationship therapy include Frederick Allen, Jessie Taft, and Clark Moustakas (O’Connor, 1991). In relationship play therapy, the emphasis is placed on the “curative power” of the therapeutic relationship and focuses on the reality of the present rather than on past history (Landreth, 2002; Rogers, 1939). In this approach, the therapist allows the child to take the lead in deciding whether or not to play. The therapist believes in the child’s inner capacity to move toward mental health, growth, and self-actualization (Landreth & Sweeney, 1997). In addition, the therapist focuses on material that is of importance to the child and does not structure, choose toys, or interpret. Carl Rogers expanded the work of relationship therapy to develop nondirective therapy, later referred to as client-centered and today as person-centered therapy (James, 1977).

Kottler (2004) gave credit to Carl Rogers for emphasizing the importance of the relationship within the context of the therapy. Rogers (1980) suggested that three specific principles must be present in order for a relationship to be growth promoting in a person-centered approach. These conditions include genuineness, unconditional positive regard, and empathetic understanding. First, genuineness, realness, or congruence is the ability of the therapist to experience openly the feelings of the moment rather than putting up a personal façade or professional front. The second characteristic, unconditional positive regard, is an attitude of acceptance that is experienced by the client as conveyed through the therapist’s attitude, which expresses the therapist’s total acceptance of the client, which is unconditional. Third, empathetic understanding means that the therapist experiences what the client is expressing and conveys this understanding back to the client. This nurturing condition, facilitated by the therapist, sets the climate for change based on the fact that the client feels accepted, prized, and heard. Through this
relationship, the client becomes more true to the self, which results in innate growth and maturity. These characteristics, accompanied by play, help facilitate full expression to otherwise inhibited thoughts and feelings (Rogers, 1942, 1951). In the 1960s and 1970s play in child development became a strong focus of research, with studies enforcing the idea that play contributes to a child’s emotional and intellectual growth (Power, 2000).

The work of Virginia Axline (1947) marked the fourth major development in play therapy. Axline’s Play Therapy (1947) discussed her application of nondirective principles to children. In this approach, children have the choice to play or not play, to talk or not talk. Acceptance is conveyed as the play therapist actively reflects the child’s feelings, thoughts, and actions. Axline (1969) wrote that this accepting relationship between the therapist and child enables the child to utilize inner resources to construct a happier life as an individual and increase positive self-perceptions about his/her relationships.

Axline (1947) believed that eight basic principles guide the therapist in developing a safe, productive environment for the child. These eight principles are, as follows: (a) develop a warm, friendly, relationship with the child; (b) accept the child exactly as he/she is; (c) develop a feeling of permissiveness so the child feels free to express feelings completely; (d) recognize and reflect feelings so that the child can gain insight into his/her behaviors; (e) respect that the child can solve his/her own problems and believe that the responsibility to change rests on the child; (f) the child leads the way, the therapist follows; (g) the therapist understands that therapy is a gradual process and does not rush the child; and (h) the therapist sets only limitations that are necessary (p. 75). These principles, introduced by Axline, are referred to as the underlying assumptions used in various research studies with children.
Garry Landreth (2002) expanded on and refined the work of Virginia Axline (1947), Louise Guerney (2001), and Clark Moustakas (1953), coining the phrase *child-centered play therapy*. A child-centered play therapist is active in the child’s play; however, it is not in the sense that he/she initiates or directs the play. The child-centered play therapist does not make interpretations, label items, ask questions, or evaluate the child’s behavior. Instead, the therapist demonstrates, both verbally and nonverbally, genuine interest in the child’s feelings, actions, and decisions, rather than in the child’s problem. By allowing the child to lead in the direction of the play, opportunities for self-discovery are increased (Landreth, 2002). Axline (1969) suggested that as the therapist observes the child, he/she gains a full understanding of the child’s world and can encourage expression of thought and feelings that may otherwise be verbally inaccessible.

In order to encourage expression and growth, the therapist is permissive and accepting, within certain limits. Functional boundaries are created in order to protect play materials, the room, the child, and the therapist. The child needs to feel free, as well as safe, to express himself or herself as the need arises. The movement towards self-actualization begins as the therapist allows the child the opportunity to express emotions, feelings, and behaviors at his/her own pace (Landreth, 2002). It is believed that play therapy can be most effective when the therapist allows the child to take the lead in order to provide the child with opportunities for self-discovery and problem solving (Guerney, 2001). Axline (1969) summarized the value of the play experience as follows:

> There is frankness, honesty, and vividness in the way children state themselves in a play situation. Their feelings, attitudes, and thoughts emerge, unfold themselves, twist and turn and lose their sharp edges. The child learns to understand him and others a little better and to extend emotional hospitality to all people more generously, (Preface).
Rationales for Using Play Therapy

Play has been called the universal language of children (Landreth, 2002; Schaefer, 1993). Children of all cultures, ethnic groups, and nationalities play naturally. They do not need to be taught to play; it is spontaneous, enjoyable, and voluntary (Landreth, 2002).

Since developmentally children have not formed the ability to think abstractly and reason as adults, play provides a concrete means of expression (O'Connor & Braverman, 1997; Piaget & Inhelder, 1967/2000). Play is for children what verbal communication is to adults, where toys and materials are used instead of verbal expression (James, 1977). Children naturally use the toys to symbolically express their experiences, so play serves as a “window” into their thoughts and feelings (Henniger, 1994). Children in play therapy can transfer anxiety onto toys rather than people.

A feeling of safety occurs when children are able to place distance between their feelings and the experience. Landreth (1993) suggested that children are able to cope and adjust to problems when traumatic events are processed symbolically in fantasy, making difficult issues less threatening (Landreth & Bratton, 1999). What was unmanageable in reality becomes manageable in fantasy through symbolic representation and expression.

The purpose of play therapy is to understand the child, rather than focusing on someone to be cured or changed (O'Connor & Braverman, 1997). In child-centered play therapy, the therapist is concerned with developing a healthy child/therapist relationship that will facilitate the child’s inner emotional growth (Landreth, 2002). Person-centered, nondirective, or client-centered therapies have been demonstrated to be efficacious with adults, as well as with children with a variety of problems (Guerney, 2001).
Developmental Rationale in Using Play Therapy Counseling

Cognitive development. Jean Piaget developed four stages of cognitive development. These levels are qualitatively different, with each stage marked by behaviors that are different altogether rather than a gradual increase in different behaviors. His work has inspired more research than any other single theory (Berk, 1994). Between the ages of birth and 2 years, children are in the sensory-motor stage. This stage is characterized by their use of senses and movements, both reflexive and intentional, in order to explore their surroundings. The preoperational stage, which extends from 2 to 7 years, involves use of symbolic play. At this stage, children can use mental images and symbols to represent their world; however, children in this stage have not developed logical thinking (Singer & Revenson, 1996). According to Piaget (1977), logical thinking and reasoning are developed after age 7, during the concrete operational stage. In this stage, children begin to understand that a one-ounce ball of Play-Doh is the same amount, even if it takes on a different shape. Finally, around the ages of 11 to 16, come the development of formal operational thought processes and the ability for abstract thought. This period is characterized by reasoning, understanding of concepts, and problem solving (Berk, 1994).

Play in development. Development is an important consideration when working with children. According to Piaget, the psychological development of a child involves growth of becoming an emotional being that is able to interact successfully with people. Piaget’s research was not based on statistical measures, but on observations and transcripts of the free conversation of children. He understood that with children, one must not be so dependent on language, but rather on tasks. His research methods were based on the premise that young children may not yet have developed the skill of verbally expressing thoughts and emotions (Singer & Revenson, 1996).
Piaget’s research involved close observation of children’s use of materials and an exploration of the child’s reasoning behind the behaviors. He found four principal categories of play. One category, symbolic play, is considered the apogee of children’s play. In this category, play demonstrates an expression of the child’s inner life as well as responses to life’s challenges (Fromberg & Bergen, 1998). Through symbolic play children cannot only adapt, but also assimilate their experiences to their perceptions of the world. In symbolic play, play materials often assist in the expression of unconscious conflicts such as sexual interests, anxiety, fears, and identification with aggressors, risks, or competition (Piaget & Inhelder, 1967/2000).

The first category, exercise play, is at a motor level and involves the child’s repetition of the functional pleasure of practicing a newly acquired skill. The second category, symbolic play, involves the child’s imitating and assimilating of their world using symbolic language rather than verbalization. Symbolic play is a high point in the play experience for children. In the third category, games with rules enrich the social life of children in that they learn what is expected and accepted by their peers. The last category includes games of construction, involving intelligent creations, experimenting with solutions, and problem solving (Piaget & Inhelder, 2000). Piaget believed that all play is significant because it comes from the child’s inherent needs and offers opportunity for growth. Play provides children with opportunities to organize and reorganize their experience of a changing world. It is through this experience that coping skills are developed and growth occurs. For Piaget, this type of growth is defined as intelligence. He asserted that play advances the child’s cognitive development (Singer & Revenson, 1996).

Although Piaget’s concepts are widely known in the field of child development, Hinman (2003) indicated that they are not universal and do not account for patterns of play in other cultures. Hinman noted examples in the Far Eastern cultures, where play behavior is considered
frivolous. Japanese children find nonstructured or symbolic play often threatening. Hinman suggested that the Hispanic culture values pretend play or symbolic play as a necessary part of child development.

Vygotsky’s (1962) view of play in child development is different from that of Piaget’s. For Vygotsky, symbolic play is significant for promoting a child’s growth in imagination and creativity, whereas social dialogue is important for cognitive development (Rozycki & Goldfarb, 2001). Vygotsky theorized that when humans are around 2 years of age, language (verbal and symbolic expression) and thought (not innate but, rather, shaped by culture), which previously have been developing independently, are occurring conjointly. The combination of social interaction and then symbolic expression plays a role in the formation of higher order thinking. Lower order thinking is the culturally mediated knowledge and experiences presented through generations of interactions with the social environment. Self-awareness occurs as the individual begins to internalize the cultural information through signs and symbols that become a function of higher order thinking (Rozycki & Goldfarb, 2001).

In symbolic play, a child transforms objects and environments into creative scenarios, replicating symbols for the purpose of play (e.g., superhero, villain). Symbolic play offers children a way to express fantasies and desires, as well as acting as a catharsis for pent-up emotions of the unconscious mind (Vygotsky, 1962). This play allows children to assimilate the information provided through the social and cultural environment and serves as a mode of expression of the child’s developing personality, sense of self, intellect, and social capacity (Vygotsky, 1933/2002).

Rationale for Using Play Therapy with Hispanic Children

Play is widely viewed among many authorities in the field as a natural medium in which all children communicate (Axline, 1947; Dunn & Griggs, 1993; Oaklander, 1988). In addition, play
is a significant part of the natural development of children, and thus its universality among children throughout the world is understood (Cochran, 1996; Landreth & Bratton, 1998). Studies in evolution have demonstrated that children integrate cultural information through imitation done in ritualistic play. Through this communication, traditions are passed to each new generation (Vandenberg & Kielhofner, 1982). In play, children express the beliefs, traditions, and history that develop their uniqueness as an individual, as well as their culture (Santiago-Rivera, 1995). Many cultures value play as important to child development, and in Hispanic culture this is especially true. Hispanic parents view play as a vital part of child development, and parents often engage children in play in order to assist them in meeting milestones (O. Ramirez, 1998).

Language offers a means of communicating the cognitive structuring of how people perceive the world, their self-concept, and their identity. When a language barrier is present, counselors are faced with the dilemma of how to effectively work with the client (Canino & Spurlock, 1994). Cochran (1996) indicated that play therapy could be one answer to this dilemma. Play therapy is considered an asset because inhibited children can use this opportunity to add vocabulary to their emotions. One caution is that counselor indifference to the significance of the historical, socioeconomic, political, and cultural factors that comprise the child’s ethnic makeup could become a barrier to effective treatment. Culturally specific toys should be chosen for their familiarity and prevalence in the child’s culture.

Santiago-Rivera (1995) suggested that culturally sensitive treatment involves allowing individuals to express their values, customs, and beliefs in their own language. They urge counselors to understand the significance of merging language and expression of culture. In order to apply this concept to children, since children use toys as a form of communication, the play environment should include culturally specific toys to allow the children symbols that they can
identify with more readily. Therapists have been urged to consult with a Hispanic therapist to gain an understanding of the needs of this group (G.Glover, as cited in Landreth, 2001).

Rationale for Using Culturally Responsive Play Therapy

Canino and Spurlock (1994) suggested that children are greatly affected by the influence of various factors, including socioeconomic, racial, ethnic, religious, and political. The influence of such variables as culture and social influence over the behavior of an individual was noted as early as the 1930s (Rogers, 1939). An article by Liu and Clay (2002) identified multicultural guidelines in working with children and adolescents. They suggested that children are unable to abstractly understand the concepts of culture and race and place themselves in these constructs. Therefore, the counselor must provide opportunities to assess the child’s level of understanding and integration of diversity and multiculturalism in his/her life and the role it plays. More significantly, the *Diagnostic and Statistical Manual of Mental Disorder, 4th-TR* (DSM-IV-TR) (American Psychiatric Association, [APA], 2000), which is recognized as a tool for categorizing symptoms into diagnoses to help in assessment, offers guidelines for understanding cultural impact on an individual’s identity. Three specific guidelines are the consideration of (a) the child’s cultural reference groups, (b) the child’s degree of involvement in host and historical cultures, and (c) the child’s language abilities and use.

Haim Ginott (1960) noted that there was a connection between the therapeutic relationship and appropriate toy selection. He indicated that the therapist must consider toys that will make it easier to understand what the child is trying to communicate. Therefore, the appropriate toy helps facilitate communication. Coleman, Parmer, and Barker (1993) suggested that children would benefit from culturally specific toys to help express the struggles that are closely related to race and culture. The list included dolls with ethnic features and ethnic skin tones, an understanding of
cultural themes that might appear in play, and an understanding of ethnic values and customs. Other authors indicated that a client with a counselor of the same culture may offer similarities or better understanding of language, cultural knowledge, and values, thus allowing the client to feel a sense of connection and safety (Esquivel & Keitel, 1990; Gibbs et al., 1998; O. Ramirez, 1998). Esquivel and Keitel (1990) warned that many minority clients may view the American counselor as having majority cultural status, and they suggested that the counselor’s level of experience and degree of empathy and competence are critical factors in determining client success in counseling.

Child-centered play therapy with Hispanic children. Early studies (Parsons, 1935; Schwartz, 1969) that examined the differences in value concepts of people from different cultures revealed that typically Hispanics are more present-time oriented and demonstrate more expressive behaviors compared to Caucasian Americans, who are generally more goal oriented and demonstrate more disciplined behaviors. These characteristics might support the use of child-centered play therapy, since it is both present-centered and expressive. However, there is controversy. Del Castillo and Torres (1988) argued that many earlier studies influenced negative thinking about the Hispanic culture. This led to misrepresentation of the culture, in particular when studies were repeated with little regard towards the validity of the research model. One example is the Hispanic value concept of “being,” which focuses on spontaneity rather than on the “doing” value of European Americans, which involves achievement, work, and action. Brice (2002) indicated that Hispanics who follow the traditional value of “being” rather than “doing” have been described as having low aspirations and possessing a low activity level.

Researchers who appear to support the use of client-centered play therapy with Hispanic children have suggested that Hispanics tend to prefer interpersonal relationships that are nurturing, loving, intimate, and respectful (Altarriba & Bauer, 1998; Constantine, 2001). Moustakas (1973)
introduced faith, acceptance, and respect as imperative attitudes of a child-centered play therapist. This accepting and respectful relationship makes child-centered play therapy an ideal intervention for Hispanic children (L. Ramirez, 1999). Koss-Chioino and Vargas (1992) noted that culturally responsive psychotherapy involves empathy and congruence on the part of the therapist. This information validates the seemingly ideal fit between Hispanic children and child-centered play therapy. While the relationship between child and therapist is of great importance, the environment is also significant in the intervention (Glover, 2001). Martinez and Valdez (1992) asserted that the play environment should contain culturally sensitive toys and materials that demonstrate the therapist’s openness to the child’s cultural background. Brice (2002) and Preciado and Henry (1997) implied that, for children whose first language is something other than English, emotions, feelings, and affect are frequently expressed in their original language; thus, culturally specific toys, as well as a same-culture counselor would be most effective with this population. In addition, it has been suggested that attempts to maintain the child’s natural language during activities would benefit the child’s growth (Brice, 2002; Landreth, 2002).

In contrast to the argument for client-centered play therapy, Hinman (2003) suggested that Hispanic parents will expect a problem-focused approach from the therapist and that any deviation from that will need clarification in order for the parent to have a better understanding of the process. Hinman argued that, in some cases, the therapist should take a directive approach, such as modeling through play sequences with dolls in order to teach coping methods. Hinman indicated that toys that encourage connectedness and interdependence are more facilitative to the Hispanic culture than toys that facilitate independence.

Dana (1998) utilized the Acculturation Rating Scale for Mexican Americans (ARSMA, ARSMA-II) in order to investigate the role of cultural orientation and the acceptability of
counseling services with Mexican American students. Dana indicated that Mexican American students prefer a more directive counseling style for personal, social, and academic/career problems. Additionally, the study suggested that Mexican American students rated an ethnically similar provider as having a strong attraction, with first-language usage being a significant factor for building trust. Although the variable of directive versus nondirective was of value, Dana suggested that ethnicity had greater importance than other provider or service variables for Mexican American students.

*Ethnic identity development.* An individual’s unique identity stems from the language of the culture, from which a wealth of information that includes values, norms, heritage, and feelings has been passed on. Brice (2002) noted that, for Hispanic people, Spanish is the language of emotions and is valued because it is familiar and comfortable. In addition, for Hispanics, the English language is respected as an avenue towards education and forward movement on the road to success. Thus, in counseling, practical application of this knowledge for a bilingual counselor might be to pay specific attention to what clients or the family system reveals about themselves in the different languages, to understand how they experience themselves and others. An individual approach in which the communication is led by the client might keep the counselor from overgeneralizing knowledge about the culture (Hinman, 2003).

Bernal and Knight (1997) investigated the relationship between age and ethnic identity. Results suggested that Hispanic children begin to have a considerable understanding of their ethnic identity between the ages of 6 to 8 years old. At this age, they have an understanding of self-identification, grouping of others, ethical knowledge, and they use ethnic role behaviors. Bernal and Knight recommended that as children develop ethnic identity, familial and nonfamilial agents may inadvertently cause conflict in transmitting views and values regarding adoption of
ethnic versus Anglo customs. Landreth, Homeyer, Glover, and Sweeney (1998) noted that child-centered play therapy with Hispanic children, who are struggling with developing a sense of ethnic identity, might offer a way to explore ethnic learning and struggles in a nonjudgmental atmosphere.

Children’s ethnic identity in the Hispanic culture is nurtured and utilized by parents as a way to teach and empower (Gibbs et al., 1998). Therefore, in counseling Hispanic children, the use of culturally specific toys may serve to encourage the child to explore freely. Toys that reflect primarily Caucasian values might indicate to the child that they are in a dominant culture and need to conform, and this might inhibit communication (Hinman, 2003; Vandenberg, & Kielhofner 1982).

*Clinical efficacy of play therapy with Hispanic children.* In a meta-analysis that examined the effectiveness of play therapy, the researchers were unable to study the effectiveness of play, historically speaking, with Hispanic children because the majority of the studies did not code ethnicity as a category (Ray, Bratton, Rhines, & Jones, 2001). Although a review of research done with Hispanic children using play therapy interventions revealed few studies, the results of its effectiveness are promising. Dunn and Griggs’s (1993) research with school-aged Mexican American boys found that games and play therapy techniques were preferred learning modalities and that talk-through counseling was generally not effective for these children. One speculation is that they are generally inhibited about talking around adults, who are seen as authority figures. This is supported by LeBlanc and Ritchie’s (2001) meta-analysis of play therapy research, which suggested that children who do not do well with talk-oriented therapies would respond well to play therapy.
One aspect of the movement to better understand the Hispanic culture is the idea that the strength of Hispanics is their ability to educate one another via storytelling, parables, chronicles, and biographies. The \textit{cuento}, or story, is seen as the way to understanding, analyzing, and teaching people of this culture, particularly children (Tejeda, Martinez, & Leonardo, 2000).

Costantino, Malgady, and Rogler (1986) developed \textit{cuento therapy} as a modeling therapy designed to be sensitive to the Puerto Rican culture. Cuento therapy involves the reading of folktales to young children, followed by identifying problem-solving skills as they relate to cultural values. Role-play was also a part of identifying alternative solutions to problem solving. Results of their study indicated that both the treatment group who received cuento therapy and the treatment group who received art/play therapy (e.g., games, puzzles, drawing, puppet role-play, and object assembly) demonstrated significantly reduced mean trait anxiety scores at posttest, when compared to the no-treatment control group.

Trostle (1988) believed that the effects of group play could serve to facilitate Puerto Rican children’s social, representational, and adaptive skills in group settings. Trostle’s study using child-centered group play therapy with bilingual Puerto Rican preschool children found that child-centered group play sessions were effective in promoting social-emotional growth. This validates the effectiveness of play therapy with this specific cultural group.

Omizo and Omizo (1989) reported that when minority children experience an educational system developed for members of the dominant Western culture, they may develop low self-esteem that inhibits their motivation towards academic achievement. In his study with Hawaiian students receiving expressive arts therapy, the children reported a significant increase in self-esteem. One might infer that, similar to child-centered play, children of diverse cultures who
are allowed to self-actualize through self-expression can gain a better understanding of themselves and their environment.

Kalish-Weiss (1989) designed a study that took place in an urban Los Angeles elementary school. Kalish-Weiss collaborated with the Los Angeles Unified School District and the Los Angeles Department of Mental Health and established that this group of Hispanic students exhibited problems that placed them at risk for school failure. The treatment group spoke mostly Spanish, and although they were attending schools in the United States, they came from families that upheld Mexican traditions and culture. The treatment involved creative therapies such as dance and art therapy, which Kalish-Weiss believed to be more culture-bound than traditional psychotherapy techniques. She believed expressive therapies to be more appropriate with this group, especially since many of the children involved in the study spoke limited English. Posttreatment anecdotal evidence revealed that the children in the program showed reduced symptoms of inattention and depression, while increasing academic success. Additionally, she noted that the children seemed to be more inclined to verbally discuss fears and concerns.

School-based Counseling

Historically, elementary school has been considered the most critical component in the education hierarchy, because it provides children with both educational and psychological foundations (Gibson, Mitchell, & Basile, 1993). The classroom setting requires children to do well in performance, conduct, and attitude in order to be successful. These demands are often different from the expectations of the child outside the school setting. Although many children deal with these new tasks without much difficulty, for some, the complexity of the new situation can be overwhelming, and many are referred to the school counselor for help. However, the majority of U.S. schools lack sufficient counseling staff to meet the needs of all students requiring
counseling services in order to reach their academic and human potential. In fact, the Surgeon General’s Report on Mental Health (U.S. Public Health Service, 2001) called for increases in school-based counseling services. The report emphasized that providing children with greater access to mental health services in the school settings could be an important factor in reducing the barriers to academic success, and by intervening early, could prevent the development of more serious mental health problems in adolescence and adulthood.

Mash and Dozois (1996) estimated 14-22 % of all children experience developmental, emotional, and behavioral disorders. Currently, schools are the primary providers of mental health services. Seventy percent of the children who receive counseling services receive services from the school rather than from outside sources. According to the U.S Census (2000b), Hispanics account for 17% of school enrollment. Today, school-based counseling must also assist the community in dealing with issues that affect children, such as the poverty, unemployment, hunger, violence, abuse, and neglect. Schools have no choice but to address the impact of these problems, because, for many families, the school is the only resort (Worzbyt & O’Rourke, 1989).

Elementary-age children are continuously developing values and skills associated with decision making, communication, and life views that shape mental and social development. Gysbers and Henderson (2001) used the term human career to define the developmental process of integrating all the aspects that formulate the total self. These include home, school, and community, as well as physical, intellectual, and emotional growth processes. In these formative years, children have experiences that enable them to live, learn, and work as productive members of society. School counseling is a supportive component in the goal of education in that it enables children to acquire skills that will help them become competent and responsible adults. School-based counseling services can help young children at risk for failure by providing social
Counseling Services in a Comprehensive School-based Program

In the past, school-based counseling services have been criticized for such issues as a lack of consistent identity, variation in roles from school to school, and non-school counselor responsibilities, all of which have contributed to the misunderstanding of the role of school counselor (Gysbers & Henderson, 2001). The governing board of the American School Counselor Association (ASCA, 2003) passed a resolution to develop a national model that would correct the historical criticisms of the profession, as well as focusing on the treatment goals, impact, and effectiveness of the services being provided. Gysbers and Henderson (2001) described the organizational framework that formulates a comprehensive school guidance program. They identified four program components: guidance curriculum, responsive services, individual planning, and system support. The national model for school counseling programs developed by ASCA proposes (Gysbers & Henderson, 2001) four components as the preferred delivery system of services to schools.

The guidance curriculum component typically consists of organized modules that teach knowledge, awareness, and basic life skills to prevent student problems in the future and to help students apply skills to everyday life. Systematic activities are presented with each module to children from grade levels K-12 and are usually presented to an entire classroom or group of children (approximately 6-8) (Gysbers & Henderson, 2001). White and Flynt (1999) suggested that, ideally, guidance counseling services should be provided in a developmentally appropriate manner. Thus, while a kindergarten classroom guidance curriculum might focus on making friends, a fifth-grade classroom guidance curriculum might entail an activity promoting the
understanding of peer pressure. The use of classroom guidance in schools provides the most efficient use of the counselor’s time, while providing for the socialization of many children by building specific resilient attributes (Gibson et al., 1993; White & Flynt, 1999). Specifically, autonomy, social competence, problem-solving skills, and a compelling sense of purpose and future are targeted as goals. In some instances, the guidance curriculum is delivered in smaller groups that are primarily didactic and structured in format while focusing on the emotional side of learning. They are generally intended to be preventative, concentrating on early identification of problem areas, but they are also used as a direct intervention (Pedersen & Carey, 2003; Worzbyt & O’Rourke, 1989).

Gibson et al. (1993) listed four rationales for school-based guidance groups:

1. By nature, human beings are group oriented.
2. Groups are influential in how individuals acquire knowledge and values.
3. Groups influence the behaviors of the individual.
4. Counselors can influence learning by use of groups.

Brice (2002) and Losey (1997) noted that Hispanic children will benefit from activities that involve groups over individuals because the group setting closely mirrors the support system of community predominant in the Hispanic culture. According to a study by Ammon (1985), bilingual classroom environments that exhibited an almost “familial” relationship among students and teacher were most successful. This suggests that considerations of language and community contribute to the student’s school success.

The second component, responsive services, addresses intervention more than preventative concerns. School counselors in this role work with students who are having learning, emotional, and social difficulties that affect personal identity development, as well as academic development.
Both individual and group guidance curriculums are utilized in this component, and additional strategies may include consultation and referral (Gysbers & Henderson, 2001). Ray, Muro, and Schumann (2004) suggested that play therapy is a developmentally appropriate intervention that qualifies as a responsive service.

Individual planning is the third component, in which the counselor assists students in understanding their educational and occupational values, goals, abilities, aptitudes, and interests. Strategies might include testing, tutoring, advisement, and establishing career options (ASCA, 2003). An example of individual planning on the elementary level might involve encouraging a student who scored high in science to enter a project in the school science fair, while referring him/her to science-based Web sites.

The last component is not directly delivered to the students; however, it is considered a major program component. Without system support, the other components of the comprehensive school guidance program are ineffective. Although often overlooked, the indirect benefits of system support to the students are undeniable. Activities such as research and development, staff development, community relations and outreach, advisory boards, program management, accountability, and program time are central to program balance and function (Gysbers & Henderson, 2001). The American School Counselor Association (2003), in endorsing these four components in their national model for a comprehensive school guidance program, urged that the national model should be integrated into each school’s mission to help emphasize students and their success.

Additionally, ASCA (2003) adopted a position statement encouraging school counselors to take action to ensure that students of culturally diverse backgrounds have access to appropriate services and opportunities that promote the maximum development of the individual. This is
supported in the No Child Left Behind Act (Paige, 2001), which indicates that it is the responsibility of schools to provide resources for supplemental services for children who are lagging behind developmentally, academically, and socially. The goal specifically is to target the achievement gap between disadvantaged minority students and their peers. The school counselor’s responsibility is to be accountable for demonstrating how the school counseling program contributes to the commitment of the school agenda in closing the gap. For the purpose of this study, bilingual services were provided to individuals and families participating in the study.

Rationale for Using Play Therapy in Schools

According to Landreth (2002), having an understanding of children through a developmental perspective includes having an understanding of their natural means of communication, which is play. Developmentally, children have not yet fully acquired the facility for expression through speech, and the concrete world of play offers a means to communicate that is both comfortable and natural to the child. Play therapy helps children in an elementary school setting become ready to profit from the learning experiences offered, as well as being a successful intervention tool for use with Externalizing or Internalizing behavior problems. White and Flynt (1999) reported that school counselors have a responsibility to provide services that are appropriate to the developmental needs of the children they serve. They emphasized that play-based experiences are a way to help facilitate cognitive development, emotional adjustment, and school success in elementary aged children. Play is already a natural activity of children through which they can communicate, test, incorporate, and master their world. Berg (1971) stressed the importance of the utilization of play-based services by school counselors by urging that play therapy skills should be as utilized as much as the use of verbalization and behavior modification.
In a year-long play therapy program provided in an elementary school, Ray et al. (2004) noted the challenges and benefits of providing play therapy in the schools. One challenge the authors noted is that the high transition rate of teachers and students in this school made it difficult to collect posttreatment data. However, qualitative data via school administrators suggested that office referrals for behavioral disturbances among play therapy children had decreased compared to their individual records prior to treatment. In addition, interviews with teachers revealed that children in the play therapy program demonstrated positive changes in the area of classroom behavior. Therefore, this evidence suggests that while collecting quantitative data can from teachers can be difficult, qualitative data via teacher and administrator reports appears to be a valuable method to assess the benefit of play therapy as a school intervention.

In a meta-analysis of play therapy outcome research spanning 6 decades, Ray et al. (2001) found that play therapy is an effective intervention for children’s problems. Of the 96 studies, 36 were conducted in a school setting. The meta-analysis revealed that groups receiving play therapy performed .80 standard deviations better than nontreatment groups. This is considered to be a “large” effect size. Outcome-based research demonstrates that play therapy is both developmentally appropriate and an effective intervention. Play therapy as a part of counseling services in elementary schools seems to be gaining momentum; however, it has been a slow process (Fall, Balvanz, Johnson, & Nelson, 1999).

Landreth (1993) described the following four factors contributing to the slow growth of play therapy programs in elementary schools:

1. Play as a form of therapy is quite young.

2. School counselors were not added to the elementary staff until the 1960s.

3. School personnel are not yet aware of what play therapy is.
4. Specific play therapy training in colleges/universities is sparse. Landreth pointed out that many professionals who work with children may believe that verbal communication is an effective approach with elementary-age children. The need for more publicity regarding the effectiveness of play therapy was recognized by the *Elementary School Guidance and Counseling Journal*, which dedicated an entire issue to the use of play in counseling (Gerler, 1993).

*Rationale for Using Curriculum-based Counseling Programs in the School.*

The Texas Education Agency (1998) has adopted the four components of counseling services as specified in the American School Counselor Association’s national model. The guidance component is the largest component utilized at the elementary school level and is defined by planned sessions, in units, designed for groups of students. The curriculum utilized for the curriculum-based small group counseling treatment group in this study was similar to typical curriculum-based material utilized in many school districts with elementary-age children.

*Kid’s Connection* is a curriculum-based counseling model that focuses on cognitive-behavioral, preventative intervention, as well as competence enhancement for the children participating in the groups. Rainbow Days (2003) indicated that its model is appropriate for children who need more structure and support and noted that the model’s success has been empirically validated with children who struggle with prosocial attitudes and behaviors. Additionally, Rainbow Days reported that it had convened a panel of experts to determine the appropriateness of the curriculum-based model and that the panel found that the *Kid’s Connection* curriculum was without gender, ethnic, or racial bias.

According to Kumpfer (1993), children who participate in intervention programs are representative of a segment of population characterized by biological, environmental,
demographic, and psychosocial risk factors. These risk factors may include children identified to have conduct problems, reside in low-income neighborhoods, or reside in neighborhoods with high drug use or crime rate. Kid’s Connection implements a variety of interactive and experiential activities designed to strengthen the interpersonal and social skills of its group members in order for them to build the resiliency to overcome adversity and succeed in spite of the negative influences in their lives (Garmezy & Masten, 1994).

The Texas Education Agency (1998) indicated that the guidance curriculum utilized in public schools is an integral part of the students’ academic experience and should be developmentally appropriate. Rainbow Days (2003) indicated that its curriculum offers an array of age, developmentally, and culturally appropriate lessons and activities. Rainbow Days was awarded the Exemplary Substance Abuse Prevention Award for its curriculum-based model of life-skills education for children in high-risk situations and reported that its curriculum-based model is empirically validated (Brown, 1998; Rainbow Days, 2003).

Summary

In summary, the current numbers of Hispanic children and estimates of their future population growth provide credible evidence that counselors will increasingly be called upon to intervene with this group. In addition, the changing demographics have significant implications for the counseling profession. One major concern is that the counseling community lacks the resources to meet the growing needs of ethnic minority students, specifically Hispanics, who often experience significant obstacles and stressors in adjusting to the school environment. These obstacles can interfere with academic success and can lead to mental health problems. Play therapy is widely accepted as an effective treatment modality for children. However, research with Hispanic children and play therapy is sparse.
The current literature implies that the child-centered approach to play therapy seems to be particularly suited to meeting the treatment needs of Hispanic children. Empirical evidence used to identify what constitutes effective treatment for minority children would greatly enhance the opportunities for gaining future funding and resources. Suggested research areas include identification of ways in which individuals are shaped by culture, language, and tradition. Research in these areas would provide beneficial information to the counseling community and lead to responsive, effective, treatment for Hispanic children.
CHAPTER 2

METHODS AND PROCEDURES

This study utilized a pretest/posttest comparison group design to examine the effects of culturally responsive child-centered play therapy on the internalizing and externalizing behaviors of Hispanic, elementary school-aged children referred for Externalizing and Internalizing behavior difficulties. Volunteer kindergarten through fifth-grade students who met the specified criteria were assigned to either the culturally responsive child-centered play therapy experimental treatment group or the curriculum-based small group counseling comparison treatment group. The experimental treatment group received 15 weeks of individual culturally responsive child-centered play therapy. The comparison treatment group received 15 weeks of curriculum-based small group counseling. This chapter outlines the methods and procedures used to carry out this study. Included are the definitions of terms, hypotheses, instrumentation, and selection of participants, data collection, treatment, data analysis, and limitations of the study.

Definition of Terms

*Child-centered play therapy:* Child-centered play therapy has been defined by Landreth (2002) as follows:

*[It] is a dynamic interpersonal relationship between a child and a therapist trained in play therapy procedures who provides selected play materials and facilitates the development of a safe relationship for the child 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.* (p.14)

Child-centered skills are listed in Appendix E.
Culturally responsive play therapy: For the purpose of this study, culturally responsive play therapy is defined as play therapy conducted by a trained Hispanic, bilingual (speaks both Spanish & English) play therapist, in a room equipped with selected toys that are perceived to be specific to the environment, culture, and lifestyle of the Hispanic children in the North Texas region. A list of toys chosen as symbols for their prevalence in the Hispanic culture is found in Appendix B.

Curriculum-based small group counseling intervention: For the purpose of this study, curriculum-based small group counseling intervention was conceptually defined as a small group counseling modality in which a counselor provides developmentally appropriate life-skills education for children in high-risk situations. The curriculum used for this study is titled Kids Connection and is a program titled Rainbow Days Incorporated (2002). The program utilizes developmentally appropriate, playful, and expressive art activities and games for children in K-5th, to specifically target social skills issues, including communication, decision making, and getting along with others. Kid’s Connection curriculum as utilized in this study is similar to the responsive service component of school-based services, one of the four components as defined by the National Model according to the American School Counselors Association.

Externalizing behaviors: Externalizing behaviors refer to the outward expression of internal problems. For the purpose of this study, the Externalizing Problems Composite scale of the Behavior Assessment Scale for Children (BASC) operationally defined externalizing behavior problems. Specifically, this scale is made up of three subscales measuring Conduct, Aggression, and Hyperactivity.
Hispanic children: For the purpose of this study, the designation of Hispanic children included children living in North Texas, who were identified by the parent as being Chicano/a, Hispanic, Latino/a, Mexican, or Mexican American.

Internalizing behaviors: Internalizing behaviors can be described as the inward expression of experiences. For the purpose of this study, the Internalizing Problems Composite scale of the Behavior Assessment Scale for Children (BASC) operationally defined internalizing behavior problems. Specifically, this scale is made up of three subscales measuring Anxiety, Depression, and Somatic complaints.

Research Hypotheses

To carry out the purpose of this study, the following hypotheses were formulated:

1. The Hispanic children in the culturally responsive child-centered play therapy treatment group will attain a statistically significant lower mean score on the Externalizing Problems scale on the Behavior Assessment Scale for Children-Parent Report Scale (BASC-PRS) posttest, as compared to the pretest, than will the Hispanic children in the curriculum-based small group counseling comparison treatment group.

2. The Hispanic children in the culturally responsive child-centered play therapy treatment group will attain a statistically significant lower mean score on the Internalizing Problems Scale on the Behavior Assessment Scale for Children-Parent Report Scale (BASC-PRS) posttest, as compared to the pretest, than will the Hispanic children in the curriculum-based small group counseling comparison treatment group.

3. The Hispanic children in the culturally responsive child-centered play therapy treatment group will attain a statistically significant lower mean score on the Externalizing Problems scale on the Behavior Assessment Scale for Children-Teacher Report Scale (BASC-TRS) posttest, as
compared to the pretest, than will the Hispanic children in the curriculum-based small group counseling comparison treatment group.

4. The Hispanic children in the culturally responsive child-centered play therapy treatment group will attain a statistically significant lower mean score on the Internalizing Problems Scale on the Behavior Assessment Scale for Children-Teacher Report Scale (BASC-TRS) posttest, as compared to the pretest, than will the Hispanic children in the curriculum-based small group counseling comparison treatment group.

Instrumentation

The Behavior Assessment Scale for Children (BASC) consists of two scales, the Parent Rating Scale (BASC-PRS) and Teacher Rating Scale (BASC-TRS). Reynolds and Kamphaus (1992) offered an English version and Spanish version of the Parent Rating Scale. For the purpose of this study, the Spanish version was provided to Spanish-speaking parents. These scales are designed to rate the child’s behavior at home and school. The instrument has two scales: Adaptive and Clinical. For the purpose of this study, two categories in the Clinical scales were utilized to assess problem behaviors. The Clinical scale measures maladaptive behaviors, including Externalizing Behaviors such as hyperactivity, aggression, and conduct problems; Internalizing Behaviors such as anxiety, depression, and somatization; and it measures problems in atypicality, withdrawal, attention, and learning problems. These scales combined determine a clinical scales overview or Behavioral Symptom Index (BSI). While the BSI combines a total of nine subscales, the two categories analyzed in this study (Externalizing and Internalizing) contain only six of the nine subscales (three each).

Reynolds and Kamphaus (1992), in a summary of reliability and validity studies for the BASC-PRS and BASC-TRS (English version), indicated that all of the PRS and TRS composites
have high internal consistency and test-retest reliability, with scores in the .80s to low .90s. The test was shown to be reliable with both genders. Reynolds and Kamphaus also reported support for the construct validity of the BASC-PRS and BASC-TRS. Overall, the scale reliabilities show an average of .70. Currently, no tests on reliability and validity have been done for the Spanish version of the BASC-PRS.

Test-retest reliability, with a median value of .88 for BASC-PRS and .89 for BASC-TRS, indicated a high degree of reliability. These results indicate that the questions are designed with clarity to minimize variations in responses so that parents and teachers are consistent in interpreting question items.

Participant Selection

The volunteer research participants were recruited from three consenting elementary schools from one school district located in the North Texas region. Participants were selected from Hispanic, Spanish-speaking, male and female kindergarten through fifth-grade students, ranging from 5 to 11 years of age, referred for counseling services by parents or teachers due to Externalizing or Internalizing behavior problems. The first 30 Hispanic, Spanish-speaking students referred for counseling and who scored in the At-Risk or Clinically Significant range on any of the subscales of the Behavior Assessment Scale for Children (BASC) and whose parents signed consents (Appendix A) were selected to participate in the research study. Note: One student moved during the study; thus, 29 of the originally selected Hispanic participants completed treatment.

Prior to proposing this study, the researcher contacted the school administrators and teachers concerning the needs of their students, as well as to determine whether or not the school was interested in participating in the study. Three schools in a local school district agreed to
participate in the study. In this school district, the procedure for student referral for counseling is for the school counselor to contact the parent/managing conservator after a child has been referred. The school counselor then obtains consent from the parent/managing conservator for counseling and administers the Behavior Assessment Scale for Children (BASC). The BASC is utilized by counseling student interns as an assessment tool to identify problem behaviors as identified by both parents and teachers. For the purpose of this study, the school counselor or assistant principal (a Spanish-speaking translator was made available if the school counselor or assistant principal did not speak Spanish) informed the parents/managing conservator of the research study and obtained the informed consent from willing participants (both English and Spanish consent forms were made available; Appendix A). After receiving parent/managing conservator consent, the school counselor or assistant principal (a Spanish-speaking translator was made available if school counselor or assistant principal did not speak Spanish) obtained student assent to participate (both English and Spanish assent forms were made available; Appendix A). The researcher, who provided additional verbal information about the study, including how confidentiality was maintained, contacted parents who gave their consent, students whose parents did not consent to participate in this study, and/or who failed to meet criteria for this study were still eligible for counseling services through the school.

The researcher received approval to use human subjects from the University of North Texas Internal Review Board on September 26, 2003. Students had to meet the following criteria to be included in the study.

1. The student was identified as Hispanic, by the parent, on the school’s student information sheet and was selected from the kindergarten through fifth-grade student population.

2. Parent/managing conservator was planning to keep the child enrolled in the
school through May 2004.

3. The child was not currently receiving counseling services.

4. The child’s parent/managing conservator or legal guardian and teacher must have completed both the pretesting and posttesting questionnaire.

5. The child must have scored in the At-Risk or Clinically Significant range on the Externalizing or Internalizing Composite Scale of the BASC-PRS or BASC-TRS.

6. Both the parent/managing conservative and the child must have agreed to participate in 15 weeks of either the 30-minute child-centered play therapy or the 30-minute curriculum-based small group counseling intervention group, based on assignment.

7. The student had to have consent of the parent/managing conservator or legal guardian and give his or her assent to participate in videotaped sessions.

8. The student had to be able to participate in 15 weeks of treatment. Students missing more than three sessions were eliminated from the study.

Participants were assigned, by school and according to grade level, to either the culturally responsive child-centered play therapy experimental group ($n=15$) or the curriculum-based small group counseling group ($n=14$). Of the 30 students who volunteered to participate in the study, 29 completed the study, and 1 was dropped from the study. One child in the curriculum-based small group counseling treatment group moved from the school and therefore did not meet the stated criteria.

The demographic information for the 29 students in the study is given in Table 1. Demographic information for all 29 research participants was collected (Appendix E) in order to better understand characteristics of the population being served. Demographic information included gender, grade level, and ethnic breakdown of all students in the study. The information is
listed by school, as well as according to the assigned group. Additionally, Table 1 describes the
ethic identity of parents for children in the study. The composite of the curriculum-based small
group counseling treatment group membership by grade-level assignment is represented in Table 2. Kid’s Connection encourages that participant assignment be based on development and grade level. Therefore, following the recommendations set in the Kid’s Connection manual, the group assignments were as follows: kindergarten, first through third grade, and fourth and fifth grades paired together.

Table 1
Demographic Information for the Students and Parents Participating in the Study

<table>
<thead>
<tr>
<th></th>
<th>Culturally Responsive Child-Centered Play Therapy Treatment Group</th>
<th>Curriculum-based Small Group Counseling Group n=14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>School A</td>
<td>School B</td>
</tr>
<tr>
<td>GENDER</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Female</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>GRADE LEVEL</td>
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<tr>
<td>K</td>
<td>3</td>
<td>1</td>
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<tr>
<td>1st</td>
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<td>0</td>
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<tr>
<td>2nd</td>
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<td>2</td>
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<tr>
<td>3rd</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>4th</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>5th</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>ETHNIC BREAKDOWN</td>
<td></td>
<td></td>
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<tr>
<td>Hispanic Child</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Mexican Child</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Hispanic Parent</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Mexican Parent</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: One kindergartner in the curriculum-based small group counseling group dropped after 8 weeks; therefore, no posttesting was obtained, and thus comparison group data were obtained on 14 children.
Table 2
*Group Composition for the Participants in the Curriculum-based Small Group Counseling Group.*

<table>
<thead>
<tr>
<th>Grade</th>
<th>Group 1</th>
<th>Group 2</th>
<th>Group 3</th>
<th>Group 4</th>
<th>Group 5</th>
<th>Group 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>K</td>
<td>2</td>
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<td>1st</td>
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<td>3rd</td>
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<tr>
<td>4th</td>
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<tr>
<td>5th</td>
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<td>2</td>
<td></td>
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<tr>
<td>Total</td>
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<td>2</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Table 1 shows demographic information for students participating in this study. Table 1 shows that the number of males assigned to the culturally responsive child-centered experimental play and curriculum-based small group counseling groups total was 9 and 8, respectively. The number of females assigned to the culturally responsive child-centered experimental play and curriculum-based small group counseling groups total was 6 and 6, respectively. Table 1 also demonstrates the breakdown of participants by grade level. The number of kindergarteners assigned to the culturally responsive child-centered experimental play and curriculum-based small group counseling intervention was 4 and 2, respectively. The number of first graders assigned to the culturally responsive child-centered experimental play and curriculum-based small group counseling groups was 2 and 2, respectively. The number of second graders assigned to the culturally responsive child-centered experimental play and curriculum-based small group counseling groups was 3 and 3, respectively. The number of third graders assigned to the culturally responsive child-centered experimental play and curriculum-based small group counseling intervention was 2 and 2, respectively. The number of fourth graders assigned to the culturally responsive child-centered experimental play and curriculum-based small group counseling groups was 2 and 2, respectively.
was 2 and 3, respectively. The number of fifth graders assigned to the culturally responsive child-centered experimental play and curriculum-based small group counseling groups was 2 and 2, respectively. Additionally, although all parents of the students were asked to specify the ethnic identity of their participating child using the classifications of Chicano/a, Hispanic, Latino/a, Mexican, and Mexican American, all parents chose either the classification of Hispanic to signify American born or Mexican to signify that the child was born in Mexico. Therefore, the total number of participants born in the United States was 17, and the total number of participants born in Mexico was 13. Every parent of the children participating in this study reported that they were born in Mexico. Table 2 demonstrates that the six groups assigned to the curriculum-based small group counseling treatment were small, with just 2 to 3 members per group. As a result of the groups being assigned by school and then by grade level, the group size was small. Children were assigned to groups based on grade level and school location. Kids Connection curriculum is designed for children to be grouped kindergarten, first through third, and fourth and fifth grades together.

Data Collection

A pretest-posttest comparison group design was used to carry out the objectives of this study. Prior to the study, parents and teachers were asked by the school counselor to complete the Behavior Assessment Scale for Children (BASC) instrument. In addition, home visits, as needed, were conducted both at pretesting and again at posttesting in order to provide the forms to families who did not have transportation or who could not come to the school setting during business hours. In cases where families had many children and for those who lived in a multi-family home, the researcher enlisted the aid of a research assistant to, when necessary, supervise the children in the home to enable the researcher to be available to answer questions or clarify items on the forms.
This approach allowed the parents to be able to complete the behavior questionnaire on their child with limited distractions. At the end of the 15-week treatment period, the posttest BASC was administered to experimental and comparison group parents/managing conservators and teachers following the procedures outlined for the collection of pretest data.

Qualitative data were recorded by the researcher throughout the study in order to analyze the clinical significance of treatment. Recorded data were in the form of observations and field notes regarding the researcher’s experiences specific to multicultural counseling issues noted during treatment, as well as comments from the parents/managing conservators, teachers, and school administrators. The counselors from both groups completed session summary forms (Appendix D) on each child, specifically noting significant play behaviors, toys used (Appendix B), as well as significant verbalizations and interactions. In addition, demographic information was gathered on all participants from parent interviews and school records. Client sessions were videotaped for supervision purposes.

To ensure confidentiality of the information provided on questionnaires and videotapes, the researcher assigned codes to each participant, with only the researcher having the master list of the participants’ names. All confidential material remained in a locked file cabinet in each respective elementary school during the course of the study. Names of subjects or their parents or teachers were not disclosed in any discussion or publication of this material. All parents of participants received a full explanation of the study, including procedures, risks, and how confidentiality would be maintained.

Treatment

Subjects who met all specified criteria, \((n=30)\) Hispanic, Spanish-speaking children were assigned within each school location. Assignment was either to the experimental treatment group,
culturally responsive child-centered play therapy, or to a comparison treatment group, a curriculum-based small group counseling group in order to control for differences in school populations. In both the experimental treatment group and the comparison treatment group, modifications and adaptations were made in order to accommodate the school setting. Modifications included (a) utilizing existing space within each school setting (while all playrooms house the same toys, the rooms themselves were different sizes) and (b) adapting length of sessions to 30 minutes sessions in order to fit the school schedule, usually with both play therapy sessions and Kids Connection curriculum meeting for 45 minutes. Adaptations included following the school schedule and being flexible with scheduled events. Sessions were scheduled around the school districts academic calendar; therefore, sessions were not held on days when the school had scheduled such events as mandatory testing, early release, or school closing. In addition, makeup sessions were made available for children attending special events such as a book fair, field trip, or holiday celebrations.

The meta-analysis conducted by Ray et al. (2001) indicated that a weakness of research is that very few studies coded ethnicity as a category to be investigated; therefore, based on what is available, only a few studies that included Hispanic children have been identified. Literature suggests that ethnicity and cultural elements should be considered in counseling to include children receiving play therapy; however, this researcher could find no studies that specifically looked at Hispanic children and child-centered therapy or studies that incorporated cultural responsiveness in child-centered play therapy. For the purpose of this study, an attempt was made to respond to the cultural elements of the Hispanic population in the North Texas region where this study was conducted. Specifically, cultural considerations were taken into account in the selection of toys in the playroom.
Experimental Treatment Group

The experimental treatment group of children \( n=15 \) received 30 minutes of culturally responsive child-centered play therapy once per week for 15 weeks, following the principles and methodology of child-centered play therapy (Landreth, 2002). The facilitator of the weekly play sessions was a Hispanic, Spanish speaking, doctoral-level child-centered counselor education student, who was a licensed masters-level social worker and who had advanced play therapy training at the doctoral level, including supervised training in the theory, principles, and application of child-centered play therapy. The play therapy sessions were held in a playroom at each participating elementary school.

The playroom was equipped with a variety of specific toys that facilitate children’s expression as outlined by Landreth (2002) (Appendix B). However, they were adapted for their sensitivity to the Hispanic culture, including multicultural toys that capture elements of Hispanic culture, such as Hispanic people, food, and music. The selection of multicultural toys was decided by a panel of five Hispanic, Spanish-speaking, registered play therapists who conduct child-centered play therapy with Hispanic children in South Texas (Y. Garza, M. Hinojosa, D. Molina, Y. Muzquiz, & E. Rinaldi, personal communication, July 18, 2003). All five registered play therapists on the panel agreed that the use of multicultural toys would be an appropriate addition to the playroom toy list; however, all of the play therapists on the panel stated that their experience was limited to playrooms furnished with the recommended toy list outlined by Landreth (2002).

Initially, the children were introduced to the playroom by the play therapist (in both Spanish and English), who informed them, “This is our special playroom and in here you can say and do many things that you would like, and you also can decide to speak English, Spanish, or
both.” “Este es el cuarto especial de jugar y aquí puedes acer y decir muchas cosas que te gustan, aquí puedes escoger hablar Ingles, Espanol, o los dos.” Additionally, the play therapist’s responses mirrored the child’s spontaneous choice of language. To explain further, when the child spoke English the therapist responded in English and when the child spoke Spanish the therapist responded in Spanish. The child-centered approach includes the play therapy principles of creating a safe and accepting atmosphere, following the child’s lead, reflecting feelings and behaviors, enhancing self-esteem, facilitating decision making, and setting therapeutic limits.

Landreth (2002) revised Axline’s Eight Basic Principles (1969) for therapeutic contact with children. The list includes the following: (a) the therapist being genuinely interested and caring for the child, (b) acceptance of the child as s/he is, (c) creating a safe and permissive atmosphere, (d) being empathetic to the child’s feelings and reflecting accurately so the child may perceive the therapist’s empathy, (e) believing in the child’s capacity for self-growth and allowing the child to do so, (e) trusting in the child’s inner direction and resisting any urges to direct conversation or behaviors, (f) trusting in the therapeutic process and not attempting to hurry the process, and lastly (g) establishing therapeutic limits only when necessary to anchor the session to reality. The child-centered play therapist responds in ways that place responsibility on the child and places limits, as needed, to ensure the safety and protection of the child and counselor. This therapeutic relationship is designed to facilitate an environment that allows the child to generate the process of change and growth.

In addition to Landreth’s (2002) revised principles, Ray (in press) (Appendix E) noted that because child-centered play therapy is not contingent on the use of language due to the belief that for children play is their avenue to communication, the use of non-verbal skills during the play therapy session is critical. The play therapist’s desired outcome is to express to the child, “I’m here,
I hear you, I understand, and I care” (Landreth, 2002). This factor helps facilitate the psychophysiological flow that is a critical piece of client-centered theory (Rogers, 1969). Ray (in press) noted the specific nonverbal and verbal skills appropriate in child-centered play therapy. The specific nonverbal skills utilized in this study included the following:

1. The play therapist demonstrates an interest in the child that is facilitated by an open posture and leaning forward.
2. The therapist appears interested in the child.
3. The therapist seems comfortable and relaxed.
4. The therapist’s reflections mirror the child’s affect.
5. The therapist’s reflections are genuine.

Ray (in press) suggested that in child-centered play therapy the delivery of the therapist’s verbal responses plays a vital role. Specific to the delivery of the responses are nuances and subtleties of the words chosen so that the therapist communicates the message via short therapeutic responses and that the therapist’s responses match the rate of interaction by the child. The following is a list of categories of appropriate verbal responses used in child-centered play therapy: (a) tracking behavior, (b) reflecting content, (c) reflecting feelings, (d) facilitating decision making and responsibility, (e) facilitating creativity, (f) esteem-building, (g) facilitating the relationship, (h) enlarging the meaning, and (i) limit setting (Appendix E) (Ray, in press).

Comparison Treatment

The comparison treatment group of children approximately (n=14) received 30 minutes of grade-level, curriculum-based small group counseling group once per week for 15 weeks, utilizing Kids Connection, a program of Rainbow Days Inc., a school-based counseling curriculum currently utilized by many schools in this school district. Generally, school guidance curriculum is
provided in a classroom setting. Kid’s Connection is designed to serve many children, approximately six to eight children per group with the use of a co-facilitator. Kids Connection can be described as a responsive service (Gysbers & Henderson, 2001) since it is a group counseling technique that addresses intervention more than preventative concerns. Kids Connection has been designated as an “Exemplary” program by the Center for Substance Abuse Prevention (Rainbow Days, 2002). The researcher had permission from Rainbow Days to utilize Kids Connection in this study and publish pages from its manual.

The facilitator of the curriculum-based small group counseling intervention was a Hispanic, Spanish-speaking, child-centered, doctoral-level intern in counselor education, trained by Rainbow Days Incorporated to conduct the Kids Connection support group curriculum. The groups were held in an available classroom at each of the elementary schools. In addition, materials were presented in both Spanish and English, according to the needs of the children in the group. Initially, the children were introduced to the group by the group facilitator and informed that, “during our special group time you can choose to speak English, Spanish, or both.” “Durante nuestro tiempo en este grupo especial, puedes escojer hablar Ingles, Espanol, o los dos.” The facilitator’s choice of language when responding to a child in the group directly mirrored the child’s choice of language.

The curriculum was grade-level appropriate in that it provided materials and content that was developmentally appropriate to the age group, academic, personal, as well as the social needs of children. While Kid’s Connection recommends a group size of about eight children, the group size in this study was two to three children per group. The child-centered theoretical application, as well as small group size made the dynamics of this group more similar to a counseling group than to a guidance group, as it is often used in the school setting. Topics included building autonomy,
self-esteem, and problem solving, and improving peer relationships. The format for the 30-minute group included time for discussion of the theme and play-based activity. Specific group activities included freedom of expression through arts and crafts, as well as opportunities for the group members to process their experiences. Group sessions were videotaped for supervision purposes.

Analysis of Data

After completion of the treatment, scoring was done on the posttest Behavior Assessment Scale for Children (BASC) answer sheets that were collected. Results obtained from the BASC pretest and posttest were analyzed in order to determine whether the experimental treatment group, culturally responsive child-centered play therapy, or the comparison treatment group, a curriculum-based small group counseling treatment group, was the most effective with Hispanic children. Both pretest and posttest data were scored twice by a research assistant using the computer scoring software available for the Behavior Assessment Checklist Scale for Children (BASC) to ensure accuracy.

To ensure that the sample data were representative of the normally distributed population data, a visual inspection of all the individual change scores (the difference from pretest to posttest) was conducted, revealing a few extreme scores (the average change score was 4) that appeared to be outliers. Hinkle, Wiersma and Jurs (1998) defined an outlier as “an unusual score in a distribution that is considered extreme and may warrant special consideration” (p. 620). For the purpose of this study, a score of (± 20 points from the mean change score) was established as the criterion for an outlier. Based on this criterion, three individual scores were identified, from teacher report, as outliers and dropped from the analysis.

The remaining data were analyzed using SPSS for Windows (2001). The data were analyzed to insure that they met the assumptions for the two factor repeated measures analysis of
variance, specifically for independence of observation and that data are from a normally distributed population. For the first assumption, independence of observation, the instrument utilized ensures that this assumption is met. For the second assumption, that data are from a normally distributed population, skewness and kurtosis values for the dependent variables were examined and all found to be within the generally accepted range (-3, +3). Therefore, the data analyzed met these two assumptions. In a repeated measures analysis (ANOVA) when there are more than two measurements taken across time, a third assumption, Sphericity, must be met. For this study, because there were only two measurements, Sphericity was not taken into account.

A two factor mixed repeated measures analysis of variance (treatment group X time) was computed on each dependent variable to determine if the culturally responsive child-centered play therapy group and curriculum-based small group counseling groups behaved differently across time. The two levels of groups were the culturally responsive child-centered play therapy group and the curriculum-based small group counseling group. The two levels of time were pretest and posttest for each dependent variable. Significant differences between the means across time were tested at the 0.05 alpha levels. This tested the significance of the change between the culturally responsive play therapy treatment groups’ pretest and posttest scores compared to the curriculum-based small group counseling intervention group’s pretest and posttest scores. On the basis of two factor repeated measures ANOVA’s results, the hypotheses were either rejected or retained.

In addition, Cohen’s $d$ effect size was calculated in order to measure the practical significance, or the magnitude of difference between the two groups due to treatment. In other words, whereas statistical significance answers the question, “Is there a difference? An effect size answers the question, “How much of a difference?” (Thompson, 2002). Cohen’s $d$ was calculated
by taking the mean of the difference scores of the experimental group and subtracting the mean of the difference scores of the comparison treatment group. This difference was then divided by the pooled standard deviation (Trusty, Thompson, & Petrocelli, 2004).

Post hoc analysis of the Anxiety subscale, one of three subscales that comprise the Internalizing Composite Scale, and, the Conduct subscale, one of three subscales that comprise the Externalizing Composite Scale, was conducted to examine these two problem behaviors more closely. Conduct problems were the most often reported presenting concerns by parents and teachers. Anxiety-related issues were the next most mentioned presenting concerns by parents and teachers. Parent, teacher, school administrator, treatment provider reports and researcher observations were also examined to aid in understanding the clinical significance of this study’s findings.
CHAPTER 3
RESULTS AND DISCUSSION

This chapter presents the results of the analysis of data for each hypothesis tested in this study, specifically investigating the effects of culturally responsive child-centered play therapy compared to curriculum-based small group counseling on the problem behaviors of at-risk, Hispanic kindergarten through fifth-grade students, as measured by the Externalizing and Internalizing Composite scores on the Behavior Assessment Scale for Children (BASC). The investigator sought outside consultation through a qualified statistician to ensure the validity and appropriateness of all statistical analyses. This section includes a discussion of the results of this preliminary study, particularly as they apply to culturally responsive child-centered play therapy and curriculum-based small group counseling with school-aged Hispanic children. Also included are limitations of the study, implications, and recommendations for future research.

Results

The results of this study are presented in the order in which the hypotheses were tested. The alpha .05 level of statistical significance was used as a criterion for either retaining or rejecting the hypothesis. The .10 level was established as a threshold to note positive trends, indicating an improvement in target behavior for the experimental treatment group when compared to the comparison treatment group. The statistical significance test assesses the reliability of the relationship between independent and dependent variables (Thompson, 2002). A two factor mixed repeated measures analysis of variance (treatment group X time) was computed on each dependent variable to determine whether the culturally responsive child-centered play therapy and curriculum-based small group counseling groups behaved differently across time.
Additionally, effect sizes were calculated in order to determine the strength of the relationship between treatment and outcome. Reporting effect size helps explain the practical significance of the results by allowing the reader to see the amount or magnitude of change experienced by the experiential group that is caused by the intervention when compared to the comparison treatment group. For the purpose of this study, Cohen’s $d$ was utilized for effect size calculations (Cohen, 1988). Cohen’s guidelines for interpreting effect sizes were used to explore practical significance of findings. He proposed that 0.20 may be considered a “small” treatment effect, and effect size of 0.50 a “medium” effect, and an effect size of 0.80, a “large” effect (Cohen, 1988; Thompson, 2002). However, Thompson (2000) suggested that researchers should not apply benchmarks with rigidity, but use clinical judgment when interpreting significance in a specific area of inquiry. He further emphasized that counseling researchers should report results in ways that are relevant to the counseling community and in relation to similar research in the field; thus interpretation of effect size is ultimately more a tool the researcher uses to help explain the treatment effect of the intervention in everyday life as it relates to clinical improvement. For example, Cohen (1988) suggested that an effect of $d=0.20$ might be defined as a small effect size for a sociologist, but appraised as a medium treatment effect for a clinical psychologist. In determining the practical significance of the findings in this study, the researcher established a minimum of $d=0.50$ to interpret the treatment effect as moderate and $d=0.80$ to interpret the treatment effect as large.

Furthermore, as suggested by Trusty et al. (2004), researchers should use clinical judgment in making decisions about what constitutes clinical significance. To further clarify, the difference between practical and clinical significance as it applies to counseling practice can be described by the following example. The results of a treatment intervention with bipolar clients may not reveal
statistical or practical significance; however, if the treatment intervention resulted in a decrease in the frequency of in-patient hospitalizations, then the clients, clients’ families, and the counseling community may value this change as clinically significant. For the purpose of this study effect size estimates (practical significance), combined with qualitative data were utilized in assessing the clinical significance (value to the client, client’s family, and counseling community) of these results.

Hypothesis 1

The Hispanic children in the culturally responsive child-centered play therapy treatment group will attain a statistically significant lower mean score on the Externalizing Problems scale on the Behavior Assessment Scale for Children-Parent Report Scale (BASC-PRS) posttest, as compared to the pretest, than will the Hispanic children in the curriculum-based small group counseling group comparison treatment group.

Table 3 presents the pretest and posttest means and standard deviations for the experimental and comparison groups. Table 4 presents the repeated measures analysis of variance data, showing the level of statistical significance of the difference between the experimental and comparison groups’ pretest and posttest mean scores across time, and it also presents Cohen’s $d$ effect size, a measure of practical significance.

Table 3

<table>
<thead>
<tr>
<th></th>
<th>Experimental group $n=15$</th>
<th></th>
<th>Comparison group $n=14$</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Posttest</td>
<td>Pretest</td>
</tr>
<tr>
<td>Mean</td>
<td>56.40</td>
<td>50.33</td>
<td>51.57</td>
</tr>
<tr>
<td>SD</td>
<td>17.66</td>
<td>13.32</td>
<td>12.99</td>
</tr>
</tbody>
</table>

*Note. A decrease in the mean score indicates improvement in behavior.*
Table 4

ANOVA Summary Tables on the Externalizing Behavior Problems Scale of the Experimental and Comparison Groups for the Behavior Assessment Scale for Children-Parent Report Scale (BASC-PRS)

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>df</th>
<th>MS</th>
<th>F</th>
<th>*p</th>
<th>d</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prepost</td>
<td>46.059</td>
<td>1</td>
<td>46.059</td>
<td>.844</td>
<td>.37</td>
<td></td>
</tr>
<tr>
<td>Prepost * Group</td>
<td>265.714</td>
<td>1</td>
<td>265.714</td>
<td>4.87</td>
<td>.04</td>
<td>.76</td>
</tr>
<tr>
<td>Error(Prepost)</td>
<td>1474.217</td>
<td>27</td>
<td>54.601</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group</td>
<td>4.306</td>
<td>1</td>
<td>4.306</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Error (Group)</td>
<td>10625.074</td>
<td>27</td>
<td>393.521</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>12415.37</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Computed using alpha=.05.

Table 4 shows that the $F$ ratio for the interaction effect (Prepost X group) was statistically significant at the .05 level ($F=4.87$, $p=0.04$), indicating that there was a statistically significant decrease in the culturally responsive child-centered play therapy groups’ Externalizing Problems as measured by the BASC-PRS when compared to the comparison group. On the basis of this data, hypothesis 1 was retained. Additionally, Cohen’s $d$ was calculated to assess the practical significance of the difference between groups across time and determined to be large ($p=.76$), which approaches the threshold of .80, considered a large effect size (Cohen, 1988).

Hypothesis 2

The Hispanic children in the culturally-responsive child-centered play therapy treatment group will attain a statistically significant lower mean score on the Internalizing Problems Scale on the Behavior Assessment Scale for Children-Parent Report Scale (BASC-PRS) posttest, as compared to the pretest, than will the Hispanic children in the curriculum-based small group counseling group comparison treatment group.

Table 5 presents the pretest and posttest means and standard deviations for the experimental and comparison groups. Table 6 presents the repeated measures analysis of variance (ANOVA)
data, showing the level of statistical significance of the difference between the experimental and comparison group’ pretest and posttest mean across time, and it also presents Cohen’s $d$ effect size, a measure of practical significance.

Table 5

Mean Scores on the Internalizing Behavior Problems Scale of the Experimental and Comparison Groups on the Behavior Assessment Scale for Children-Parent Report Scale (BASC-PRS)

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>df</th>
<th>MS</th>
<th>$F$</th>
<th>*p</th>
<th>d</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prepost</td>
<td>186.705</td>
<td>1</td>
<td>186.705</td>
<td>4.081</td>
<td>.05</td>
<td></td>
</tr>
<tr>
<td>Prepost * Group</td>
<td>119.808</td>
<td>1</td>
<td>119.808</td>
<td>2.619</td>
<td>.12</td>
<td>.58</td>
</tr>
<tr>
<td>Error(Prepost)</td>
<td>1235.295</td>
<td>27</td>
<td>45.752</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group</td>
<td>173.096</td>
<td>1</td>
<td>173.096</td>
<td>1.089</td>
<td>.31</td>
<td></td>
</tr>
<tr>
<td>Error (Group)</td>
<td>4290.629</td>
<td>27</td>
<td>158.912</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>6005.533</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Computed using alpha=.05.

Table 6 shows that the $F$ ratio for the interaction effect (Prepost X group) was not statistically significant at the .05 level ($F=2.619, p=0.12$), indicating that there was not a statistically significant decrease in the play therapy groups’ Internalizing Problem Behaviors score as measured by the BASC-PRS when compared to the comparison group. On the basis of this data, hypothesis 2 was rejected. Additionally, Cohen’s $d$ was calculated to assess the practical significance of the difference between groups across time and determined to be moderate ($d = .58$).
Hypothesis 3

The Hispanic children in the culturally responsive child-centered play therapy treatment group will attain a statistically significant lower mean score on the Externalizing Problems scale on the Behavior Assessment Scale for Children-Teacher Report Scale (BASC-TRS) posttest, as compared to the pretest, than will the Hispanic children in the curriculum-based small group counseling group comparison treatment group.

Table 7 presents the pretest and posttest means and standard deviations for the experimental and comparison groups. Table 8 presents the repeated measures analysis of variance (ANOVA) data, showing the level of statistical significance of the difference between the experimental and comparison groups’ pretest and posttest mean scores across time, and it also presents Cohen’s $d$ effect size as a measure of practical significance.

Table 7

<table>
<thead>
<tr>
<th></th>
<th>Experimental Group $n=15$</th>
<th>Comparison Group $n=14$</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Posttest</td>
</tr>
<tr>
<td>Mean</td>
<td>48.30</td>
<td>49.07</td>
</tr>
<tr>
<td>SD</td>
<td>8.76</td>
<td>9.86</td>
</tr>
</tbody>
</table>

Note. A decrease in the mean score indicates improvement in behavior.
Table 8
ANOVA Summary Table of the Externalizing Behavior Problems Scale of the Experimental and Comparison Groups for the Behavior Assessment Scale for Children-Teacher Report Form (BASC-TRS)

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>df</th>
<th>MS</th>
<th>F</th>
<th>*p</th>
<th>d</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prepost</td>
<td>.692</td>
<td>1</td>
<td>.692</td>
<td>.040</td>
<td>.84</td>
<td></td>
</tr>
<tr>
<td>Prepost * Group</td>
<td>13.000</td>
<td>1</td>
<td>13.000</td>
<td>.753</td>
<td>.39</td>
<td>-.34</td>
</tr>
<tr>
<td>Error(Prepost)</td>
<td>414.308</td>
<td>24</td>
<td>17.263</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group</td>
<td>162.763</td>
<td>1</td>
<td>162.769</td>
<td>.892</td>
<td>.35</td>
<td></td>
</tr>
<tr>
<td>Error (Group)</td>
<td>4378.154</td>
<td>24</td>
<td>182.423</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>4968.917</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Computed using alpha=.05

Table 8 shows that the $F$ ratio for the interaction effect (Prepost X group) was not statistically significant at the .05 level ($F= .753, p=0.39$), indicating that there was not a statistically significant decrease in the play therapy groups’ Externalizing Behavior score as measured by the BASC-TRS when compared to the comparison group. On the basis of this data, hypothesis 3 was rejected. Additionally, Cohen’s $d$ was calculated to assess the practical significance of the difference between groups across time and determined to be small ($d= -0.34$).

**Hypothesis 4**

The Hispanic children in the culturally responsive child-centered play therapy treatment group will attain a statistically significant lower mean score on the Internalizing Problems Scale on the Behavior Assessment Scale for Children-Teacher Report Scale (BASC-TRS) posttest, as compared to the pretest, than will the Hispanic children in the curriculum-based small group counseling group comparison treatment group.

Table 9 presents the pretest and posttest means and standard deviations for the experimental and comparison groups. Table 10 presents the repeated measures analysis of variance (ANOVA) data, showing the level of statistical significance of the difference between the experimental and
comparison groups’ pretest and posttest mean scores across time, and it also presents Cohen’s $d$
effect size as a measure of practical significance.

Table 9

*Mean Scores for the Internalizing Behavior Problems Scale of the Experimental and Comparison Groups on the Behavior Assessment Scale for Children-Teacher Report Scale (BASC-TRS)*

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>df</th>
<th>MS</th>
<th>$F$</th>
<th><em>p</em></th>
<th>$d$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prepost</td>
<td>23.558</td>
<td>1</td>
<td>23.558</td>
<td>1.879</td>
<td>.18</td>
<td></td>
</tr>
<tr>
<td>Prepost * Group</td>
<td>.019</td>
<td>1</td>
<td>.019</td>
<td>.002</td>
<td>.97</td>
<td>.17</td>
</tr>
<tr>
<td>Error(Prepost)</td>
<td>300.923</td>
<td>24</td>
<td>12.538</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group</td>
<td>438.481</td>
<td>1</td>
<td>438.481</td>
<td>1.854</td>
<td>.19</td>
<td></td>
</tr>
<tr>
<td>Error (Group)</td>
<td>6373.895</td>
<td>27</td>
<td>236.070</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>7136.876</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Computed using alpha=.05.*

Table 10 shows that the $F$ ratio for the interaction effect (Prepost X group) was not statistically significant at the .05 level ($F=.002$, $p=0.97$), indicating that there was not a statistically significant decrease in the play therapy groups’ Internalizing Behavior score as measured by the BASC-TRS when compared to the comparison group. On the basis of this data, hypothesis 4 was rejected. Additionally, Cohen’s $d$ effect size was calculated to assess the practical significance of the difference between groups across time and determined to be very small ($d= 0.17$).
Post Hoc Analyses

Post hoc analyses were calculated on the Conduct and Anxiety subscales of the Externalizing and Internalizing Behavior Scales of the Behavior Assessment Scale for Children for both parent and teacher reports (BASC-PRS, BASC-TRS). Post hoc analyses on these subscales were important to the study. Conduct was the major reason for parent and teacher referral, while Anxiety was the second major reason for parent and teacher referral.

Post Hoc Parent Report

Conduct subscale. Table 11 presents the post hoc pretest and posttest means and standard deviations on the Conduct subscale of the BASC for the experimental and comparison groups, according to parent report. Table 12 presents the repeated measures analysis of variance (ANOVA) data, showing the level of statistical significance of the difference between the experimental and comparison groups’ pretest and posttest mean scores across time, and it also presents Cohen’s $d$ effect size as a measure of practical significance.

Table 11
Post Hoc Mean Scores for the Conduct Problems Subscale of the Experimental and Comparison Groups on the Behavior Assessment Scale for Children-Parent Report Scale (BASC-PRS)

<table>
<thead>
<tr>
<th></th>
<th>Experimental group $n=15$</th>
<th></th>
<th>Comparison group $n=14$</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Posttest</td>
<td>Pretest</td>
<td>Posttest</td>
</tr>
<tr>
<td>Mean</td>
<td>60.00</td>
<td>53.31</td>
<td>56.41</td>
<td>62.00</td>
</tr>
<tr>
<td>SD</td>
<td>11.24</td>
<td>8.52</td>
<td>12.25</td>
<td>22.02</td>
</tr>
</tbody>
</table>

Note. A decrease in the mean score indicates improvement in behavior.
Table 12
Post Hoc ANOVA Summary Table for the Conduct Subscale of the Experimental and Comparison Groups on the Behavior Assessment Scale for Children-Parent Report Scale (BASC-PRS)

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>df</th>
<th>MS</th>
<th>F</th>
<th>*p</th>
<th>d</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prepost</td>
<td>3.837</td>
<td>1</td>
<td>3.837</td>
<td>.046</td>
<td>.83</td>
<td></td>
</tr>
<tr>
<td>Prepost * Group</td>
<td>470.152</td>
<td>1</td>
<td>470.152</td>
<td>5.603</td>
<td>.02</td>
<td>.86</td>
</tr>
<tr>
<td>Error (Prepost)</td>
<td>1929.843</td>
<td>23</td>
<td>83.906</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group</td>
<td>81.437</td>
<td>1</td>
<td>81.437</td>
<td>.251</td>
<td>.62</td>
<td></td>
</tr>
<tr>
<td>Error (Group)</td>
<td>7447.843</td>
<td>23</td>
<td>323.819</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>9933.112</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Computed using alpha=.05.

Table 12 shows that the $F$ ratio for the interaction effect (Prepost X group) was statistically significant at the .05 level ($F=5.603$, $p=0.02$), indicating that there was a statistically significant decrease in the play therapy groups’ Conduct scores as measured by the BASC-PRS when compared to the comparison group. Additionally, Cohen’s $d$ was calculated to assess the practical significance of the difference between groups across time and determined to be large ($d=0.86$).

Anxiety subscale. Table 13 presents the post hoc pretest and posttest means and standard deviations on the Anxiety subscale of the BASC-PRS for the experimental and comparison groups, according to parent report. Table 14 presents the repeated measures analysis of variance (ANOVA) data, showing the level of statistical significance of the difference between the experimental and comparison groups’ pretest and posttest mean scores across time, and it also presents Cohen’s $d$ effect size as a measure of practical significance.
Table 13

Post Hoc Mean Scores for the Anxiety Problems Subscale of the Experimental and Comparison Groups on the Behavior Assessment Scale for Children-Parent Report Scale (BASC-PRS)

<table>
<thead>
<tr>
<th></th>
<th>Experimental group</th>
<th></th>
<th>Comparison group</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n=15</td>
<td></td>
<td>n=14</td>
<td></td>
</tr>
<tr>
<td>Pretest Mean</td>
<td>55.66</td>
<td>47.71</td>
<td></td>
<td>50.57</td>
</tr>
<tr>
<td>Posttest Mean</td>
<td>49.73</td>
<td>50.57</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SD</td>
<td>13.52</td>
<td>13.08</td>
<td></td>
<td>13.35</td>
</tr>
</tbody>
</table>

*Note. A decrease in the mean score indicates improvement in behavior.*

Table 14

Post Hoc ANOVA Summary Table on the Anxiety Subscale of the Experimental and Comparison Groups on the Behavior Assessment Scale for Children-Parent Report Scale (BASC-PRS)

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>df</th>
<th>MS</th>
<th>F</th>
<th>*p</th>
<th>d</th>
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</thead>
<tbody>
<tr>
<td>Prepost</td>
<td>34.262</td>
<td>1</td>
<td>34.262</td>
<td>.345</td>
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<td></td>
</tr>
<tr>
<td>Prepost * Group</td>
<td>279.780</td>
<td>1</td>
<td>279.780</td>
<td>2.819</td>
<td>.10</td>
<td>.60</td>
</tr>
<tr>
<td>Error(Prepost)</td>
<td>2679.324</td>
<td>27</td>
<td>99.234</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group</td>
<td>183.254</td>
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<td>183.254</td>
<td>.891</td>
<td>.35</td>
<td></td>
</tr>
<tr>
<td>Error (Group)</td>
<td>5555.229</td>
<td>27</td>
<td>205.749</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Total</td>
<td>8731.849</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

*Computed using alpha=.05.

Table 14 shows that the $F$ ratio for the interaction effect (Prepost X group) was not statistically significant at the .05 level ($F=2.819, p=0.10$), indicating that there was not a statistically significant decrease in the play therapy groups’ Anxiety score as measured by the BASC-PRS when compared to the comparison group. The results indicate a positive trend ($p=.10$) in the decrease of Anxiety behavior problems when compared with the comparison group. The positive trend suggests that further research with a larger sample size may produce statistical significance and is warranted. Additionally, Cohen’s $d$ was calculated to assess the practical significance between groups across time and determined to be medium ($d=0.60$).
Post Hoc Teacher Report

Conduct subscale. Table 15 presents the post hoc pretest and posttest means and standard deviations on the Conduct subscale of the BASC-TRS for the experimental and comparison groups, according to teacher report. Table 16 presents the repeated measures analysis of variance (ANOVA) data, showing the level of statistical significance of the difference between the experimental and comparison groups’ pretest and posttest mean scores across time, and it also presents Cohen’s $d$ effect size as a measure of practical significance.

Table 15
Post Hoc Mean Scores for the Conduct Problems Subscale of the Experimental and Comparison Groups on the Behavior Assessment Scale for Children-Teacher Report Scale (BASC-TRS)

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>df</th>
<th>MS</th>
<th>F</th>
<th>*p</th>
<th>d</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prepost</td>
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<td>1</td>
<td>23.003</td>
<td>.694</td>
<td>.42</td>
<td></td>
</tr>
<tr>
<td>Prepost * Group</td>
<td>47.003</td>
<td>1</td>
<td>47.003</td>
<td>1.42</td>
<td>.25</td>
<td>-.36</td>
</tr>
<tr>
<td>Error(Prepost)</td>
<td>629.473</td>
<td>19</td>
<td>33.130</td>
<td></td>
<td></td>
<td></td>
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<td>Group</td>
<td>71.315</td>
<td>1</td>
<td>71.315</td>
<td>.499</td>
<td>.49</td>
<td></td>
</tr>
<tr>
<td>Error (Group)</td>
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<td></td>
</tr>
<tr>
<td>Total</td>
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<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

*Computed using alpha=.05.

Table 16 shows that the $F$ ratio for the interaction effect (Prepost X group) was not statistically significant at the .05 level ($F=1.42$, $p=0.25$), indicating that there was not a statistically
significant decrease in the play groups’ Conduct scores as measured by the BASC-TRS when compared to the comparison group. Additionally, Cohen’s $d$ was calculated to assess the practical significance of the difference between groups across time and determined to be small ($d= -0.36$).

**Anxiety subscale.** Table 17 presents the post hoc pretest and posttest means and standard deviations on the Anxiety subscale of the BASC-TRS for the experimental and comparison groups, according to teacher report. Table 18 presents the repeated measures analysis of variance (ANOVA) data, showing the level of statistical significance of the difference between the experimental and comparison groups’ pretest and posttest mean scores across time, and it also presents Cohen’s $d$ effect size as a measure of practical significance.

Table 17

<table>
<thead>
<tr>
<th></th>
<th>Experimental group n=15</th>
<th></th>
<th>Comparison group n=14</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Posttest</td>
<td>Pretest</td>
<td>Posttest</td>
</tr>
<tr>
<td>Mean</td>
<td>49.69</td>
<td>49.61</td>
<td>54.64</td>
<td>55.00</td>
</tr>
<tr>
<td>SD</td>
<td>8.91</td>
<td>7.84</td>
<td>12.59</td>
<td>12.04</td>
</tr>
</tbody>
</table>

*Note.* A decrease in the mean score indicates improvement in behavior.

Table 18

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>df</th>
<th>MS</th>
<th>$F$</th>
<th>*p</th>
<th>$d$</th>
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</thead>
<tbody>
<tr>
<td>Prepost</td>
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<td>.692</td>
<td>.017</td>
<td>.89</td>
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<tr>
<td>Prepost * Group</td>
<td>.308</td>
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<td>.308</td>
<td>.008</td>
<td>.93</td>
<td>.05</td>
</tr>
<tr>
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<td>398.769</td>
<td>1</td>
<td>398.769</td>
<td>2.153</td>
<td>.15</td>
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<tr>
<td>Error (Group)</td>
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<td>27</td>
<td>393.521</td>
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</tbody>
</table>

Total | 45806.692

*Computed using alpha=.05
Table 18 shows that the $F$ ratio for the interaction effect (Prepost X group) was not statistically significant at the .05 level ($F=.008, p=0.93$), indicating that there was not a statistically significant decrease in the Anxiety Behavior scores as measured by the BASC-TRS when compared to the comparison group. Additionally, Cohen’s $d$ was calculated to assess the practical significance of the difference between groups across time and determined to be negligible ($d=0.05$).

Discussion

Researchers in the counseling field have been strongly urged to go beyond merely discussing statistical significance of findings and to also interpret effect sizes to better understand the magnitude of the treatment effect and to draw conclusions regarding clinical significance of findings. The statistical, practical, and clinical results of this study, including comments from parents, teachers, treatment providers, school administrators, and participants, as well as researcher’s observations, provide valuable information regarding the effectiveness of culturally responsive child-centered play therapy compared to curriculum-based small group (2-3 children) counseling with Hispanic children.

Specifically, results examined the effects of treatment on kindergarten through fifth-grade Hispanic students ($n=29$) who met the criteria for At-Risk or Clinically Significant, as measured by the Behavior Assessment Scale for Children (BASC). Of important note, Hispanic, Spanish-speaking counselors provided all treatment in order to provide culturally responsive interventions for both treatment groups. Treatment outcomes were measured through pretest and post-treatment parent and teacher reports on children’s internalizing and externalizing behaviors. Of the four hypotheses, one (based on parent report) was retained at the 0.05 level of significance. Additionally, Cohen’s $d$ was calculated for each hypothesis in order to gain a better understanding
of the practical significance of findings. The two hypotheses that utilized parent measures showed moderate to large treatment effects for the Hispanic children receiving the play therapy intervention. Neither of the hypotheses that utilized teacher report supported the use of play therapy with Hispanic children to decrease behavior problems. The researcher had reason to question the validity of the findings related to teacher report; however, teacher results have been discussed, along with cautions in interpreting their results.

A discussion of the treatment results are organized as follows: (a) parent report of children’s externalizing/internalizing behavior problems, (b) teacher report of children’s externalizing/internalizing behavior problems, and (c) cultural consideration and observations related to culturally responsive counseling services. For all clinical examples, names were excluded to protect the confidentiality of the research participants.

**Parent Report of Children’s Behavior Problems**

*Externalizing behavior problems.* Table 4 shows that children in the culturally responsive child-centered play therapy treatment group demonstrated a statistically significant difference ($p=0.04$) in their posttest scores on the Externalizing Problems scale of the BASC-PRS, at the .05 level, when compared to the curriculum-based small group counseling treatment group’s posttest scores. Also shown in Table 4, practical significance of the difference between treatments was calculated to be large ($d=0.76$), which approaches the threshold of 0.80, considered a large effect size (Cohen, 1988). This indicates that, on average, Hispanic children receiving play therapy performed more than three fourths of a standard deviation better on the Externalizing Behavior Composite Scores of the BASC-PRS, when compared to Hispanic children receiving curriculum-based small group counseling. Externalizing behaviors problems are one of the primary reasons children are referred for counseling. These behaviors are generally less tolerated
by parents, and children exhibiting these behavior difficulties often have problems maintaining relationships with teachers and peers. Parents and teachers alike often expend a significant amount of energy trying to change children’s problematic behaviors; the findings of this research support play therapy as an agent in changing externalized behavior problems.

The present study’s finding is similar to meta-analytic findings on the effects of play therapy on externalizing behavior problems. In a meta-analytic study of 93 controlled outcome studies, Bratton et al. (in press) found that play therapy had a large treatment effect on children’s externalizing behavior \((ES = 0.78)\), when compared to no treatment. Other controlled play therapy studies have shown moderate to large treatment effects on externalizing problems, when play therapy was compared to no treatment (Jones, Rhine, & Bratton, 2002; Kot, 1995; Packman & Bratton, 2003; Tyndall-Lind, 1999), while other controlled play therapy studies have reported less favorable results on externalizing behaviors (McGuire, 2001; Rennie, 2000). Play therapy research has been criticized for relying on research that compares play therapy to an absence of treatment, and researchers (Ray et al., 2001) have stressed the need for well-designed outcome studies comparing play therapy to other treatments. This study has answered this call by comparing play therapy to an empirically supported, award-winning curriculum-based school counseling intervention (Rainbow Days, 2003). In light of previous findings regarding the effects of play therapy on externalizing problems compared to no treatment, the findings in the present study are particularly noteworthy.

**Post Hoc Analysis of Conduct**

Conduct problems were the most common referral complaint from parents and teachers; as a result, a post hoc analysis was conducted on the Conduct subscale, one of three subscales of the Externalizing Composite score on the BASC. According to parent results, children in the culturally
responsive child-centered play therapy treatment group experienced a statistically significant ($p=0.02$) reduction in conduct scores when compared to the curriculum-based small group counseling intervention. Additionally, Cohen’s $d$ was calculated ($d=0.86$) on the Conduct subscales of the BASC-PRS to assess the magnitude of the treatment effect, indicating that the play therapy intervention had a large treatment effect on children’s conduct problems when compared to the small group counseling intervention.

These results indicate that parents of the culturally responsive child-centered play therapy group experienced the most change in their children in the area of conduct. According to the BASC-PRS, behaviors characteristic of conduct problems include behaviors such as (a) shows lack of concern for others feelings, (b) lies to get out of trouble, (c) gets into trouble in the neighborhood, (d) uses foul language, (e) has friends who are in trouble, and (f) has been suspended from school. These behavior problems are consistent with behaviors that have been identified as placing Hispanic children at a higher risk for academic struggles and delinquency (NCES, 2003; U.S. Department of Education, 1999; Intercultural Development Research Association, 2000).

The statistical and practical significance of these results is supported by comments from parents, teachers, and school administrators, as well as observations of the treatment providers. Of particular note, the researcher observed during the intake interview that most Hispanic parents responded to the question, “What concerns you most about your child?” by answering, “no me haga caso,” translated “he doesn’t mind me.” This observation suggests that Hispanic parents place a high value on the role of children to mind, obey, or pay strict attention to the wishes and requests of their parents. This can be supported by the frequency in which the Hispanic parents of children in the study also responded with “me haga caso,” “he minds me” in response to the
question, “What do you like most about your child?” It is the researcher’s experience that non-Hispanic families generally respond to this question with characteristics such as “he/she is creative,” “he/she has a great sense of humor,” “he/she is considerate”; therefore, the frequency of these types of responses from Hispanic parents might be unique to this ethnic group, which further suggests that these findings regarding play therapy’s large treatment effect on conduct problems are perhaps more clinically meaningful for this population.

**Internalizing Behavior Problems**

Table 6 shows that while the difference between groups over time was not statistically significant ($p=0.12$), the culturally responsive child-centered play therapy intervention demonstrated a moderate treatment effect ($d = 0.58$) on the improvement of children’s internalizing behaviors when compared to the curriculum-based small group counseling intervention. This indicates that, on average, Hispanic children receiving play therapy performed more than one-half of a standard deviation better on the Internalizing Behavior Composite Score of the BASC-PRS compared to children in the small group intervention. Internalizing behavior problems, including anxiety and depression, often go unidentified and untreated in young children until they become serious, or even deadly. Typically, parents and other significant adults in children’s lives have difficulties recognizing the subtle problem behaviors associated with anxiety and depression; teachers may assume the child is shy or quiet, while parents may attribute these behaviors to a phase the child will outgrow. With suicide, the third leading cause of death in adolescents, and a growing trend of suicide among middle school students 10 to 14 years of age (U.S. Centers for Disease Control and Prevention, 2003), identifying proven treatments for internalizing problems that are responsive to the developmental needs of young children is critical. This is particularly true for Hispanics; Trevino (2003) indicated that Hispanic students were 13.4% more likely than
Caucasian students to attempt suicide. The findings of this research provide support for play therapy as an agent in changing internalizing behavior problems in elementary school-aged Hispanic children.

According to Bratton et al. (in press), meta-analytic findings on the effects of play therapy on children’s internalizing behavior problems showed a large treatment effect (0.81). Although the present study’s findings show a lesser treatment effect (0.58), it must be noted that the vast majority of the 93 controlled outcome studies included in the meta-analysis compared play therapy to no treatment. It is reasonable to assume that comparing play therapy to an empirically-supported, award-winning school counseling curriculum (Rainbow Days, 2003) would produce a smaller treatment effect than when play therapy is compared to the absence of treatment. Other controlled play therapy outcome studies have shown moderate to large treatment effects on internalizing problems when play therapy was compared to no treatment (Brandt, 1999; Jones, Rhine, & Bratton, 2002; Kot, 1995; Packman & Bratton, 2003; Tyndall-Lind, 1999); while other play therapy studies have reported less favorable results on internalizing behaviors (Rennie, 2000; McGuire, 2001; Danger, 2003). In light of previous findings regarding the moderate to large effects of play therapy on internalizing problems compared to no treatment, the findings in this study are particularly promising.

Post Hoc Analysis of Anxiety

Anxiety and anxiety-related issues was the second most common reason for referral at the time of intake for parents and teachers; as a result, a post hoc analysis was conducted on the Anxiety subscale, one of three subscales of the Internalizing Composite score on the BASC. Parents, in particular, noted school-related concerns about children’s attitudes towards teachers, homework, and peers. Although none of the parents used the word “anxious” to describe their
child, the concerns they expressed were consistent with BASC items that contribute to the anxiety subscale, such as (a) tries to hard to please others, (b) worries about school work, (c) says, “I’m not very good at this,” (d) worries, and (e) is too serious. According to the post hoc analysis of parent report on the Anxiety Subscale, children in the culturally responsive child-centered play therapy treatment group did not experience a statistically significant ($p=0.10$) reduction in the anxiety scores, when compared to the curriculum-based small group counseling group. However, these findings demonstrate a trend toward more positive behavior change for the play therapy group over the comparison group. To better understand the practical significance of the difference in groups due to treatment on the anxiety subscale, Cohen’s $d$ was calculated ($d=0.60$), indicating that the culturally responsive child-centered play therapy intervention had a moderate treatment effect on Hispanic children’s anxiety problems when compared to curriculum-based small group counseling. Bratton et al. (in press), in their meta-analysis of 93 controlled play therapy outcome studies, found a similar treatment effect on children’s anxiety ($d=0.69$).

These results indicate that parents of children receiving the play therapy treatment demonstrated a noticeable increase in their ability to internally cope with their problems and seemed less lonely, less nervous, cried less, and most notably, demonstrated gains in observable behaviors associated with less anxious children. These results provide support for the efficacy of play therapy with elementary-age children to reduce internalizing behavior problems, primarily anxiety, before their problems become more serious. The practical significance found on the Internalizing Composite Scale and on the Anxiety Subscale of the BASC-PRS is supported by teacher and parent comments, as well as by observations by treatment providers and the researcher.
Treatment providers recorded observations that many children moved from anxious behaviors to improved self-confidence and engaging behaviors during treatment. Teachers reported similar observations in the classroom for many of the children, most notably regarding improved confidence and interactions. For example, one example is the case of Ramiro (a pseudonym), who was referred for school-counseling services by his teacher. The teacher reported that Ramiro’s father had fled to Mexico after Ramiro’s 9-year-old sister disclosed sexual abuse by the father. At the time of referral, Ramiro’s father had been out of the home for approximately 8 months. As per teacher report, Ramiro had been held back from the previous year and was again assigned to her class for the new school year. The teacher’s concerns included Ramiro’s tense behaviors, particularly his “zoning out” of reality. The teacher reported that Ramiro’s “sad” affect and lack of focus was affecting his grades and again placing him at risk for academic failure. She added that, since the incident, Ramiro’s attitude and behaviors had changed as demonstrated by (a) refusing to actively participate in class or group activities, (b) maintaining close proximity to the teacher when given free time outside, (c) lack of interest in class celebrations, and (d) crying easily. The 15-week treatment intervention of culturally responsive child-centered play therapy resulted in positive changes in Ramiro’s Internalizing Problem Behaviors as reported by parent, teacher, and the treatment provider. Specific observations related to positive changes in play behaviors include Ramiro’s ability to (a) identify fears and concerns, (b) freely express emotions, (c) manage fears in more positive ways, and (d) increase confidence in his own abilities to face difficult situations. Ramiro’s parent verbalized that she experienced Ramiro as “mas valiente,” braver, and less “pegado,” attached to her. She added that she noticed he had started going outside to play on his own without insisting on the company of a family member and had been able to sleep in his own bed as opposed to sleeping with his mother. At the posttest interview with the teacher
she responded, “He has improved so much; he is now working at grade level and has really come out of his shell.” This example is just one of many teacher and parent reports of observed improvement in internalized behavior problems and points to the clinical significance of the play therapy treatment.

_Teacher Report of Children’s Behavior Problems_

**Externalizing Behavior Problems**

Table 8 shows that, different from what was hypothesized, children in the culturally responsive child-centered play therapy treatment group did not demonstrate a statistically significant ($p=0.39$) difference in their pretest and posttest scores on the Externalizing Problems scale of the BASC, at the .05 level of significance, when compared to the curriculum-based small group counseling treatment group. Also shown in Table 8, Cohen’s $d$ was calculated to assess the practical significance of the differences between groups across time and determined to be small ($d=-0.34$). According to teachers’ perceptions of children’s externalizing behaviors, the Hispanic children receiving culturally responsive child-centered play therapy did not show behavioral improvement compared to the small group (2-3 children) intervention. Due to problems in data collection integrity for teacher BASCs, which is discussed in more detail at the end of the Teacher Report section, the reader is urged to interpret these results with caution.

_Pos Hoc Analysis of Conduct_

Since conduct problems were the most common referral complaint from parents and teachers, a post hoc analysis was conducted on the Conduct subscale to examine this specific behavior. According to teacher results shown in Table 16, children in the culturally responsive child-centered play therapy treatment group did not experience a statistically significant ($p=0.25$) reduction in conduct scores, at the .05 level of significance, when compared to children in the
curriculum-based small group counseling treatment group. Also shown in Table 16, Cohen’s $d$ was calculated to assess the practical significance of the differences between groups across time and determined to be small ($d=-0.34$). According to teachers’ perceptions of children’s conduct, the Hispanic children receiving culturally responsive child-centered play therapy did not show behavioral improvement compared to the small group (2-3 children) intervention. Due to problems in data collection integrity for teacher BASCs, discussed in more detail at the end of the Teacher Report section, the reader is urged to interpret these results with caution.

Internalizing Behavior Problems

Table 10 shows that, different from what was hypothesized, the children in the culturally responsive child-centered treatment group did not demonstrate a statistically significant ($p=0.97$) difference in their pretest and posttest scores on the Internalizing Problems scale of the BASC, at the .05 level of significance, when compared to the curriculum-based small group counseling group. Also shown in Table 8, Cohen’s $d$ was calculated to assess the practical significance of the differences between groups across time and determined to be very small ($d=.17$). According to teachers’ perceptions of children’s internalizing behaviors, the Hispanic children receiving culturally responsive child-centered play therapy did not show behavioral improvement compared to the small group (2-3 children) intervention. Due to problems in data collection integrity for teacher BASCs, discussed in more detail at the end of the Teacher Report section, the reader is urged to interpret these results with caution.

Post Hoc Analysis on Anxiety

Anxiety and anxiety-related issues was the second major concern at the time of intake for both parents and teachers; as a result, a post hoc analysis was conducted on the Anxiety subscale, one of three subscales on the Internalizing Composite scores on the BASC. According to teacher
results shown in Table 18, children in the culturally responsive child-centered play therapy treatment group did not experience a statistically significant \( p=0.93 \) reduction in anxiety scores, at the .05 level of significance, when compared to children in the curriculum-based small group counseling treatment group. Also shown in Table 18, Cohen’s \( d \) was calculated to assess the practical significance of the differences between groups across time and determined to be negligible \( (d=0.05) \). According to teachers’ perceptions of children’s anxiety, the Hispanic children receiving culturally responsive child-centered play therapy did not show behavioral improvement compared to the small group (2-3 children) intervention. Due to problems in data collection integrity for teacher BASCs, which are discussed in more detail at the end of the Teacher Report section, the reader is urged to interpret these results with caution.

*Problems in Data Collection Integrity for Teacher BASC*

The integrity of the data collection process for teachers is suspect due to several factors. Most importantly, the researcher failed to provide a controlled environment for teachers to complete the pre and posttesting protocol without distraction from school responsibilities. The researcher assumed that teachers would find a time and location during the school day (such as conference periods) that was free from distractions to complete the BASC, which would allow them sufficient time and focus to report accurate observations on the child of focus. The potential problems of failing to provide a controlled environment for data collection was further compounded by several other factors related to post testing that the researcher failed to anticipate:

1. Because of missed sessions due to schedule conflicts, holidays, and mandatory state-wide academic assessment, posttesting occurred during the last week of school, during which teachers were observed to be overwhelmed with administrative duties related to the end of the school year.
2. The environment at two of the schools where the majority of subjects attended was observed to be chaotic for both teachers and students (teachers yelling at students in the halls, etc).

3. Due to construction at one of the schools, teachers had to pack the entire content of their classrooms before the last day of school, adding to the end-of-year chaos.

4. Some teachers had several children from their classrooms in the study, therefore had to complete several post BASC-TRS’ within a few days. These factors likely contributed to the researcher having to ask several teachers numerous times for their post-BASC-TRS. In light of the researcher’s failure to provide a controlled testing situation, along with the observed stressful conditions at the schools during the last week of school, it is impossible for the researcher to state with confidence that data collected from teachers, particularly during posttesting, are a reliable measure of subjects’ behavior. Therefore, readers are urged to interpret findings related to teacher report with this caution in mind.

Conversely, the researcher anticipated that Hispanic parents (because of large families and in some cases multi-families living together) might have difficulties finding a time free from distractions to report accurately on the problem behaviors of their child. Therefore, for parents, a plan was implemented for pre- and posttesting that helped control for the reliability and integrity of testing results. For pre- and posttesting, the researcher, along with a research assistant were available to provide childcare and answer questions, and in most cases, made home visits to accommodate parents’ needs. Parents were observed taking their time to read and answer BASC-PRS items, asking questions when clarity was needed. Based on the data collection procedures utilized with parents, the researcher is able to state with a reasonable amount of confidence that the BASC-PRS data are a reliable measure of subjects’ behavior.
A review of the school-based play therapy outcome research literature revealed that other researchers have reported similar discrepancies in parent and teacher reports on outcome measures and have expressed similar concerns regarding reliability of teacher reports (McGuire, 2001; Rennie, 2000; Rhine, 2000). For example, Rhine (2000) reported on her observations that teachers seemed to take insufficient time to accurately score subjects’ pretest and posttest. The observations from the present study, along with observations from other school-based researchers, suggest that careful consideration is needed in controlling for the environment in which teachers complete testing protocols. Furthermore, consideration should be given to the length of time required by teachers to complete assessments; therefore researchers may want to explore alternative measurements. Additionally, Ray et al. (2004), in reporting on a yearlong pilot study in an elementary school, reported concerns regarding teacher lack of attentiveness to both intensified or subsided emotional experiences of the child. In a similar vein, McGuire (2001) expressed the need for measures that were more sensitive to the culture of teachers to assist them in reporting on students’ behavior, particularly subtle changes in the behavior of children that, while noticed at home, are less observed in the classroom setting. And finally, it goes without saying that researchers should avoid data collection at times of the school year that are inherently demanding for teachers, such as the last week of a semester.

Culturally Responsive Considerations and Observations

In response to suggestions in the literature for counselors to take a more culturally-responsive approach to working with minority clients (Durodoye, 2002; Koss-Chionino & Vargas, 1992; Sue & Sue, 2003), and based on the researcher’s personal and professional experiences, modifications were made to traditional child-centered play therapy (Landreth, 2002). In addition, the researcher made every effort throughout the planning and implementation stages to
respond to the cultural uniqueness and special needs of this population. Examples of the researcher’s active stance, as well as rationales for cultural modifications are explained in this section. Also included in this section are the researcher’s observations of cultural elements of this study, such as similar ethnic pairings, use of language, cultural toys, and materials, and the role of cultural values regarding data collection and treatment.

_Counselor Ethnicity and Language_

In responding to the literature that calls for the application of culturally sensitive therapeutic practices, the importance of similar client/counselor ethnic pairings, and consideration of the unique needs of culturally diverse populations (Cochran, 1996; Esquivel & Keitel, 1990; Ramirez, 1998), it seemed imperative that counselors for the study be both Hispanic and Spanish-speaking. This is particularly important since every parent of the children participating in this study reported they were born in Mexico and although 17 of the children in the study were born in the United States, the total number of participants born in Mexico was 13. This indicates that, in general, the population of Hispanics in this North Texas area is fairly indigenous. The researcher’s experience working with this population was similar to the literature that suggests that Hispanic, Spanish-speaking, trained counselors are rare (Altarriba & Bauer, 1998; Cochran, 1996; Precidio & Henry, 1997). It was with some difficulty that the researcher was able to find counselors who met the qualifications for this study and lived in this area. This may indicate that training institutions need to work toward recruiting and training Hispanic students interested in the helping professions and specifically interested in working with children in the school setting. It is the researcher’s observation that the inclusion of the Hispanic, Spanish-speaking therapists had an impact on the children and families who participated in this study. A discussion of the impact is provided, using anecdotal information, later in this chapter.
Cultural Modifications

Toys and materials. While the literature strongly encourages culturally responsive practices with Hispanic clients (Altaribba & Bauer, 1998; Cochran, 1996; Precidio & Henry, 1997; Sue & Sue, 2003), the researcher found it difficult to find literature regarding what constitutes culturally responsive play therapy, specifically toys and material selection. In fact, the prevailing attitude in the literature seems to reflect that play is the universal language, and while there were suggestions that toys are used to “communicate their world to the counselor” (Landreth, 2002), there was no mention of cultural considerations for children from diverse populations. Martinez and Valdez (1992) suggested that a counseling environment that has been modified to express an understanding of diversity demonstrates to the client the counselor’s openness to their world. With this in mind, the researcher organized a focus group for the purpose of identifying culturally responsive toys, and materials appropriate for child-centered play therapy.

The focus group consisted of five masters-level degreed, licensed, Hispanic, Spanish speaking mental health professionals, who additionally were credentialed as registered play therapists (Garza et al., 2003). With the exception of the researcher, all four of the counselors currently practice in South Texas, which may be a limitation of the study, since counselor experiences were limited to play therapy with children from a similar ethnic subgroup. However, based on the researcher’s clinical experience with clients from South Texas, in comparison to the Hispanic community in North Texas, it is the researcher’s observation that the two Hispanic populations share similar characteristics.

The focus group drew from its own cultural experiences as well as from literature, including the following: (a) Kottman (1999), who noted the importance incorporating familiar colors, and textures for minority clients; (b) the research done by Bernal and Knight (1997), which
investigated the relationship between age and ethnic identity; and (c) Gibbs et al. (1998), who indicated that toys limited to symbols of Caucasian values might indicate to the child that they are in a dominant culture and therefore, need to conform, thus limiting communication. A list of the culturally responsive toys and materials selected for use in this study, as selected by the focus group, can be found in Appendix B.

**Home Visits to Collect Data**

From the beginning of the study, parents who had referred their child for counseling had difficulty coming to the school in order to participate in the initial intake process, which included receiving information about counseling services, signing consent forms, and completing the pretest behavior assessment (BASC-PRS). This seemed to be a frequent problem among Hispanic families, and the researcher found that home visits became the most commonly employed method for collecting pre- and posttesting data. The researchers observed that the Hispanic families in this study failed to keep scheduled appointments at the school due to the following reasons:

1. A majority are one-car families, where the father worked and used the car, leaving the mother without transportation during school and after school hours.

2. The mother does not drive or have a driver’s license.

3. Many have younger children at home, making it difficult for the parents to come to the school.

4. In some cases, if counseling was not a priority for the father, he would not bring the mother to appointments.

5. A few parents, who said that they had had previous negative experiences with what they called *consejeras* or “counselors” from Child Protective Services, feared they might be in trouble and avoided the appointment, since they believed that the school appointment would be with a
school official. Several of the parents reported that their experiences with school officials had been negative. A few examples follow:

1. School officials have high expectations that parents felt they were unable to meet due to language barriers, financial constraints, lack of familiarity with “la sistema”, or the “system.”

2. They experienced conversations with school officials as one-sided and that they were not given a chance to give their side of the story.

3. They experienced their child to be singled out as a “un nino malo” or “bad child” and felt that school officials placed blame on the parents. Altarriba & Bauer (1998) reported similar concerns by Hispanic parents.

Of the home visits conducted, in two cases school administrators suggested that the father of the child had demonstrated aggressiveness towards school personnel. In these cases, for safety purposes, the male and female Hispanic, Spanish-speaking treatment providers were especially cautious in conducting all testing as well as parent consults as a team. In general, when conducting home visits it is wise to have some prior knowledge about the family, including such things as history of violence; in most cases, school personnel can help with this. Also, a regular practice of conducting home visits as a team is sensible. Additionally, in order to control for the integrity of the data collection, during home visits, specific attention was given to providing an environment in which parents could complete the behavior questionnaire with minimal distractions. In most cases, both researchers went to the home so that one of the researchers could occupy the children to allow parents to concentrate on the paperwork with limited distractions. The other researcher was able to translate and/or answer questions.
Explanation of Counseling Treatments

Literature on Hispanics and mental health suggests that, as a culture, Hispanics do not label mental unhealthy, as is customary in our Western culture, using common diagnosis terms (Sue & Sue, 2003). Rather, for Hispanics, counseling and diagnosis are seen as for “crazy people,” and the term holds a negative stigma against the family (Constantine, Chen, & Ceesay, 1997). As illustrated in the pretest interviews in this study, the parents steered away from terms like depressed, anxious, or aggressive and used examples of problem behaviors to help explain their major concerns. It would seem that cultural values, particularly among less assimilated Hispanics, play a part in how Hispanic individuals might define mental unhealth or Externalizing and Internalizing behavior problems. Constantine et al. (1997) noted a culturally significant finding in their research study with ethnic minority college students. They learned that, when students reported the reason for attending counseling, 45% reported “relationship difficulties” rather than identifying their problem as depression, anxiety, or other common diagnosis terminology.

In response to the literature regarding this cultural view of counseling, researchers approached this attitude with caution; thus, when informing parents about the research study, the researcher intentionally focused on the empirical evidence that supports counseling as a method to improve motivation, self-esteem, and behavior to improve school success. Additionally, the researchers used the term support services in lieu of counseling, stressed improved motivation and self-esteem in lieu of terms like depression and anxiety, and mirrored language used by parents such as “no te haga caso,” he doesn’t mind you, in lieu of conduct problems.

Other Unique Factors

Due to language barriers among the school and families, the treatment providers employed in this study found themselves on occasion (a) working as translator between parent and teacher
and (b) working with school administrators to explain the parents’ desire to obtain academic tutoring for their child. In supporting parents, the treatment providers employed the use of person-centered reflections of content and feeling, which facilitated empathy and understanding of parental concerns. The treatment providers also showed openness to hugs and physical contact when the parents initiated, which the researchers’ experience to be culturally specific behaviors.

Researcher Observations

Culturally responsive child-centered play therapy. Researcher observations were included in this study as a means of further exploration of the culturally responsive child-centered play therapy treatment group. Specifically, session summaries were used to note children’s use of multicultural toys, their choice of language, and other culturally significant happenings. These results are preliminary observations, and further research to investigate statistical significance is needed. Researcher observations are as follows:

1. Use of language: it seemed that younger children spoke mostly Spanish, and older children spoke mostly English.

2. Many of the children commented on noticing that some toys were “from Mexico.”

3. Many of the children commented on owning similar toys from Mexico.

4. Comments related to the culturally-specific toys seemed to be made primarily during the first three sessions and seemed to enhance trust-building, rapport, relation-building, and a feeling of familiarity and security. These results are supported by the literature. Esquivel and Keitel (1990) indicated that matching cultural factors can help foster rapport with minority clients.

5. After the first few sessions, the Hispanic girls receiving play therapy used culturally specific toys on a more limited basis than they had did in the first few sessions. For example, girls
seemed to prefer to use the “American” doll over the “Hispanic” doll. However, the culturally specific foods were used more frequently than non-Hispanic foods.

6. Boys frequently utilized the tools, and a few referred to having worked on projects with their fathers.

7. Both boys and girls played with Mexican instruments with more frequency than with other instruments.

*Curriculum-based small group counseling.* The following observations were noted by the counselor for the curriculum-based small group counseling group. The counselor reported that while walking his children back to their classroom after a group session all three children pointed out (to the male researcher) a classroom craft project hung outside their classroom. The wall was decorated with individually labeled projects, with the participants’ names on their individual projects. The researcher noticed, based on student names, that whereas many of their American peers utilized craft beads and macaroni noodles to decorate, the Hispanic children selected pinto beans and rice as craft materials for their projects. The example taken from this group of children may indicate that Hispanic children tend to prefer craft items that are culturally familiar and it further points to the need for cultural sensitivity in selecting toys and materials for Hispanic children.

The male researcher, who was also facilitating non-Hispanic groups, observed that the males in his Hispanic group demonstrated a sense of camaraderie that he sensed was indicative of the way in which males in the Hispanic culture bond. Specifically, the children spoke Spanish with each other, referring to each other as “*compadres,*” a term that when translated means an expression of kinship or crony, and spoke in an informal Spanish language. Esquivel and Keitel (1990) noted that a sense of closeness in regards to family and community is of high value among
Hispanics. This value may have been a factor in the quality of interactions of the group members in this study, and at preliminary investigation was unique to the group intervention. Additionally, the researcher observed that the children in the groups chose to speak Spanish when disclosing personal or intimate information (emotionally laden topics or things difficult to talk about) on such topics as smoking cigarettes, stealing, the use of drugs by family members or peers, and skipping school; one girl discussed issues around her mother’s promiscuous behavior.

Observations regarding parent participation in the study. A noteworthy observation is that in most cases where there was a two-parent family, the father gave the permission for counseling services, but the mother actually signed the consent and completed the BASC pretest and posttest. The researcher observed that in these cases, obtaining the father’s permission first seemed imperative to the child is obtaining consent for counseling services, and in a couple of cases, the mother indicated to the researcher what matters to stress in order to gain permission from the father.

Limitations of the Study

The following limitations are offered for the reader’s considerations when interpreting the data analyses.

1. The group variable for the curriculum-based small group counseling group was not controlled for, and group membership was small (2-3 children). It is difficult to determine if changes in the comparison group’s treatment were due to the Kid’s Connection curriculum or effects of participation in a small group.

2. Many parents who completed the BASC-PRS demonstrated limited reading skills, thus necessitating that the BASC-PRS be read to them. In certain cases where families were unsure of
the meaning of a certain word, clarification was needed. Reader bias may have existed due to the defining or rewording of BASC-PRS questions.

3. Due to the lack of Hispanic, Spanish-speaking play therapists in this area, the researcher functioned as the play therapist, and along with another Spanish-speaking research assistant conducted the majority of the interviews with the parents and teachers. This investigator’s participation may have contributed to researcher bias.

4. Since the treatment providers collected the children from their classrooms, teachers who completed the BASC-TRS were aware of which children received play therapy or small group counseling. This prior knowledge could have biased the ratings.

5. Participant selection was limited to volunteers from consenting elementary schools in one school district in the North Texas area. This limits the ability to generalize the results to other populations.

6. Selection of culturally specific toys was limited to the ethnic background and experience of the researcher and the panel of Hispanic, Spanish-speaking, and play therapy specialists chosen to produce input and may not have been an accurate representation of all Hispanic subgroups.

7. The sample size of this research was small (experimental group $n=15$, comparison group $n=14$). A larger sample size would increase the power of the analyses, thereby allowing for greater ease in finding statistical and practical significant in the differences between the groups.

8. Reliability and validity studies have not been conducted for the Spanish versions of the BASC-TRS and BASC-PRS.
9. The internal validity of this study is threatened by the possible effect of maturation. Inherent to the design of this study exists the potential for the children’s developmental changes in physical and emotional areas to impact the outcome irrespective of the treatment administered.

10. Environmental occurrences that existed on the school campus at the time of the study, including campus-wide reconstruction and end of the school year term produced subjectively evident stress on the part of the students and staff. For example, in one of the schools the teachers who participated in the study were required to be out of their classrooms for the summer by the last day of school. Posttesting occurred 2 days prior to this event. These occurrences were not controlled for and may have impacted or altered the participants’ emotional state during the course of the study.

11. The treatment providers were of different genders (1 female, 1 male). It may be possible that any differences at posttest between the groups were due to gender differences rather than treatment.

12. Lack of integrity of data collection from teachers. The researcher did not control for the atmosphere/environment. Therefore, teachers were not afforded the same consideration of a relaxed, quiet environment to complete the testing on their child/children of focus, as was done with parents.

Summary of Remarks and Contributions of the Study

Foremost to the uniqueness of this study are the careful considerations and adaptations in planning and implementing culturally responsive services to Hispanic children. Services were offered in the school setting and adapted to fit the needs of the school. The school setting allows for Hispanic children to have greater access to services that they otherwise may not have utilized. Additionally, a strength of the study is that it employed treatment providers of similar ethnicity,
language, level of education, level of training, and similar theoretical orientations, which lessens the chances that the results may be due to other variables. Although there are limitations that affect the generalizability and interpretation of some of the findings, this study contributed to the play therapy literature as the first study concentrating on culturally responsive child-centered play therapy with Hispanic children. While there has been a global focus on culturally sensitive counseling modalities with adults or families, by comparison, only a few studies have addressed working with ethnic minority children. Yet, historically, Hispanic children are overrepresented in the area of school failure. In this study, at pretest, every child referred met the criteria for either scoring in the At-risk or Clinically significant area on either the Externalizing or Internalizing problem behaviors scale. This suggests that these problems, if unattended, may have led to academic struggles or failure.

Qualitative data from teachers, parents, and school administrators, as well as the treatment providers, supported the clinical significant benefits of culturally responsive child-centered play therapy with Hispanic children and the quantitative data are encouraging. Although only one of the four hypotheses was found to be statistically significant in reducing externalizing behavior problems as reported by parents, it is significant since the majority of the children were referred for Externalizing, specifically conduct problems. Further analysis of this area resulted in a large, practically significant, treatment effect that was reinforced by qualitative data. These results indicated an improvement in externalizing behaviors for the children receiving the culturally responsive child-centered play therapy intervention; thus, the combined result is clinically significant. Additionally, post hoc analysis of the Conduct and Anxiety subscales on the BASC-PRS and BASC-TRS resulted in a statistically significant difference on the Conduct
subscale, according to parent report and a trend in positive gains on the Anxiety subscale in favor of the culturally responsive child-centered play therapy intervention.

Results found in this study are particularly noteworthy because this study utilized a treatment group versus comparison treatment group design. Critics of play therapy research historically have called on play therapy researchers to utilize comparison treatment groups when examining the effectiveness of play therapy interventions. Of additional mention is that the comparison intervention (Kid’s Connection) is an empirically supported curriculum that has won an Exemplary award (Rainbow Days Inc., 2003), thus validating that child-centered play therapy when compared to a second treatment intervention resulted in significant findings.

Training programs within the universities should explore techniques that are most useful across cultures, as well as incorporating issues specific to children. Critical to the philosophy of play therapy is the ability to design appropriate interventions based on clients’ needs and their perceptions about themselves and their world, including culture (Sue & Sue, 1999). Kottman (1999) wrote of the “utopian future” in play therapy in which researchers have perfected methods for working with people from all cultures of the world. In order for this to happen, she urged counselors to take responsibility for their part in modifying present and future treatment with diverse cultures.

Recommendations for Further Research and Practice

Based upon results of this study, the following recommendations are offered:

1. A replication study using a larger sample size should be conducted. A larger sample size would increase the power of the statistical measures.

2. Conduct a replication of this study with the addition of a control group. This addition will control for maturation of the children over time.
3. Services to Hispanics from other areas should be extended in order to better generalize the results to other Hispanic groups.

4. The treatment should be implemented over a consistent amount of time, without interruptions from sessions such as holidays and school-wide exams in order to improve power and statistical significance.

5. Collecting posttest materials from teachers should be done with caution, controlling for factors such as hurriedness to complete the BASC and hectic environment. Testing should be conducted in an environment without distractions, at a time when the teacher is relaxed and can fully concentrate on the task at hand.

6. Conduct a follow-up study to ascertain maintenance and generalizability of improved social skills and behavior.

7. A recommendation for future research is to explore the outcome of similar and dissimilar client-therapist pairings in child-centered play therapy.

8. Conduct a replication of the study so that posttesting may be done earlier in the school year. This will protect the integrity of the study by removing the impact of stress that accompanies school staff, student body, and parent at the end of the school year.

9. Utilize an assessment tool that measures variables from the child’s point of view, thus reducing the reliance upon outside observation and the effects of rater bias.

10. Explore the use of multicultural toys in the play room by Hispanic children.

11. Explore the use of language (English and Spanish) for children when expressing emotionally laden topics.

12. Conduct a study comparing individual and group child-centered play therapy with Hispanic children in order to control for the “camaraderie” factor.
Concluding Remarks

A current review of the literature suggests that this research study is the first study designed to explore the effects of culturally responsive child-centered play therapy treatment with Hispanic, Spanish-speaking children. The one statistically significant result, paired with its large practically significant finding, as well as the clinically significant findings supported through parent, teacher, and treatment provider observations, is encouraging. Further research in this area with consideration to this study’s limitations could greatly enhance the success of the study.

Additionally, families who participated in the study reported feelings of gratitude for receiving assistance, specifically services that were responsive to the needs of this population. In general, parents seemed appreciative of the researchers’ approach. The following translated example is representative of the statements made by several mothers of children involved in this study. After the study was completed, one mother stated how grateful she was that there had been a Spanish speaker who could help her be involved in what was going on with her child. She said that for years she had been unable to fully communicate with her child’s teachers and school personnel and, therefore, had felt disconnected from the child’s academic issues. Finally, she took the researcher’s hand and tearfully verbalized how fortunate she felt that services had been brought to the Hispanic community, which she experienced as often being “forgotten” when it came to participation in school-based projects and activities. The researcher felt that these types of statements were genuine, as well as powerful, indications of the lack of culturally responsive services to the Hispanic community in this North Texas region.
APPENDIX A

PARENTAL CONSENT AND CHILD ASSENT FOR PARTICIPATION IN RESEARCH STUDY

(ENGLISH AND SPANISH VERSION)
RESEARCH CONSENT FORM

Subject Name:_____________________________________ Date:______________

Title of the study: The Effectiveness of Culturally Responsive Child Centered Play Therapy with Hispanic Children.

Principal Investigator: Yvonne Garza, doctoral student, Department of Counseling, Development, and Higher Education.

Co-Investigators: Dr. Sue Bratton, Assistant Professor, Counseling program, Director, Child and Family Resource Clinic; Dr. Dee Ray, Assistant Professor Counseling program, Director, Counseling and Human Development Center; Dr. Dennis Engels, Regents Professor; Carmen Bray, Counselor, Eva Hodge Elementary School; Benjamin Orozco, doctoral student, Department of Counseling, Development, and Higher Education.

Before agreeing to participate in this research study, it is important that you read and understand the following explanation of the proposed procedures. It describes the procedures, benefits, risks and discomforts of the study. It is important for you to understand that no guarantees or assurances can be made as to the results of this study.

Your participation is voluntary and you and/or your child may chose to withdraw at any time during the study without penalty of any kind. Your signature indicates that you meet all of the requirements for participation and have decided to participate and you have been told that you will receive a signed copy of this consent form.

Your decision whether or not to participate will not affect your child’s standing at school. At the conclusion of the study, a summary of results will be made available to all interested parents and teachers.

Purpose of the study and how long it will last:

The study involves 30 minute counseling sessions for your child, one time per week for 15 weeks. You will also be asked to complete a questionnaire at the beginning and at the end of your child’s counseling. Each questionnaire will take approximately 20 minutes to complete.

Description of the study including the procedures to be used:

If you allow your child to participate, first, your child will be assigned to receive either individual play therapy or group skills counseling. Both counseling procedures will be for 30 minutes, one time per week for 15 weeks.

Second, you and your child’s teacher will also be asked to complete two questionnaires, one at the beginning and one at the end of the study. The questionnaire is scored by computer and puts behaviors into categories as well as giving important information about your child’s behaviors. Both the parent and teacher questionnaire take approximately 20 minutes to complete. The Behavior Assessment System Checklist is the questionnaire used here at Hodge Elementary and
for research purposes. The Principal Investigator will record the results and compare results.

The researcher is also interested in the children’s use of culturally specific toys (example: musical instruments, foods, dolls). For this reason the researcher will videotape individual play sessions. Videotapes will be coded and only the researcher will know to whom the tape belongs. The tapes will be kept in a locked cabinet in the researcher’s office. Only the researcher and her employed associate will review the tapes for coding toy use. After the child’s use of the toys is coded, the researcher will keep the videotapes for future study.

**Description of procedures/elements that may result in discomfort or inconvenience:**
There is no personal risk or discomfort directly involved with this study other than the normal expression of anger, sadness or frustration associated with expressing emotions through play. You and/or your child may choose to withdraw at any time without penalty or prejudice.

**Description of the procedures/elements that are associated with foreseeable risks:**
There are no foreseeable risks involved with this study other than those associated with normal daily activities.

**Benefits to the subjects or others:**
The play times are based on the fact that play is the natural medium of communication for children. Selected play materials are utilized to help young children express feelings, thoughts, experiences, and behaviors. This interaction between children, selected play materials, and the trained play therapist may help enhance your child’s self esteem, self-control, and self-confidence. There may be times after the play sessions when your child may behave a little differently (more quiet or more active). The counselor for your child will be available to help you understand what is going on with your child and give you ideas about responding to your child.

Elementary school is a time when students develop attitudes concerning self, peers, social groups and family. Those children selected to receive group skills counseling will attend small group guidance sessions that teach skills that may help to improve their academic, personal/social and career development. Most elementary schools use group skills counseling as a regular part of counseling services for children.

**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 information will be recorded with code numbers to preserve confidentiality. Only the researcher, Yvonne Garza, the group skills counselor and the children’s teachers will know the participants names. At the end of the study the list of names will be destroyed. The only exceptions to confidentiality are if a) a child disclosed abuse, neglect or exploitation, b) the child is a danger to oneself or to someone else, c) a court orders disclosure of information, or d) the parent or legal guardian requests release of information.

**Review for protection of participants:**
This research study has been reviewed and approved by the UNT Committee for the Protection of Human Subjects (940) 565-3940.
Research Subjects’ Rights:
I have read or have had read to me all of the above.

Yvonne Garza has explained the study to me and answered all of my questions. I have been told the risks or discomforts and possible benefits of the study. I have been told of other choices of treatment available to me.

I understand that I do not have to take part in this study, and my refusal to participate or to withdraw will involve no penalty or loss of rights or benefits or legal recourse to which I am entitled. The study personnel may choose to stop my participation at any time.

In case there are problems or questions, I have been told I can call Yvonne Garza or Dr. Sue Bratton or Dr. Dee Ray at telephone number 940-565-2066.

I understand my rights as a research subject, and I voluntarily consent to participate in this study. I understand what the study is about and how and why it is being done. I have been told I will receive a signed copy of this consent form.

__________________________________________
Signature of Parent or Guardian               Date

__________________________________________
Signature of Witness                         Date

The researchers may wish to present some of the tapes from this study at scientific conventions or as demonstrations in classrooms. Please sign below if you are willing to allow us to do so with the tapes of your child’s participation.
I hereby give permission for the videotape made for this research study to be also used for educational purposes.

__________________________________________
Signature of Parent or Guardian               Date

For the Investigator or Designee:
I certify that I have reviewed the contents of this form with the person signing above, who, in my opinion, understood the explanation. I have explained the known benefits and risks of the research.

__________________________________________
Signature of the Principal Investigator        Date
Carta de Informacion Para Padres/Guardianes
Terapia de Juego y Consejos de Guianza

Usted y su niño están invitados para participar en un estudio para determinar la efectividad de un programa de terapia de juego centrado en el niño y responsivo a la cultura para niños Hispanos. La que participacion es completamente voluntaria.

Su niño sera designado para recibir la terapia de juego de un terapista entrenado o guia consular por 30 minutos una vez a la semana por quince semanas. Usted y la maestra de su niño contestaran una serie de preguntas al comenzar el estudio y tambien al terminarlo.

Las sesiones de terapia de juego estan basados en el hecho que el juego es el medio de comunicacion natural para los ninos. Selectos materials son utilizados para ayudar a los ninos jovenes a expresar sentimientos, pensamientos, experiencias, y acciones. Es posible que este intercambios entre los ninos, selectos materials y el terapista entrenado pueda aumentar el auto estima, auto dominio y confianza de los ninos. Es possible que haya tiempos despues de la terapia cuando su niño se porte un poco diferente (mas callado o mas activo). El consejero para su niño estara disponible para ayudarle a entender que esta pasando con su niño y darle sugerencias sobre como responder a su niño.

Durante los anos de la escuela primaria los estudiantes desarrollan actitudes sobre si mismo, sus amigos, grupos sociales y la familia. Los ninos escojidos para recibir la terapia participaran en sesiones de consejo en grupo que les enseñan habilidades que les pueden mejorar su desaroro academico, personal, social y en su carrera. La informacion que usted proveyo cuando respondio al cuestionario sera mantenido en confidencia y no sera publicado en ninguna publicacion o discussion de este material. Toda informacion sera archivado con numeros de codigo para mantener la confidencia de la informacion. Solamente la directora del estudio, Yvonne Garza, el guia consular, y la maestra de los ninos sabran los nombres le los participantes. Al final del estudio la lista de los ninos que participaron sera destruida. La informacion sera compartida solamente bajo cuatro condiciones: a.) el niño revela abuso, negligencia o explotacion, b.) el niño presenta peligro a si mismo o a otra persona c.) una corte manda que el informacion sea revelada d.) un padre guardian pide que el informacion sea revelada.

No hay riesgo personal o dolor envuelto con este estudio a parte de la expression normal de ira, tristeza o frustracion que viene de expresar las emociones por medio del juego. Usted o su niño pueden dejar de participar el cualquier tiempo sin ninguna pena. La decision de participar con el estudio no afectara la posicion de sus ninos en la escuela.

Al final del estudio se hara un resumen de los resultados y sera dada a todos los que tengan interes. Si quiere participar en el studio, favor de llamar la forma de consentimiento. Para mas informacion, favor de llamar a Yvonne Garza en 565-2066 o Dr. Sue Bratton o Dr. Dee Ray 565-2066 en la Universidad de North Texas. Muchas gracias por el tiempo, cooperacion, y participacion.

Sinceramente,

Yvonne Garza
PLAY THERAPY-RESEARCH INFORMATION FOR CHILDREN

(To be read to child subjects age four to 11. The underlined part will be omitted for children age five and younger due to their shorter attention span and limited abstract reasoning ability. Questions will be allowed and responded to immediately during the reading of this statement.)

I am a counselor for children. This means I spend time with children in the playroom and help them with their problems. I am studying about some better ways to help children who speak Spanish and would like your help. Some of the children who agree to help me will meet with another counselor and a few other children at your school and talk with the counselor about certain stories the counselor will read to you, other children will help me by playing in the playroom. In the playroom, you can play with the toys, draw pictures, talk to the counselor, and do things that you like to do. Everyone will meet with a counselor for 30 minutes every week for about 15 weeks.

What you say or do in counseling is private. The counselor will not tell your mother or other people about what you say or do during that time. The counselor will only break this rule if he or she thinks that you are not safe and need to be protected. However, if you like, you can tell your mother or other people about what you do during your counseling time.

I have talked to your parent or guardian and was told that it would be all right to ask you to help me with this study. If you agree, you will go with a counselor one time a week. I would like to check if it is all right with you. It is up to you to decide. You can choose to help by going with a counselor for 15 times or you can choose not to do this. Tell me which you choose. (Allow the child to respond and confirm his or her response.) Also, I would like you to know that you can change your mind any time and you can tell your parent or guardian that you do not want to go with a counselor for this study any more.

If you have other questions later, you can always ask me. If you do not see me when you have questions you can ask your parent or guardian to call me. I will call you or come talk to you. (Give child a business card of the researcher.)

Thank you for your help.

Sincerely,
Yvonne Garza, LMSW, RPT
Licensed Masters Social Worker, Registered Play Therapist
Doctoral Student Counseling Intern, University of North Texas
CHILD ASSENT FORM

You are making a decision about whether or not to have your child participate in this study. Your signature indicates that you have decided to allow your child to participate, that you have read (or have had read to you) the information provided in this consent form and that you have received a copy of it.

________________________________________________________________________
Signature of Parent, or Guardian     Date

________________________________________________________________________
Signature of Investigator      Date

________________________________________________________________________
Signature of Witness       Date

ASSENT OF CHILD

_________________________(name of child) has agreed to participate in research

Title of Project

Signature of the Subject. of assent is required.      Signature of the Parent or Guardian must be substituted if waiver of assent is required.

WAIVER OF ASSENT

The assent of __________________________(name of child) was waived because of

_____ Age

_____ Maturity

_____ Psychological state of the child

Signature of Subject, Parent, or Guardian     Date
Forma de Consentimiento para el Estudio- Ninos
PLAY THERAPY-RESEARCH INFORMATION FOR CHILDREN

(To be read to child subjects age four to 11. The underlined part will be omitted for children age five and younger due to their shorter attention span and limited abstract reasoning ability. Questions will be allowed and responded to immediately during the reading of this statement.)

Yo soy una consejera para ninos. Este significa que paso tiempo con ninos en una cuarto de jugar para ayudarlos con problemas. Estoy estudiando mejores maneras de ayudar a ninos que hablan espanol y gustaria su ayuda. Algunos de los ninos que estan de acuerdo para participar van a estar con otro consejero y otros ninos de su escuela para hablar de estorias que el consejero te va leer. Otros ninos van a ayudar me a la manera que van a jugar en un cuarto de jugetes. En este cuarto usted puede jugar con jugetes, dibujar, hablar con la consejera o hacer otras cosas que gustarias hacer. Todos van a juntar con un consejero por 30 minutos cada semena por 15 semanas.

Lo que dices o haces in consejeria es privado. Este significa que el consejero/a no le va dicer a sus padres lo que dices o lo que haces durante el tiempo de consejeria. El unica manera que el consejero/a puede quebrar este regla es si el/ella piensa que estas en riesgo y necesitas proteccion. Pero tu puedes decider a otros de lo que haces durante el tiempo que estas en consejeria.

Hable con tus padres o guardian y me dijieron que puedo preguntarte ayudarme con este estudio. Si pones de acuerdo, vas con un consejero/a una vez a la semana. Me gustaria ver si estas de acuerdo. Tu puedes decider. Puedes ir con una consejera por quince veces o puedes escojer no acer esto. Dime ahora que decides. (Allow the child to respond and confirm his or her response.) Tambien quiero decirte que puedes cambiar de opinion a qualquer tiempo y puedes decir a tus padres o guardian que ya no quieres ir con el consejero/a para este studio.

Despues si tienes preguntas me puedes preguntar. O puedes decirle a tus padres o guardian que me hable para contestar tus preguntas y luego yo te hablo o vengo a verte para responder a sus preguntas. (Give child a business card of the researcher).

Gracias para tu ayuda.

Yvonne Garza, LMSW, RPT
Licensed Masters Social Worker, Registered Play Therapist
Doctoral Student Counseling Intern, University of North Texas
FORMA de ASENTIMENTO de NINO

Estas haciendo una decision para dejar a su hijo participar en este estudio. Su firma indica que decidistes dejar a su hijo participar y que as leido o te leeron el informacion tocante este estudio y que te van a dar una copia firma de este consento.

__________________________________________________________
Firma de Padre or Guardian     Fecha

__________________________________________________________
Firma de Investigadora     Fecha

__________________________________________________________
Firma de Testigo      Fecha

ASSENTIMENTO DE NINO

_________________________(name of child) he decidido participar en este estudio.

The Effectiveness of Culturally Responsive Child- Centered Play Therapy with Hispanic Children.
Title of Project

__________________________________________________________
Firma del Participante.     (Signature of the Parent or Guardian must be substituted if waiver of assent is required).

RENUNCIA DE ASSENTIMIENTO

El assentimiento de ________________________________________(name of child) esta renunciado por razon de

_____ Edad

_____ Madurez

_____ El estado psicologico del nino

__________________________________________________________
Firma del Participante, Padre o Guardian     Fecha
APPENDIX B

TOY LISTS
List of Toys/Materials (Landreth, 2002)

Baby dolls, doll bed, clothes, etc.
Balls
Bendable nondescript figure
Bop bag or bag of air
Building blocks (different shapes and sizes)
Chalkboard, chalk, colored chalk, eraser
Clay
Crayons, pencil, paper, blunt scissors
Dishes (plastic or tin), pans, silverware, pitcher
Doll house, furniture, and doll family
Egg cartons
Firefighter hat, other hats and items used for dress up
Hand puppets
Mask
Medical kit, band aids
*Multi-wheeled type vehicle for scooting around on
Pacifier, nursing bottle (plastic)
*Paints, easel, newsprint, brushes
Plastic food, empty fruit and vegetable cans
Play money and cash register
Pounding bench and hammer
Purse and jewelry
*Refrigerator (wood)
Rubber knife, handcuffs, rope, dart gun, noise-making gun
*Sandbox, large spoon, funnel, sieve, and a pail
School bus
Stove (wood)
Sponge, towel, broom, and dust pan, soap, brush, comb, tissues
Telephone (two)
Tongue depressors, popsicle sticks
Toy soldiers and army equipment
Toy watch
Transparent tape, glue, construction paper, pipe cleaners
Truck, car, airplane, tractor, boat
Xylophone, cymbals, and a drum
Zoo animals, farm animals, rubber snake, alligator

*For the purpose of this study the refrigerator and riding vehicle was not used due to lack of space in the playrooms. The paint easel was eliminated due to lack of space; however, smaller paint supplies were offered such as glitter paints and watercolors. *Rice was used in lieu of sand in one of the schools; this was done at the request of the principal.
Culturally Responsive Toys/Materials

In addition to the toy list recommended by Landreth (2002), the following toys have been added that are perceived to be specific to the environment, culture and lifestyle of the Hispanic children in the North Texas region (Y. Garza, M. Hinojosa, D. Molina, Y. Muzquiz, & E. Rinaldi, personal communication, July, 2003).

Alcohol (empty plastic liquor bottle)
Animals (rooster, parrot, rattlesnake common in south Texas and Mexico)
Assortment of musical instruments from Mexico (accordion, bongos, maracas)
Bus (public transportation type)
Bingo cards (with Spanish pictures and titles)
Cars (symbolic of lowriders)
Coffin and skeleton
Cooking (molcajete, rolling pin, utensils with Spanish designs)
Dolls, life-like puppets (darker skin colors)
Dress up (cowboy hat, boots, and men’s belt)
Food (avocado, chili pepper, and taco)
Markers (multicultural by Crayola)
Symbols that represent religious/spiritual culture (cross, holy water, candle with religious picture, rosary beads)
Tools (realistic hammer, screwdriver, nails, and tape measure)
Wrestling figures (popular in Mexico)
APPENDIX C

RAINBOW DAYS KIDS CONNECTION PERMISSION LETTER
October 20, 2003

Yvonne Garza
703 Woodland St.
Duplex A Denton, TX 76209

Dear Miss Garza,

This letter is in support of your utilization of the Kids’ Connection Support Group Curriculum as part of your dissertation study for the counseling program at the University of North Texas. I understand that the group facilitators who will be conducting the curriculum based support groups have attended, our two-day Kids’ Connection training and I have every confidence that they are prepared to effectively utilize the curriculum as modeled during the training seminar. You have our approval to utilize this curriculum as part of your research study.

Please keep us updated on the progress of your project and please let us know if you have any questions or need assistance.

Sincerely,

Cathey Brown Executive Director
APPENDIX D
CHILD-CENTERED PLAY THERAPY SKILLS LIST
Non-verbal Skills

Play therapy is heavily reliant on non-verbal skills. Because play therapists believe that play is the language of children, the verbal world becomes less important in a play therapy session. Non-verbal skills are critical to any therapy, but especially to play therapy.

*Leaning forward/Open stance.* The play therapist is physically directed toward the child at all times. The play therapist moves in the chair as the child moves so that the therapist is always squarely facing the child. Arms and legs are positioned to convey a sense of openness to the child.

*Appearing interested.* The therapist looks as if she is interested in the child throughout the session. The therapist does not appear preoccupied with other thoughts or matters.

*Seems comfortable.* The therapist seems comfortable with the child and the situation. The therapist remains relaxed throughout the session.

*Therapist’s tone/Expression congruent with child’s affect.* The therapist matches the level of affect displayed by the child. Often, new play therapists will present themselves as overly animated to the child. This is generally the way that many adults relate to children. Therapists new to working with children often carry the idea that their role is to make the child happy and therefore use their tone of voice toward this end. As with counseling adults, the therapist should strive to be congruent with how the child expresses himself.

*Therapist’s tone/Expression congruent with therapist’s responses.* The therapist should not only match the child’s affect but should also convey a sense of genuineness. The skill of matching verbal response with non-verbal response is symptomatic of the therapist’s level of genuineness with the child. Specifically speaking, the therapist would not flatly present the response, “You’re
excited by how you made the bubbles.” In this example, the therapist would need to add the affect of excitement to the response. In addition, this skill also addresses the tendency of some therapists to end their responses in a higher tone, indicating a question. When making definitive responses, therapists should avoid this habit, which is confusing to the child. The child is left to figure out how to respond to the therapist, “Should I answer or not?”

Verbal Skills

The delivery of verbal responses by a play therapist to the child is almost as impactful as the words chosen. Two delivery skills are observed specifically in the supervision of play therapists, succinct/interactive responses and rate of responses. Because play therapy is offered to children and because play therapy recognizes the limited language ability of children, the importance of short therapeutic responses is key. Supervisors help play therapists to communicate their intent in as few words as possible. A maximum of ten words is a good rule of thumb. Lengthy responses lose the interest of the child quickly, confuse the child, and often convey a lack of understanding on the part of the therapist.

Rate of responses is a second skill in the delivery of verbal responses. The therapist should match the interaction of the child. If the child is quiet and reserved, then the play therapist will slow his responses. If the child is highly interactive and talkative, the play therapist will want to match this level of energy with increased number of responses. In initial sessions with children, play therapists will have a quicker rate of responses, because silence can be uncomfortable for the child in a new situation. In subsequent sessions, the therapist will learn to create a pace that matches the child. Both delivery skills of length of responses and rate of responses are typically problematic skills at the very beginning of a play therapist’s experience. These skills are quickly acquired and most supervisors will not address them with experienced play therapists.
In the initial supervision of the play therapists, it helps to present categories of verbal responses. These categories provide the play therapist with structure from which to work when the situation is new and foreign to them. For experienced play therapists, the construct of categorical responses helps them to review the basics when they are feeling unfocused or confused about specific cases. The following are several relevant categories of verbal responses.

Tracking behavior. Tracking behavior is the most basic of play therapist responses. The therapist tracks behavior when she verbally responds to the behavior of the child simply by stating what is seen or observed. Tracking behavior allows the child to know that the therapist is interested and accepting of the child. It also helps the therapist immerse herself into the child’s world. Examples of tracking behavior include, (as a child picks up the clay) “You’re picking that up” or (as child runs in a circle) “You’re running around and around.”

Reflecting content. Reflecting content in play therapy is identical to reflecting content in adult talk therapy. To reflect content, the play therapist paraphrases the verbal interaction of the child. Reflecting content validates the children’s perceptions of their experience and helps to clarify children’s understanding of themselves (Landreth, 2002). An example of reflecting content includes, (child excitedly shares detailed story of building a rocket with his dad) “You got to build something cool with your dad this weekend.”

Although tracking behavior and reflecting content are essential to the play therapy process, they are the most basic skills in play therapy. These two skills help to build a relationship with a child so that the child can benefit from higher-level skills. The following skills are used to move directly toward the goals of building self-concept, developing self-responsibility, creating awareness, and building the therapeutic relationship.

Reflecting feeling. Reflecting feeling is the verbal response to emotions expressed by children
in play therapy. Reflecting feeling is considered a higher-level skill, because children rarely communicate in terms of verbally expressing emotion. However, they are quite emotive. In addition, the reflection of feeling can sometimes be threatening to a child and should be presented carefully. Reflecting feeling helps a child become aware of emotions, thereby, leading to the appropriate acceptance and expression of such emotions. Examples of reflecting feeling include, (child throws the spider across the room while saying, “He’s bad, I hate him.”) “You are really angry with that bad spider” or (child tries several times to take the top off marker unsuccessfully and then throws it on the floor) “You’re really frustrated with that.”

Facilitating decision-making/Returning responsibility. One of the play therapist’s goals is to help the child experience a sense of their own capability and to take responsibility for their expression of capability. The therapist does not do for a child what a child can do for himself (Landreth, 2002). Responses that facilitate decision-making or return responsibility help a child experience self as able and empowered. Examples of responses that facilitate decision-making or return responsibility include, (child wants to draw a picture and asks, “What color should the car be?”) “In here, you can decide the color you want it to be”, or (without making an attempt, the child asks, “Can you get the ball from behind the shelf for me?”) “That looks like something you can do.”

Facilitating creativity/Spontaneity. Helping a child experience his own sense of creativity and freedom to experience creativity is another goal of play therapy. Acceptance and encouragement of creativity sends a message to the child that she is unique and special in her own way. Maladjusted children are often trapped in rigid ways of acting and thinking. Experiencing the freedom of expression allows them to develop flexibility in thought and action. Examples of responses that facilitate creativity or spontaneity include (child asks, “What do I make with these
straws?”) “You can create whatever you want with those”, or (child moves from one project to another in play session) “You changed to do just what you want.”

**Esteem-building/Encouraging.** Encouraging children to feel better about themselves is a constant objective for the play therapist. The use of esteem-building statements works to help children experience themselves as capable. Examples of esteem-building/encouraging responses include, (child tries a few ways to reach the top shelf) “You’re not giving up, you just keep trying” or (child tries and tries to fit doll into car, after a few attempts, she succeeds) “You did it. You figured it out.”

Initially, play therapists often struggle with the difference between praising and esteem-building responses. The play therapist supervisor must often help a play therapist determine how an esteem-building response is more effective than a praising response. A praise response, such as, “That’s a pretty picture” or “I like the way you did that” encourages the child to perform for the therapist, and continue to seek external reinforcement, thereby eroding a sense of self. An esteem-building response, such as, “You’re really proud of your picture,” or “You made that just the way you wanted,” encourages children to develop an internal sense of evaluation leading to an internal sense of responsibility.

**Facilitating relationship.** Responses that focus on the relationship between the therapist and child help the child to experience a positive relationship. Because the therapy relationship serves as a model for all intimate relationships, the therapist should respond to any attempt by the child to address the relationship. Relational responses help the child learn effective communication patterns and express the therapist’s care for the child. Example of responses that facilitate the relationship include, (child is building something in sand and stops to look up at therapist but says nothing) “You’re wondering what I think about that,” or (therapist sneezes, child gives therapist a
bowl and says, “Eat the soup so you’ll feel better.”) “You really want to take care of me” or (after therapist sets limit, child responds, “I hate you. I hate you.”) “You’re really angry with me for this.” Relationship responses should always include a reference to the child and reference to self as therapist.

Limit Setting

Landreth (2002) proposed a specific method for setting limits in play therapy. This method has been widely adopted by play therapists as the initial response to setting a limit in the playroom. The A-C-T model of limit-setting includes: Acknowledge the feeling, Communicate the limit, and Target an alternative. In this model, the play therapist recognizes and addresses the child’s feelings in the moment, “You’re really angry with me.” Secondly, the therapist sets a short, concrete, definitive limit, “but I’m not for hitting.” Finally, the therapist provides an alternative to the action, “You can hit the Bop bag.” When children have directed energy in the moment, it is important to provide them an alternative for that energy so that they do not feel the need to act on impulse. Although there are other methods for setting limits, the A-C-T model is short, direct, and works effectively.
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