EFFECTIVENESS OF CHILD-CENTERED PLAY THERAPY WITH JAPANESE CHILDREN IN THE UNITED STATES

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This study explored the use of child-centered play therapy (CCPT) as a culturally responsive intervention and a prevention treatment method for the psychosocial well-being of Japanese children in the United States. In light of the demand for the evidence-based therapeutic treatment for children as well as the need to conduct multicultural research without ignoring within-group differences, this study was composed of two research methodologies; quantitative research design and individual analysis. Single-group repeated measures ANOVA was utilized for the group analysis and linear regression was employed for individual analysis in addition to qualitative data obtained through parent feedback and the researcher’s observation of play therapy sessions. The participating children received a total of eight CCPT sessions.

The impact of CCPT was measured by a decrease in a child’s behavioral problems perceived by a parent measured by scores of the Internalizing Problems, Externalizing Problems and Total Problems on the Child Behavioral Checklist and a reduction of parent-child relationship stress manifested in the Child Domain, Parent Domain and Total Stress Score of the Parenting Stress Index. Data from a total of the four assessment points; the baseline, pretest, second assessment, and third assessment, was gathered for use in the analysis.

A total of 16 children were recruited from the Japanese School of Dallas for participation in this study. However, some children did not complete the entire set of 8 play therapy sessions, and as a consequence, neither were all assessments completed
by their parents. Therefore, data from 10 children, age ranging from 4 to 9, were utilized for the statistical analysis.

The results of the analysis did not reveal any statistical significance. However, large and medium effect sizes were obtained on all the six aforementioned subscales during the treatment period. Individual analysis provided further information on possible environmental, developmental, and cultural factors that are considered influential issues on the change of individual scores.
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CHAPTER I
INTRODUCTION

Cultural diversity in the United States has rapidly become more evident, and an ever-increasing variety of colors accurately describes the diversity that now exists. By 2050, research has assumed that the White majority will be a minority exceeded by the total number of all the minority groups (Meacham, 2000) and that minority children will outnumber the population of Caucasian children in the United States by the year 2025 (Dana, 1998).

Despite this trend, the U.S. Department of Health and Human Services (1999) has indicated that the U.S. mental health system is not well equipped to satisfy the needs of racial and ethical minority groups. Accordingly, scholars have begun to heed the call for mental health research aimed at describing, understanding, and remedying disproportionate access to mental health care services for racial and ethnic minorities. National interest in the mental health needs of minority groups in the United States has increased over the past few decades as a result, research on multicultural issues and competence has been consistently conducted (Sue & Sue, 1999). However, failure to exploit the results of those studies to advance the underutilization of mental health services among minority group indicates some faults in adapting traditional methods of research to explore cultural concerns. The American Psychological Association (APA, 2003) advocated the importance of conducting culture-centered and ethnic psychological research, listing some limitations inherent in multicultural research. Among the limitations is the presumption that all people of color are similar, and large
within-group differences are ignored despite of the great within-group heterogeneity of all the major racial and ethnic groups in the United States. (APA, 2003).

The Asian-American population is one of the fastest growing minority groups in the United States, and has high heterogeneity within this group itself (Kerl, 1999). According to the U.S. Bureau of the Census (2000), 11.9 million people (4.2%) out of the U.S. population identified themselves as Asian, defined as Asian only, or Asian and at least one other race. The latest census reflects the non homogeneous nature of the Asian population, acknowledging the composition of many groups who differ in language, culture, and length of residence in the United States.

The Japanese, one of the 11 identified Asian groups, comprise 7.8% of the total Asian population in the U.S. (U.S. Bureau of Census, 2000). Even within the Japanese, there is diverse heterogeneity because of the specific immigration history and also due in part to the fact that their interracial marriage rates are the highest of all Asian Americans (Le, n/d), resulting in an increased number of biracial or multiethnic Japanese children. The “model minority” myth is often applied to the Japanese in the United States, indicating that they are considered relatively successful and problem-free because of their high socioeconomic and educational status (Sue & Sue, 1999). However, existing research reports various psychosocial issues, including acculturation, language, and interpersonal difficulties among Japanese children in the United States. In addition to the understated attention to the mental health issues in Japanese children in the United States, a stigma attached to mental health services and a lack of mental health care providers with Japanese ethnic backgrounds are major obstacles for Japanese parents who seek professional psychological support for their children.
Improving the accessibility to mental health services for Japanese children in the United States. may includeemploying the expertise of trained therapists who have an understanding of the Japanese culture, can speak their language, and have the ability to provide a developmentally appropriate intervention such as play therapy.

For almost 100 years, play therapy has been recognized and practiced as a therapeutic alternative for children. Play is the “native language” of children and an innate and universal communication system with which children communicate in a direct or symbolic way (Landreth, 2002). The significant role of play in children’s development is even recognized in the United Nations' “Declaration of the Rights of the Child,” in which the importance of play is accorded equally to nutrition, housing, education, and health care (Kim, 2002).

According to Landreth, Homeyer, Glover, and Sweeney (1998), empirical evidence supports play therapy as an effective intervention in treating a variety of issues in children. Ray, Bratton, Rhine, and Jones (2001) and also Bratton, Ray, Rhine, and Jones (2005) conducted the largest meta-analysis of play therapy outcome studies, including 93 studies dating from 1942 to 2000. The result of the meta-analysis revealed a treatment effect size 0.80 standard deviation, indicating the strong effectiveness of play therapy. Although the meta-analysis includes studies presenting a wide array of children’s issues, only 5 out of 93 studies treated minority children. Ray et al. specifically noted a lack of ethnic diversity in populations studied and called for increased research on play therapy with culturally diverse children.

Play therapy has been accepted, acknowledged, and utilized as a main mental health intervention for children in various settings in Japan for over the past 5 decades.
However, empirical research studies that identify play therapy as an appropriate treatment methodology for Japanese children are scarce, and the effectiveness of play therapy is reported predominantly in case study layout. Abe and Maeda (1981) postulated that lack of consistency in the theoretical approaches in play therapy in Japan may have been hindering researchers from adopting scientific methodologies to examine the effectiveness of play therapy. As regards play therapy with Japanese children in the United States, no study has yet been performed.

A major mission of multicultural research in play therapy is to provide cross-cultural information so that play therapists can build their sensitivity, acquire knowledge, responsibility and develop active competence (Gil, 2005). Therapists will be able to have more a flexible and expanding frame of reference to view children in play therapy. Along with this mission is the examination of the validity of play therapy that was established and developed in predominantly Western cultures. Moreover, because of the universal nature of play as a communication medium for children, there is a presumption that this practice has universal application to any ethnicities, overlooking the possibility of inherent cultural bias in this practice. Although existing studies support play therapy as an effective treatment modality for minority children (Baggerly, & Parker, 2005; Cosico-Berge, 2002; Garza & Bratton, 2005; Shen, 1999), reevaluation of traditional play therapy and consideration for modifications are both critical in providing more culture-centered play therapy for minority children.
Statement of the Problem

The problem that this researcher explored was the impact of the use of child-centered play therapy (CCPT) with Japanese children in the United States. Although abundant studies have revealed adjustment issues with which this population is likely to struggle, there is a dearth of studies on empirically supported intervention or prevention methods to increase the mental health well-being of Japanese children in the United States. Diversity within this population due to a variety of immigrant backgrounds is one of the obstacles facing researchers in their attempts to conduct group experimental design methodology, which requires control for variables to reduce the threat to internal validities. In order to respond to the need for evidence-based treatment for this population as well as the need to conduct multicultural research without ignoring the within-group differences, this study was composed of two research methodologies: quantitative research design and case-study analysis. The intent of this study was to provide preliminary results regarding the effectiveness of CCPT as a culturally responsive intervention and prevention modality for Japanese children in the United States to expand the repertoire of culturally centered care for this underserved population.

Review of Related Literature

The review of literature concentrated on the following themes: (a) Japanese and Japanese Americans in the United States, (b) Conflicts and Struggles in Japanese and Japanese American Children in the United States, (c) History and Principles of Child-
Centered Play Therapy; (d) History of Play Therapy in Japan, (e) Child-Centered Play Therapy With Ethnic Minorities, and (f) Dilemma in Research With Minority Groups.

*Japanese and Japanese-Americans in the United States*

The U. S. Bureau of the Census (2000) reported that Asian Americans as a whole were the fastest-growing major racial and ethnic group from 1990-2000. The term *Asian or Asian American* is the most diverse regarding ethnic origin. The U.S. Census reported the diversity within this population by listing 11 Asian sub groups, with the Asian population data divided into two broad categories: people who identify themselves as one race and those who report more than one race.

However, there is a general public misunderstanding that Asians are ethnically homogenous. Failure to acknowledge and distinguish diverse ethnic cultural, religious, political, and language groups composing this population can lead to faulty conclusions regarding the individual mental health needs of Asians (U.S. Department of Health and Human Services, 2001).

Currently, Japanese individuals compose 7.8% of the total Asian population in the United States (U.S. Bureau of the Census, 2000). Japanese immigration hit the first major wave between the late 1800s and the early part of the 1920s when Japanese men entered the United States, as contract laborers (Shibusawa, 2001). Since then, because of the unique immigration history of the Japanese, such as the antimiscegenation laws and the Immigration Exclusion Act, Japanese Americans have been identified by generation (Shibusawa, 2001). The first generation was called *Issei* meaning the first generation; children of Issei who were born in the United States are called *Nisei*’,” second
generation. The offspring of Nisei are Sansei, the children of Sansei are Yonsei, and their grandchildren are Gosei. Through generational development in the United States, Japanese descendants married citizens outside of their ethnic background. Although it has been about only 40 years since interracial marriage became constitutional, Japanese in the U.S. have the highest rate of intermarriage and lowest rate of endogamous among the six major Asian American ethnic groups (U.S. Bureau of the Census, 2000; Le, n/d). Interracial marriage of the Japanese results in increased numbers of Japanese American children who are biracial or multiracial, creating more diversity within this ethnic group.

One of the reasons for the high rate of intermarriage of the Japanese is that many Japanese adults are now in their fifth (Gosei) or higher generation in the United States and they are among the most assimilated of all Asian American groups. The fact that among all detailed 11 Asian groups, the Japanese are the only group with over 50 % who speak only English at home serves as an example of the high assimilation level of the Japanese (U.S. Bureau of the Census, 2000).

Collins (2000) noted that despite the ethnic and racial complexity and diversity of the U.S. population, the research on biracial identity development is scarce. Collins also highlighted that the identity development process of biracial individuals is different from that of other minorities because of the effects of integrating two different cultures without the marginalization of one or both cultures. Recent awareness of multicultural issues in the mental health field in response to the tremendous diversity in the U.S. population is a remarkable advancement in the field. However, multicultural issues have been excessively dependent on grouping by ethnicity, and precise attention has not been
paid to individual differences among an ethnic group such as biracial or multiracial individuals and their acculturation level. Japanese in the United States are among the Asian groups who have the most variety among their population. In order to better understand Japanese children in the United States and to avoid simple categorization, further research on this population based on an ecological view of the person is necessary.

Another unique group of the Japanese population in the United States is Japanese sojourners. According to the Japanese Ministry of Foreign Affairs, there are 240,033 Japanese sojourners in the United States, the majority of whom are *Chuzaiin*. *Chuzaiin* refers to Japanese corporate sojourners who are assigned by a company to work and live abroad temporarily in a country where the company is conducting their business through a branch, subsidiary, or joint venture. After the completion of assignments (usually in 3 to 5 years), *Chuzaiin* are expected to return to Japan or move to another place overseas (Isa, 2000). Their career path may be either positively or negatively influenced by agreeing to work abroad and by the results of their work (Ward, Bochner, & Furnham, 2001).

*Chuzaiin* are often accompanied by their families and experience exposure to unfamiliar cultural settings. Okazaki-Luff (1991) reviewed the literature on the adjustment of Japanese sojourners in order to determine the validity of the popular belief that many Japanese sojourners experience more difficulties living in the United States compared with other nations. She reported that the notion was not empirically supported. However, she reported that problems concerning communication ability and lack of friendships with inhabitants of host nations are more specific difficulties that
Japanese sojourners are apt to encounter. On the other hand, these problems are not commonly observed in Japanese children, indicating that adjustment issues in children need to be examined separately from those of adults (Okazaki-Luff, 1991).

Arnault (2002) examined how cultural factors regulate seeking help and social support among Japanese sojourners’ wives living in the United States in relation to the social exchange theory. The Japanese culture-specific concept of *enryo*, which indicates the awareness of bother or burden imposed on the relationship when help is sought, was identified as an inhibitor in help seeking. Doi (1971) mentioned that enryo decreases proportionally with intimacy and closeness and increases with distance in relationships. Hence, in a parent-child relationship, *enryo* is minimal. *Enryo* is in general perceived to be a confining state of mind, and if possible, absence of *enryo* is ideal. However, hierarchy in social status is a strong component of *Chuzaiin* society, and this hierarchical social structure seems to generate *enryo*, discouraging this population from seeking help.

Nakagawa, Teti, and Lamb (1992) studied mother-child attachments among Japanese corporate sojourner wives in the United States and examined the applicability of the results of Western studies that found positive correlations between the quality of mothers’ interactions with their children and either marital support or social support. The results of their study indicated that the quality of social support improved perceptions of parental well-being among mothers with high levels of stress. In addition, the results revealed a negative correlation between marital harmony and attachment security and between parental stress and attachment security. A negative correlation between marital harmony and attachment security in Japanese sojourners’ wives can
be explained by the “compensatory” child-parent subsystem (Engfer, 1988). In this system, mothers seek emotional closeness and satisfaction in their relationships with their children in compensation for a lack of intimacy in the marital relationship. Chuzaiins usually have strong commitments to their employers; many men remain at work 80 hours per week or more (Isa, 2000). Men's extreme dedication and commitment to their companies remove them from a paternal role in the family, resulting in a pathological “fatherless family” or so-called “mother-centered family” (Kameguchi & Murphy-Shigematsu, 2001). Social support appears to play a critical role in Chuzaiin wives as a buffer to stress, yet they are reluctant to seek support.

Conflicts and Struggles in Japanese and Japanese American Children in the United States.

The dearth of research on mental health issues in Asian immigrant children can be partially attributed to the “model minority’ myth, in which Asian minorities children are considered relatively successful in the U.S. society, hence rarely experience psychological issues (Sue & Sue, 1999). While some minority groups tend to be overdiagnosed because of cultural insensitivity and bias in clinical judgment in mental health professionals, Asian Americans are one of the minority groups which are predisposed to underdiagnosis (U.S. Department of Health and Human Services, 1999).

In addition, it has been reported that Asian minorities more likely internalize psychological problems, exhibiting depression, isolation, and low self-esteem (James, 1997), which are not as apparent in drawing attention as externalizing behaviors. Zahn-Waxler, Friedman, Cole, Mizuta, and Hiruma (1996) reported results consistent with this propensity of internalizing emotional conflicts among Japanese children. In a
comparative study of Japanese preschool children in the United States with U.S. preschool children regarding responses to interpersonal conflicts and distress, Zahn-Waxler et al. reported that Japanese children seem to have strongly internalized sanctions regarding issues of bringing harm to others, which discourages externalizing behaviors such as aggression, tantrums, or demandingness. The researchers speculated that inhibition of emotions and behaviors against others in Japanese children are due to the fact that anger and aggression are incompatible with some Japanese cultural values which include collectivism. This study also supported the hypothesis that cultural differences begin in early childhood and awareness of cultural identity in children is more evident in their affect and behaviors than their verbalization due to their early stage of verbal development.

Among Japanese in the United States, oversea sojourners are identified as struggling with isolation from local communities and change in family dynamics. Ishizaki and Ishizaki (2001) examined the effect of living temporarily abroad on the psychosocial conditions of Japanese children and their relationship with their mothers. The researchers hypothesized that mothers’ deteriorating psychosocial condition due to maladjustment to living abroad may result in adverse effects on their children.

The study by Ishizaki and Ishizaki (2001) revealed that 10% of 61 participant Japanese children were found as depressive and 30% were identified as having high levels of anxiety. Researchers also found a positive correlation between the level of children’s depression and anxiety and their mothers’ decreased health conditions. The authors conjectured that families’ isolation from a local community and the absence of fathers due to their work tended to excessively intensify an enmeshed interaction
between mothers and children in Japanese sojourners families. Hence, the psychosocial state of the mothers may be easily transmitted to their children. However, caution should be used in drawing inferences from the results of this study because correlation does not evidence cause and effect. Therefore, the children’s depressive or anxious symptoms may be causing some health issues in their mothers. Although several research studies have explored the impact of living abroad on sojourners’ and their wives’ mental health, research on mental health issues of the children of sojourners is lacking. The transition of moving from their native country to a foreign country, along with being newly identified as a minority, creates difficulty with self-identity issues among these Japanese children (Nagata, 1998).

Shibusawa (2001) reported that Japanese children in the United States tend to share a common thread, retaining certain norms and values of traditional Japanese culture. Adaptation to social norms, modesty, self-control, respect and loyalty to authorities, and fostering empathy are generally valued in Japanese or Japanese American families in the United States compared to the assertiveness and self-confidence values of the dominant Caucasian culture (Shibusawa, 2001). These differences become a source of conflict for Japanese in the U.S. who are struggling to balance both the Japanese and the dominant culture. Collins (2000) conducted a qualitative study exploring complex development of biracial Japanese Americans, in which 15 Japanese Americans were interviewed to tell retrospectively about their biracial identity development. The results of the study revealed that Japanese American children who grew up in predominantly White, middle-class neighborhoods exhibited difficulty with acknowledging their Japanese side. Interview participants also reported
that their experience in school contexts and family atmosphere had significant impact on their identity development. According to the participants, limited interaction with other biracial or children of color at school failed to validate self positively, and parents’ positive acknowledgement of both cultures helped biracial children to integrate the identities of both parents. Another unique aspect of biracial identity development reported by Collins is “a situational use of ethnic identity” (Collins, 2000, p.125). They take full advantage of one of their ethnic identities, making their roles fluid and flexible. Collins mentioned that this “chameleon” phenomenon of biracial individuals can be their survival tool through by a self-protective mechanism.

Yeh and Inose (2002) conducted a qualitative study to examine the mental health concerns and coping strategies of a total 274 Chinese, Japanese, and Korean immigrant junior high and high school students. In this study, Japanese students addressed more interpersonal conflicts and problems compared with their Chinese and Korean counterparts. The researchers postulated that this issue, unique to Japanese students, may be attributable to conflict between maintaining their Japanese tradition and adopting values and customs of the main culture. The Japanese self is traditionally situational, relationally bound, and they have fluid boundaries in order to maintain the harmonious relationship with others. According to the authors, this cultural characteristic can be an obstacle for Japanese adolescents who are also eager to adopt a more independent and individually oriented Western culture-self.

Using results from 75 child participants, the author concluded that Japanese American children in the study scored significantly lower only on scores that were related to physical self-concept. As early as 2 or 3 years old, children start developing attitudes toward racial characteristics. Since they are in the preoperational stage, observation and perception become central information resources for them to establish the concept of race. Pang also noted that having a model figure who has the same racial/ethnic background may help Japanese American children accept themselves physically and mentally.

Awareness of physical sensations is fostered from as early as infancy in Japan because a strong tie between physical reaction and emotional status is emphasized in the culture. Therefore, it is common among Japanese that psychosocial conflicts and distress are transformed into psychical complaints.

Oki (2003) reported that 8.2% of children, ages 6 to 15, who visited pediatric wards in Japan for somatic symptoms exhibited no need for medical intervention but responded to psychosocial intervention. Oki also reported in his survey that 12.6% of elementary school students and 14.6% of middle school students who visited a nurse’s office presented somatic symptoms (Oki, 2003). Miyamoto (2003) noted that Japanese children are more vulnerable to somatic reactions compared with adults because (a) the distinction between psychological reaction and physiological reaction is underdeveloped in childhood; (b) children have less tolerance for stress; (c) children are more dependent on social support and susceptible to the surrounding environment; and (d) children have less ability to access social support services by themselves. In addition, their language sophistication level in addressing abstract phenomena and complex emotional status is
at an early stage of development; therefore, presenting somatic symptoms may be employed as a substitute expression of their intricate inner experiences. Struggles with a lack of proficiency in English, lack of social support, or higher stress with acculturation process in Japanese children in the United States can place them in a position vulnerable to somatic symptoms.

Some research revealed that children and families served by mental health programs designed to be linked to community cultures are less apt to drop out of treatment compared with similar families assisted by mainstream programs (Takeuchi, Sue & Yah, 1995). For example, Asian American children at an Asian community- or Asian culture focused program were found to utilize more services, drop out less, and improve more than did Asian American children at mainstream programs. Yeh, Takuchi, and Sue (1994) conducted a study to examine the differences between ethnic-specific and mainstream out-patient mental health services for Asian American children. They used 489 clients from parallel centers, which are to provide mental service specifically to the Asian community, and 423 children from mainstream centers, which are not designed to serve the minority community for data analysis. Their results revealed that Asian child clients had better service utilization patterns at the parallel centers, with a 6 % rate of client dropout after a first session, compared with 28% at the mainstream centers. In addition, the authors reported that Asian clients at the parallel centers received significantly more sessions than at the mainstream centers.

Although there are about 70 Japanese language advancement schools in the United States, only schools in New York, New Jersey, Los Angeles, San Diego, and Detroit are served by Japanese mental health professionals, indicating a disregard of
mental health programs designed to be linked to community, which results in failure to maintain and improve the psychological well-being of Japanese children in the United States (Kurihara, 2004). Recently, this has become a significant issue under consideration of the Ministry of Education, Culture, Sport, Science and Technology in Japan.

*History and Principles of Child-Centered Play Therapy*

The significant role of play in the lives of children has long been recognized. Landreth (2002) mentioned that as early as the 18th century, philosopher Jean Jacques Rousseau advocated the importance of observing play to learn and understand children. Due to the strong tie between education and development, Rousseau’s promulgation of the nature of play as a natural education is well emphasized in the child development field. Piaget (1972) revealed that play bridges gaps between concrete experience and abstract thoughts, helping children organize their experiences using the symbolic function of play. Vygotsky (1966) believed that one function of play was to satisfy unsatisfied desire, allowing a child to create an imaginary situation. Bettleheim (1987) stated that play is a “loyal road” to the child’s conscious and unconscious inner world as well as a useful tool for children to prepare themselves for the future and its tasks.

On the other hand, in the mental health field, until the beginning of the 20th century, no specific approach or treatment targeted children. According to Landreth (2002), the first case describing the therapeutic use of play to work with a child was Sigmund Freud’s report in 1909 of a 5-year-old boy with a phobia, “Little Hans.” This report is now considered the origin of play therapy, which developed from an effort to
apply psychoanalytic therapy to children. Prior to the works by acknowledged psychoanalytic play therapists such as Melanie Klein and Anna Freud, Hug-Hellmuth (1921) was the first therapist who empathized significance of play in child analysis and provided play materials for children to express themselves. Her use of play to understand children resulted from her struggle with applying the established adult therapy approach to children that heavily depended on verbal and cognitive development. Children were still too immature to process intra- or interpersonal conflicts. Melanie Klein (1959) considered a child’s play in therapy as equivalent to adult’s free association and as a vehicle to access a child’s unconscious from which she made analysis and interpretation. Around the same time, Anna Freud (1946) also employed play in her psychoanalytic therapy with children. However, she utilized play as a medium to encourage children to establish an alliance with a therapist. Anna Freud believed that the relationship between a therapist and a child that was facilitated through play was considered a vital precondition prior to the interpretation stage in analysis, whereas Melanie Klein proposed using play as a direct substitution of verbalization in adult therapy. These pioneers who valued the importance of play in a child’s healing process made a revolutionary contribution to changing the perception of play and its use in a variety of theoretical schools of psychotherapy.

The philosophy of child-centered play therapy (CCPT) originated from person-centered therapy developed by Carl Rogers (1951). His core belief reflected in this approach is that every human being possesses a self-actualizing tendency, naturally striving toward growth. The therapeutic relationship that provides three conditions, empathy, genuineness, and unconditional positive regard, will facilitate this innate
propensity of human beings. Virginia Axline (1947), a student and a colleague of Rogers, successfully applied person-centered principles to children in play therapy and developed nondirective play therapy. Roger’s strong faith in the self-actualizing and self directive tendency in every person led him to change the name of the therapy from “nondirective” to “person-centered” therapy. Consequently, nondirective play therapy was also renamed “child-centered play therapy.” Since Axline’s primary efforts, many therapists such as Moustakas (1953), Guerney (2001), and Landreth (2002) have succeeded and expanded CCPT. The fundamental principle of this approach lies in a therapists’ abiding and unshakable belief in children’s capacity to be internally motivated to constructively self-direct toward greater maturity, betterment, and adjustment. Therefore, CCPT therapists do not attempt to control or change the children. Rather, the therapist strives to provide a secure relationship in which the child can reach self-awareness, self-direction, and self-healing ability and access the self-actualizing tendency. The therapist’s responses in play therapy are generated from the purpose to convey the three core conditions that eventually help children accept themselves as who they are (Landreth, 2002).

Axline (1947) proposed eight basic principles that guide therapists in developing a secure and therapeutic environment in play therapy. Those principles are as follows:

1. The therapist must develop a warm, friendly relationship with the child
2. The therapist accepts the child exactly as he/she is.
3. The therapist develops a feeling of permissiveness so that child feels free to express feelings completely.

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3. The therapist develops a feeling of permissiveness so that child feels free to express feelings completely.
4. The therapist recognizes and reflects feelings (of a child) so that the child can gain insight into his/her behaviors.

5. The therapist respects that the child can solve his/her problems and believes that the responsibility to change rests on the child.

6. The therapist does not attempt to direct the child, instead, lets the child lead the way, the therapist follows.

7. The therapist understands that therapy is a gradual process and does not rush the child.

8. The therapist establishes only those limitations that are necessary to anchor the therapy to the real world and to facilitate the child’s awareness for his/her responsibility in the relationship. (p. 75)

**History of Play Therapy in Japan**

Play therapy has been practiced in Japan as a treatment modality for children since the 1950s. The oldest article on play therapy in Japan is probably one by Hayasaka (1953). In this article, he noted several healing elements of play, specifically those related to release and catharsis in psychotherapy. However, his theoretical foundation was weak; he cited person-centered concepts, such as acceptance and self-actualization while he also emphasized social embeddedness, which is an important aspect of Adlerian therapy. In 1954, a book on psychotherapy that contained a chapter briefly mentioning play therapy was published (Ikeda, 1954).

Play therapy appeared to flourish with the publication of the Japanese versions of *Client-Centered Therapy* by Rogers in 1956 and *Play Therapy* by Axline in 1959. Prior
to the introduction of play therapy, common practices for emotionally disturbed children were limited to offering advice to parents or teachers, or for the severe cases, hospitalization (Hatase, 1957). From the late 1940s, child guidance centers were rapidly developed in Japan. However, the treatments offered at these centers were limited to assessments of children and an investigation into their home environments, where they reside, but no direct treatment was conducted with children (Tsuchiya, 1967).

In response to the lack of mental health treatment for children in Japan, play therapy was enthusiastically accepted as an innovative, practical, and promising direct approach to children in the 1950s (Sato & Yamashita, 1978). Along with the awakening of person-centered therapy in Japan, Jungian therapy was introduced to Japan in the mid-1960s by Hayao Kawai (Enns & Kasai, 2003). Kawai, who trained with Dora Kalff, was instrumental in introducing Hakoniwa therapy which is an integration of sandplay therapy with Japanese cultural practices. Hakoniwa means “box garden” in Japanese. Gardening in Japan is considered spiritual work and is based on Zen Buddhism (Enns & Kasai, 2003). Japanese gardens are regarded as microcosms that symbolically depict the larger world outside. They are also viewed as a representation of “human efforts to form an enclosed and protected space in which individuals work through dilemmas as well as cultivate growth and build an orderly productive world (Enns & Kasai, 2003, p. 94). The conceptualization of Hakoniwa as a mirror of a person’s sensory and visceral experience of an outer world as well as of self was applied to play therapy, and the Jungian approach became an important method of counseling children and adolescents in Japan. However, Jungian theory has not been well integrated into play therapy.
training curricula, causing confusion related to this theoretical approach among play therapists in Japan.

An essential social issue, school refusal, also fueled the development of play therapy starting in the 1960s. School refusal is defined as a pattern of behavior in which children do not or cannot attend school for 30 days per year due to their psychological, emotional, or social issues (Ministry of Education, Culture, Sports, Science and Technology, 2003). The number of children who are considered suffering from school refusal has been increasing, with 126,226 cases reported in 2003. This figure counts only children in elementary and junior high school, which comprise the 9 years of compulsory education in Japan. The problem of school refusal in Japan emerged around 1960. Takikawa (2005) explained the onset of school refusal, concluding that Japanese culture made a drastic shift at that time from an agricultural society to an industrial society, which required higher academic skills. As a result, marked emphasis was placed on education, and pressure to be successful in academics became more intense. Being different by not going to school is experienced as shameful by children with school refusal and their families. As a result, the children tend to become withdrawn, remaining in their homes all day. School refusal syndrome can subsume a number of diagnostic categories; however, most cases are considered “pure” school refusal syndrome, indicating that a psychiatric diagnosis is not appropriate (Lock, 1986). Due to the numerous etiologies of school refusal, various treatments have been developed and attempted, including play therapy. Although no empirical studies on the efficacy of play therapy with children with school refusal have been reported, numerous
case studies have established play therapy as a successful treatment modality for this specific population (Hara, 2001; Kaminaka, Ichikado & Ogata, 2003; Koga, 2002).

As play therapy gained more recognition by Japanese mental health professionals as a therapeutic modality for children, there was a growing interest in elucidating how play therapy works. For instance, Sato (1957) investigated the process of establishing an initial relationship between a play therapist and a child. Yasuhara and Hatase (1955) attempted to investigate the effectiveness of CCPT. However, because the researchers failed to control variables such as session numbers and the theoretical orientation of the therapists, the study results were presented in case report format. Miyama and Tsushima (1960) investigated variables that played significant roles in the therapeutic results of play therapy treatment. They conducted play therapy for 64 children and examined the magnitude of its effectiveness by observing sessions, obtaining information from parents, and conducting a follow-up session. They concluded that age, number of sessions, history of psychopathology in family members, and issues in family dynamics were predictors for successful play therapy outcomes. Younger children, aged under 6 years old, exhibited more improvement in their behaviors through play therapy compared with the children who were older than 6 years. Also, Miyama et al. reported that most of the children who received more than nine play therapy sessions showed progress in their behaviors, while only half of the children who received four play therapy sessions exhibited some progress. Miyamoto et al. also reported that a parent’s awareness of a problem in the parent–children relationship and a parent’s active involvement toward a solution of the problem often correlates with the outcome of play therapy treatment. However, Miyama observed that a parent’s
awareness and involvement are not inevitable factors for successful play therapy outcome. Results of this study are informative and beneficial, yet caution is required because the scale of large, medium, and small effectiveness of play therapy was determined based solely on the researcher’s observation of a child’s behaviors relative to the initial presenting problems.

These aforementioned research studies lack control of therapist-specific variables, such as the education, training, and experience of play therapists and their theoretical orientations. In addition, the methods utilized to obtain data were heavily dependent on direct observation by therapists or narratives from parents and teachers. Among very rare empirical studies, Wakaba (1979) conducted a single case study on group play therapy process with a stuttering child. She assessed the stuttering severity and symptoms at the beginning and ending of therapy as well as conducted intensive observation of 19 group play therapy sessions regarding the child’s play behaviors with other members, stuttering, and frequency of his aggressive behaviors. The results showed that the recovery process from stuttering coincided with the shift from his solitary play to cooperative group play. Furthermore, the changing of stuttering symptoms was related to the appearance of his aggressive behaviors in group play therapy. In most research studies in Japan, the theoretical orientations of researcher are not identified, but in this study, the researcher mentioned that she adhered to the nondirective play therapy approach. However, group play therapy sessions in this study were conducted by two play therapists interchangeably, leaving the doubt of theoretical consistency in her approach. The relationship between child and therapist is considered
the most crucial factor in CCPT, and changing therapists does not provide a consistent environment where a relationship can be established.

Another experimental study on play therapy with Japanese children is Kuroiwa’s (2004) study on the play therapy behaviors of physically abused children. In this study, Kuroiwa attempted to develop a Japanese version of the Play Therapy Observational Instrument (PTOI) in order to make it a cross-cultural instrument and to allow comparisons of the behaviors between children in Japan and the United States. Although 13 items were validated to rate Japanese physical abuse victims’ play therapy behaviors appropriately, small sample size (10 raters), inconsistencies in therapists’ play therapy training background, and their theoretical orientations obscured the validity of the results. In addition, the author changed the PTOI format from a direct observation of a videotaped play therapy session to a questionnaire format. In this format, a rater is asked to imagine, “a session of a typical child who was physically abused.” The definition of “typical” is unclear in this research. The results also suggested that children’s emotional expressions appeared to be one of the most difficult elements to evaluate for Japanese clinicians (Kuroiwa, 2004). The researcher attributed this difficulty to the Japanese cultural tradition of discouraging explicit emotional expressions. However, a rater’s lack of training or experience should also be considered a factor that might inhibit his or her ability to accurately evaluate emotional expressions in children.

Despite the early period of play therapy development, in 1959 Tatara advocated the need for objective data obtained through the use of scientific method in order to prove the effectiveness of play therapy. He also argued that employing rating scales that were originally developed for process analysis of adult therapy was not valid for
process analysis of play therapy because the former was dependent on the verbal mode of expression whereas the latter treatment consists of child’s play, which is often nonverbal (Tatara, 1959). Tatara also stressed the importance of validity and reliability in play therapy assessment in order to produce meaningful and applicable information. Although his statement was made about 45 years ago, little improvement seems to have been made in play therapy research methodology in Japan since that time. Play therapy has been gaining more recognition as one of the treatment approaches for children in Japan. However, validation of the effectiveness of play therapy has not been supported due to the dearth of empirical research studies on this approach with Japanese children. Most of the published articles still depend on case study designs with transcript of a session.

Shimoyama (2005) noted that the lack of interest in conducting empirical mental health research in Japan may be attributed to vague distinctions between “counseling,” “clinical psychology,” and “psychotherapy” as well as a general lack of training in psychotherapy theories. He also mentioned that Japanese mental health professionals tend to practice based on the presumption of the efficacy of their guiding theory; that is, Japanese therapists espouse their guiding theory without feeling the need to validate or prove its effectiveness by scientific procedure.

Mental health professionals have an ethical responsibility to practice empirically supported treatments; they must be held accountable for their work in order to protect the public (American Counseling Association [ACA], 2005). Japanese psychotherapists face a significant challenge in their efforts to support their practices of play therapy by conducting empirical studies.
Child-Centered Play Therapy with Ethnic Minorities

The American Counseling Association Code of Ethics and Standards of Practice has emphasized the importance of recognizing diversity, embracing a cross-cultural approach, and understanding people within their social and cultural context (ACA, 2005). The preamble to the ACA code of ethics indicates that it is insufficient for counselors to be “culturally sensitive”; rather, the document stresses the importance of “cultural responsiveness” among counselors. That is, culturally responsive counselors take an active stance of applying knowledge into actions and behaviors in counseling with diverse populations (Durodoye, 2002).

The concept of “cultural responsiveness” has also been discussed in the field of play therapy. Although the basic tenets of play therapy are universal -- since children have an innate ability to play -- careful consideration and some modification of play therapy established in Western society has been advocated (Carmichael, 1991; Coleman, Parmer, & Barker, 1993; Garza & Bratton, 2005; Gil, 2005; Kao & Landreth, 2001). Gil (2005) encouraged practitioners to consider three principles in order to be cross-culturally competent and responsive play therapists: building sensitivity, gaining knowledge responsibly, and translating knowledge obtained into action. She noted that due to the paucity of tangible guidelines for cross-cultural play therapy, the third response, the action stage, is the most challenging for therapists and requires the use of caution and reasonable judgment.

Among the scant literature on multicultural issues in play therapy, adaptation of play therapy for Hispanic children is often discussed, reflecting the fact of the skyrocketing population of Hispanic children in the United States. Martinez and Valdez
(1992) introduced a directive approach to play therapy with Hispanic children. They created a play environment, similar to structured play therapy, in which culturally relevant themes can emerge and the therapist can ask questions about the child’s play. Representing the Jungian perspective, Acosta (1985) recommended the use of the sand tray for immigrant Hispanic children, since it is a “virtually infinite version of the world view which the child and his/her family can create” (p. 3). Costantino, Malgady, and Roger (1986) created “cuento therapy” for Puerto Rican children, which utilizes cuentos, or folktales, from their culture. Costantino et al. stated that use of cuentos helped to tailor therapy more isomorphic to the Cuban clients’ culture because they contain values and messages and coping skills that are inherited in the culture. In addition, characters in cuentos can serve as models of adaptive behavioral and emotional functioning. Their research showed a decrease in the children's trait anxiety and observer-rated aggressive behaviors, as well as an increased score on the Comprehension subtest of the Wechsler Intelligence Scale for Children-Revised among the children who received cuento therapy (Costantino et al., 1986).

Garza and Bratton (2005) conducted culturally responsive child-centered play therapy with 29 Hispanic, Spanish-speaking students from kindergarten to fifth grade. She defined “culturally responsive play therapy” as “conducted by a trained Hispanic bilingual 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” (p. 39). In addition to the list of the toys and play materials presented by Landreth (2002), Garza and Bratton (2005) added toys that are considered to be specific to the lifestyle of Hispanic children. The goal was to provide culture-specific toys that are familiar to this
population in order to promote a variety of expression that encompassed the children’s cultural heritage. The results of Garza and Bratton’s study demonstrated a statistically significant decrease in children’s externalizing behavior problems after 15 weeks of culturally responsive child-centered play therapy treatment compared to the curriculum-based small group counseling treatment at posttest. According to Garza and Bratton (2005), culturally specific toys seemed to facilitate rapport and a feeling of familiarity and security, especially during the first three sessions; Garza and Bratton also noted that one of the considerations was the choice of the words to explain counseling treatment to parents. Due to the existing stigma toward mental health service, common mental health diagnostic terminology such as depression and anxiety was avoided. Garza and Bratton also stated that a flexible role change from a counselor to a translator between a parent and a teacher or a school administrator is necessary. In addition, Garza and Bratton conducted home visits to collect data for the study in order to accommodate a majority of one-car families.

Studies on play therapy with African American children are sparse. As early as 1940, Axline conducted group play therapy with Caucasian and African American children. Although she did not make any modification in the therapy setting, obvious awareness of racial issues on the part of children emerged, and they resolved the conflicts by themselves. Axline’s account (1948) of play therapy with mixed groups successfully illustrated that given the therapeutic relationship (grounded in the therapist’s genuineness, unconditional acceptance, and empathy), children develop the ability to get beneath the surface, have respect for others, accept their differences, and gain appreciation of a common bond between them. Baggerly and Parker (2005)
conducted group play therapy as an early intervention for African American boys at the elementary school level. In this study, Baggerly and Parker suggested that child-centered group play therapy was an appropriate approach for this population because it values African worldviews such as emotional validity, interdependence, and collective survival as well as facilitates self-confidence which is a crucial component for African American children who often face numerous social challenges such as prejudice, discrimination, and economic disadvantages.

Mitchum (1989) described some values in Native American cultures which the children from this background may manifest. Group play therapy can be an effective approach for Native American children, owing to the high value they place on cooperation and harmony, their tendency to be taciturn, and their preference for symbolic expression such as art and play. Glover (2005) mentioned the importance of recognizing the level of acculturation in Native American clients because it may affect their belief in treatment. For instance, the Native American’s traditional present-time orientation may be an obstacle for them to believe in the gradual process of therapy. Glover also mentioned that Native American children’s play behaviors in play therapy are not distinctively dissimilar to those of the dominate, yet that it is imperative to provide culturally appropriate toys and playroom environment in order to bring culture in their play.

Research studies on play therapy with Asian children are also scarce. Sue and Sue (2003) mentioned that Asian Americans represent a “model minority” who are comparatively well-adjusted, function successfully in society, have reduced social distance from Whites, and who experience fewer difficulties than other minority
populations. Due to this general positive image of Asian Americans or Asians in the United States mental health professionals tend to fail to be cognizant of the struggles of this population. For instance, Pang (1981) reported that Japanese American children scored significantly lower on the physical subscale of the Piers-Harris Children’s Self Concept Scale, cautioning that academic success does not necessarily reflect a general good feeling that children hold about themselves.

Shen (1999) conducted a phenomenological qualitative study in order to explore the current perception and application of play therapy for children in a school setting in Taiwan. Eight assertions emerged from the analysis of the qualitative data that supported a positive belief in the future growth of play therapy in Taiwan. Those assertions included (a) perception of play as a medium in counseling for children, (b) affirmation of play therapy as a compatible modality in a school setting, (c) recognition of play and its therapeutic values regardless of culture, (d) demands for including play therapy programs as a part of professional roles, (e) immature development of theoretical orientation in play therapy, (f) lack of resources for professional growth as a play therapist, (g) recommendations from participants, and (h) controversial issues.

Shen’s (2002) further research is innovative since it is the first experimental study on the effectiveness of child-centered group play therapy with Chinese children who have a history of trauma. Fifteen Chinese children were assigned to an experimental group and 15 to a control group, with a total of 30 children who were victims of an earthquake. The experimental group received child-centered group play therapy for 4 weeks, having two to three sessions per week. The results of this research demonstrated statistically significant reductions in the experimental group’s posttest
scores on a child’s anxiety and worry/oversensitivity. In addition, statistically significant reductions were observed in the experimental group’s posttest scores on the suicide-risk level. These results supported the effectiveness of child-centered group play therapy with Taiwanese children. However, Shen cautioned that lack of instruments in the native language presented a validity challenge to the study. Shen also reported a conflict between the traditional Chinese concept of play, which is not encouraged in children, and the therapeutic use of play. Any special cultural modification was not utilized in this study.

Siu (2004) conducted an extensive investigation of Chinese culture in order to practice culturally sensitive play therapy with Chinese children. She examined the philosophical influences of Taoism, Buddhism, and Confucianism because these systems are believed to impact one’s worldview, personality traits, symptomology, and coping styles, which are thought to be reflected in the play therapy process. The philosophies and values that are inherent in minority cultures can be significantly different from the philosophies and values that the majority culture preserves for itself, which may cause conflict. Coleman et al. (1993) demonstrated that minority children may have trouble fitting into the American ideal of “success,” which is often grounded in a strong sense of individualism or competition. As a result, they might be considered “losers.” Siu (2004) also presented “culturally sensitive and appropriate play therapy guidelines” (p. 80) in which she emphasized precautions for working with Chinese parents. Siu noted that because of strong filial piety, Chinese parents often experience their children’s problems personally and that these problems are viewed as bringing shame or embarrassment to the entire family. In addition, the intense shame, disgrace,
and taboo attached to mental health treatment may create a barrier to play therapists working with Chinese parents.

Kao and Landreth (2001) discussed some characteristics of Chinese children, such as being obedient to elders, cooperation, and tolerance of academic pressure, as well as strong child-parent bonding, and the possible influence of these traits on the process of play therapy. They suggested some specific modifications of play therapy procedures in order to ensure the efficacy of play therapy with Chinese children. For instance, Chinese children are disciplined to behave appropriately, and not to lose face in front of others. Given this, the usual procedure of limit setting might bring out strong feelings of guilt or shame in Chinese children. In order to avoid this risk, Kao and Landreth suggested a shift in focus from the child’s feelings toward the therapist to the child’s own feelings. Although these changes are subtle, they will contribute to facilitating children’s free expression (Kao & Landreth, 2001). Both Siu (2004) and Landreth (2002) recommended using culture-specific toys and materials with Chinese children in play therapy. The basic principle in selecting appropriate play materials is to promote a feeling of familiarity and comfort for the children in order for them to access their utmost inner capacity (Landreth, 2002).

Salgado (2003) examined the relationship between the frequency of use of play therapy or other nonverbal counseling techniques by elementary school counselors and counselors’ perceptions of their self-efficacy when counseling children who speak a language in which the counselors are not fluent. Results showed statistically significant correlations between the frequency with which participants utilized play therapy/nonverbal counseling techniques and their perceptions of themselves as
effective counselors. This study indicated that play therapy may help counselors develop keener sensitivity to nonverbal communications and as a consequence, provide better services to diverse populations. However, self-reports of their effectiveness as counselors in this study, such as an absence of awareness for the need to seek supervision, indicated that counselors may have provided inaccurate assessments of their competencies.

As an inaugural study of play therapy with internationally adopted children, Wilkinson (1982) conducted CCPT with 8 adopted Korean children. She identified some needs demonstrated in play therapy sessions that are specific to the subjects in the study, such as a need for nurturing, for trust, and for acceptance. Wilkinson also explained that adopted Korean children in the study perceived their difference in appearance from “American” children as negative and threatening and that the children considered being fluent in English as providing greater acceptance into the majority culture in the United States. She mentioned that those issues are highly related to their self-esteem issues. Cochran (1996) also claimed that communication difficulties, difficulty fitting in socially, high stress resulting from assimilation into mainstream culture, and low self-esteem are some of the issues specific to culturally different children. The negative impact of cultural identity struggles on minority children’s self-esteem is often reported in the literatures. (Cochran, 1996; Locke, 1989; Mitchum, 1989).

As the existing literature reveals, although play therapy is widely recognized as an effective therapy modality for children, studies on play therapy with minority children are limited and empirical studies on this topic are rare. Ritter and Chang (2002) conducted a survey to assess play therapists’ self-perceived multicultural competence.
and found that play therapists considered themselves most competent in awareness and terminology and least competent in racial identity development and multicultural knowledge. The researchers reported that the areas that play therapists perceived themselves as proficient are also areas in which they believe they received adequate training. Empirical research on play therapy with minority children is necessary in order to respond to demographic changes in the United States and to provide practical training that enhances play therapists’ cognizance and competence in working with minority children.

*Dilemma in Research With Minority Groups*

Demand for scientifically proven interventions for children remains a current major topic within the psychology, social work, and counseling professions. The demand urges clinicians to demonstrate empirical support for specific interventions for specific problems and diagnoses using clinical and non clinical populations (Lonigan, Elbert, & Johnson, 1998). This demand stems from mainly two sources: One is a report from the Surgeon General’s Conference on Children’s Mental Health conducted 2000 (United States Public Health Service, 2001). This report brought the nation’s attention to the critical needs of mental health care services for children and the need for scientifically proven mental health treatment for children and adolescents. The American Psychological Association’s (APA) Division Task Force 12 on Promotion and Dissemination of Psychological Procedures is another precursor to the promotion of empirically supported treatments. Lonigan et al. (1998) summarized criteria for “well-established psychosocial interventions,” and “probably efficacious psychosocial
interventions” which largely emphasize hard science approaches and development of treatment manuals. Hence, research in mental health fields has been supplanted by quantitative approaches, utilizing a large sample size.

Meanwhile, multicultural issues in counseling have emerged as another major topic in the mental health field because of the recent rapid change in the make-up of the U.S. population. Due to the focus on quantitative research design in the mental health field, research on multicultural counseling has been dominated by this method. However, quantitative methods are limited when it comes to making sense of cultural issues and understanding (Darcy, Lee, & Tracey, 2004; Lee & Tracey, 2005; Sanchez-Hucles & Jones, 2005). Recently, researchers have noted some problems resulting from applying traditional quantitative methods to multicultural research. One of the examples of the problems is the issue of internal validity. Even in one minority ethnic group, an individual’s acculturation level, language proficiency level, and length of residency in the United States widely varies, and those within-group differences are hard to control when dealing with a small targeted population. External validity is another problem. Ethnic minority groups tend to be more unfamiliar with the concept and process of counseling and a strong stigma may still be prevalent, which may hinder researchers in soliciting enough participants in a study to generalize the results to the targeted population. In order to overcome those limitations, qualitative research has been claimed as a more suitable method in multicultural counseling research (Darcy et al.; 2004; Lee & Tracey, 2005; Ponterotto, 2002; Sanchez-Hucles & Jones, 2005).

In addition to the attention to qualitative research design, small sample designs and single case experimental designs are becoming more valued as research methods
that are sensitive to the exigencies of everyday practice (Lundervold & Belwood, 2000; McDougall & Smith, 2006). Small sample designs have proven to be valuable in examining the intervention effects that include single or a few subjects, require repeated measures of an individual’s progress across time, and seek either short –term or long-term outcomes (McDougall & Smith, 2006). Foster, Watson, Meeks and Young (2002) also discussed the advantages of utilizing small sample designs, which include recognizing individualities among subjects and reducing the threat to validities by comparing an individual’s behaviors under baseline and treatment conditions so that the individual becomes his or her own control group. Okazaki and Sue (2002) acknowledged the challenge in collecting large samples of ethnic minorities due to the small overall population and some possible cultural values that may influence participation of minorities. Mistrust and fear in mental health services, the stigma of mental illness, cost, limited English proficiency, and a lack of awareness about the availability of mental health services among minorities are major barriers to the receipt of mental health treatment of minority groups (U.S. Public Health Service, 1999).

In order to diminish difficulties in conducting research on efficacious mental health treatment methods for minorities, a growing number of researchers have promoted the combined use of qualitative and quantitative method. The use of multiple and diverse approaches for minority groups provides deeper and extensive understanding individuals without disregarding within-group differences (Blink, 1994; Shorter-Gooden, 2002). The U.S. Department of Health and Human Services (1999) has also acknowledged this dilemma and encourages strategically maintaining and also integrating two points of views, that of the cultural group and that of evidence-based
mental health practices, in order to value and utilize culture and practice in a way that promotes the mental health of minority groups.

**Summary of Literature Review**

In summary, according with the United States’ increasingly diverse population, mental health professionals heed the attention to multiculturalism in counseling. However, existing research has evidenced that the U.S. current mental health system is not well equipped to respond to the needs of racial and ethnic minority groups (The U.S. Department of Health and Human Services, 1999). Additionally, it has been identified that the traditional scientist research method to minority populations risks negating for diverse within-differences among minority groups and, as a result, facilitating more racial profiling.

Empirical research has evidenced that play therapy is an effective treatment modality for children. However, few studies which have examined the effectiveness of play therapy with minority children as exampled by no existing research on play therapy with Japanese children in the United States. The field of play therapy is currently ripe for a contribution of multicultural research.

Psychosocial issues of Japanese children in the United States have been disregarded due to their common image of being a model minority. Stigma attached to the mental health service as well as lack of the minority group-focused treatment hinder Japanese parents from seeking services for their children. This underutilization of the service has nourished the image of their being problem free.
Purpose of the Study

The purpose of this study was to examine the effectiveness of child-centered play therapy (CCPT) with Japanese children in the United States. The changes in the parent and child relationship as well as child behaviors as observed by their parents were investigated as a group to assess the impact of CCPT. In addition, the process of play therapy with each individual child was explored to identify within-group differences.
CHAPTER 2

METHODOLOGY AND PROCEDURES

This chapter presents the methods and procedures utilized for this study. This quantitative research study employed a single-group repeated measures analysis of variance (ANOVA) design to examine the effectiveness of child-centered play therapy (CCPT) with Japanese children referred for Externalizing and Internalizing behaviors and parental stress related to the parent-child relationship. In addition, linear regression was employed to examine individual child participants’ changing patterns of behavior as observed by parents throughout the period of study.

Included in this chapter are the research question, the definition of terms, descriptions of the instruments utilized for data collection, a discussion of the selection of participants, a description of participants, specific methods of data collection, a description of the treatment, and an explanation of the data analysis procedures.

Research Question

In this study, the researcher intended to explore a topic that has previously been unexamined in the literature; thus, the researcher chose to approach the data with an exploratory research question. Because there are no logical assumptions regarding play therapy and its effect on Japanese children in the United States, hypotheses were not developed, and an exploratory approach was preferred. The research question for this study was what is the impact of child-centered play therapy with Japanese children in the United States?
In order to address the above research question, the parent-child relationship between the participant Japanese children as a group and their parents, as well as child behavioral change as observed by their parents were investigated. In addition, the impact of CCPT for the participant children was examined by exploring the process of play therapy with each individual child. In order to investigate the process and effect of CCPT, the children’s responses to CCPT were measured over several points throughout the study.

Definition of Terms

*Child-Centered Play Therapy:*  
[It] is a dynamic interpersonal relationship between a child (or person of any age) and a therapist trained in play therapy procedures who provides selected play materials and facilitates the development of a safe relationship for the child (or person of any age) to fully express and explore self (feelings, thoughts, experiences, and behaviors) through play, the child’s natural medium of communication for optimal growth and development. (Landreth, 2002, p. 16)

*Culturally responsive Child-Centered Play Therapy:* In this study culturally responsive child-centered play therapy is defined as play therapy conducted by a trained doctoral - level Japanese-English bilingual play therapist able to respond with either language depending on the child’s choice of language during a play therapy session. In addition, culturally responsive child-centered play therapy was conducted in
a playroom equipped with selected toys that are perceived to be specific to the environment, culture, and lifestyle of Japanese children in the North Texas area.

*Japanese children:* For the purposes of this study, Japanese children were exclusively defined as children who were of Japanese or Japanese-related ethnicity (at least one parent is of Japanese descent), who were students at The Japanese School in Dallas, and who had command of expressive and receptive Japanese language skills.

*Externalizing behaviors:* Externalizing behaviors refer to behaviors that express inner conflict or internal problems outwardly. In this study, the Externalizing Behaviors subscale of the Child Behavior Checklist (CBCL) operationally defined externalizing behaviors.

*Internalizing behaviors:* Internalizing behaviors refer to behaviors that are symptomatic of an attempt to cope with internal conflicts as an inward expression of experience, such as being withdrawn or depressed. In this study, the Internalizing Behavior subscale of the Child Behavior Checklist (CBCL) operationally defined internal behaviors.

*Parental stress:* Parental stress refers to the amount of stress resulting from the parent-child relationship. Parental stress in this study was defined by the Total score and two domains of the Parenting Stress Index (PSI): the Parent Domain and the Child Domain. The Parent Domain measures stress related to a parent’s functioning. The Child Domain assesses the child’s characteristics that contribute to stress in the parent-child system.
Instruments

Two assessments were utilized in this study in order to ensure accuracy and consistency in the interpretation of results by assessing the same construct from different perspectives. Those instruments were the Parental Stress Index (PSI) (Abidin, 1995) and the Child Behavior Checklist (Achenbach & Rescorla, 2000a, 2000b). The Parental Stress Index (PSI), originally developed by Abidin in 1983, is currently in its third edition (Abidin, 1995). The PSI is a self-report inventory consisting of 120 questions. The PSI yields 17 scores, including 7 Child Domain scores, 8 Parent Domain scores, a Life Stress score, a Total Stress score, and a Defensive Responding score. The Child Domain reflects a parent’s perceptions of a child’s characteristics that may affect parenting roles. Abidin (1995) defined the six subscales of the Child Domain as follows:

*Distractibility/Hyperactivity*: High scores on this subscale appear to be associated with (a) children who display behaviors associated with ADHD; (b) parents lacking the energy to keep up with a normal child; (c) older parents with a formerly stable life patterns who are having difficulty adjusting to the child; or (d) unreasonable parental expectations for mature, adult-like behavior.

*Adaptability*: High scores on this subscale are associated with the child’s inability to adjust to changes in his or her social environment.

*Reinforces Parent*: High scores on this subscale indicate that the parent does not experience his or her child as a source of positive reinforcement.

*Demandingness*: High scores on this subscale indicate that the parent experiences the child as placing many demands upon him or her such as crying,
physically hanging on the parent, frequently requesting help, or having a high frequency of minor problem behaviors.

*Mood:* High scores on this subscale are associated with children whose affective functioning shows evidence of dysfunction. These children may frequently cry and display few signs of happiness.

*Acceptability:* High scores are produced in this area when the child possesses physical, intellectual, and emotional characteristics that do not match the expectations the parent had for the child.

Parent Domain, on the other hand, displays a degree of stress that stems from parents’ perception of their functioning as parents. The parent’s characteristics measured by this domain include the following items (Abidin, 1995):

*Competence:* High scores on this subscale may be produced by a number of factors contributing to the parent’s sense of incompetence (e.g., young parents of an only child, parents who are lacking practical child development knowledge, and parents who do not find the role of parent as reinforcing as expected). High scores are also associated with a lack of acceptance and presence of criticism from the child’s other parent.

*Isolation:* Parents who score high in this area are under considerable stress due to a sense of loneliness. Parents are often socially isolated from their peers, relatives, and emotional support systems. In many instances, the relationships with spouses are distant and lacking in support for their efforts as parents.

*Attachment:* The presence of high scores on this subscale suggests two possible sources of dysfunction: (a) The parent does not feel a sense of emotional closeness to
the child, and/or (b) The parent has a real or perceived inability to observe and understand the child’s feelings and/or needs accurately.

**Health:** High scores are suggestive of deterioration in parental health that may be the result of either parenting stress or an additional independent stress in the parent-child system.

**Role Restriction:** High scores on this subscale suggest that the parent experiences the parental role as restricting his or her freedom and frustrating attempts to maintain his or her own identity.

**Depression:** High scores are suggestive of the presence of significant depression in the parent.

**Spouse:** Parents who earn high scores on this subscale are those who are lacking the emotional and active support of the other parent in the area of child management.

The Life Stress scale includes 19 items measuring the degree of external stress that a parent is currently experiencing but that is not resultant from the parent-child relationship. High Life Stress scores are indicative of parents who find themselves in stressful situations frequently beyond their control (e.g., death of a relative or unemployment). The total stress the parent reports may be intensified by the Life Stress scores (Abidin, 1995).

The Total Stress Score reflects the underlying assumption of this instrument, “sources of stress are additive” (Abidin, 1995, p. 1). The Total Stress Score is a sum of the Parent and Child Domain scores. Abidin (1995) asserted that parents who earn high scores should be referred for professional intervention.
Interpretation of PSI scores may contain different meanings, depending on the outcome of the Defensive Responding scores. A Defensive Responding score of 24 or less indicates that a parent who completes the PSI is likely responding in a defensive manner, resulting in scores that do not accurately reflect the stress level of the parent. Very low Defensive Responding scores may also be found in situations where it is “obvious that the parent is very competent and that the parent-child relationship exists within a supportive social situation that is economically advantaged” (Abidin, 1995, p. 6).

Internal consistency of the PSI was calculated using coefficient alpha reliability, with an established range from 0.70 to 0.83 for the subscales of the Child Domain, and from 0.70 to 0.84 for those of the Parent Domain. The reliability coefficients for the two domains and the Total Stress scale, which is a combined score of both domains, were 0.90 or greater (Abidin, 1995). The test-retest coefficient of reliability, utilized in Zakreski’s (1983) study, yielded values of 0.77 for the Child Domain, 0.69 for the Parent Domain, and 0.88 for the Total Stress index. The coefficient reported for the Child Domain was 0.89. The Parent Domain coefficient was 0.93, and the total reliability coefficient was 0.95, indicating a high degree of internal consistency of the PSI (Hauenstein, Scarr, & Abidin, 1987).

The Child Behavior Checklist (CBCL) is one of the forms that comprise the Achenbach System of Empirically Based Assessment (ASEBA). The CBCL is an instrument that measures parents’ reports of children’s competencies and behavioral/emotional problems based on the children’s activities, social relationships, and school performance. The CBCL was originally developed by Achenbach and Edelbrock in 1983. The most current version of the CBCL has two age-specific versions:
CBCL for children ages 1 ½ to 5 (Achenbach & Rescorla, 2000a) and CBCL for ages 6-18 (Achenbach & Rescorla, 200b). Achenbach and Rescorla (2000a, 200b) ensured the comparability of the two different age versions by summarizing T-scores of Internalizing, Externalizing, and Total Problems scales between the instruments; they found that the two instruments were comparable in terms of differentiation. In the CBCL/6-18, parents are asked to provide information for 20 competency items including their child's activities, social relations, and school performance. The CBCL/6-18 has 118 items that describe specific behavioral and emotional problems, as well as two open-ended questions for reporting additional problems. Parents rate their child on how true each item is now or within the past 6 months using the following scale: 0 = not true (as far as you know); 1 = somewhat or sometimes true; 2 = very true or often true (Achenbach & Rescorla, 200b).

The scoring profile for the CBCL/6-18 includes (s) Competence Scales; (b) Syndrome Scale; (c) Internalizing, Externalizing, Total Problems Scale; and (d) DSM-oriented Scales. The Competence Scale was established in order to assess the favorable characteristics that distinguish children who display adaptive functioning from those deemed to have maladaptive functioning. The items that measure competence are grouped into four scales designated as Activities, Social, School, and Total Competence. In the Competence Scale, T-scores between 31 and 35 demarcate a borderline clinical range and T-scores at or below 30 are considered in the clinical range (Achenbach & Rescorla, 200b).

The Syndrome Scale identifies the syndromes of co-occurring problems, which helps mental health professionals evaluate children in terms of patterns of problems.
The scale consists of Aggressive Behavior, Anxious/Depressed, Attention Problems, Rule-Breaking Behavior, Social Problems, Somatic Complaints, Thought Problems, and Withdrawn/Depressed. T-scores between 65 and 69 are considered to be in the borderline clinical range, and T scores at or above 70 are considered clinical in this scale (Achenbach & Rescorla, 2000b).

On the CBCL, Internalizing Problems mainly refer to problems within self, such as anxiety, depression, somatic complaints, and withdrawal from social interactions. By contrast, Externalizing Problems are defined as child behavior that conflicts with other people, especially representative of behaviors that do not meet adult expectations of child behavior. Specifically, rule-breaking and aggressive behaviors that express inner conflict outwardly are described as externalizing problems (Achenbach & Rescorla, 2000b). Achenbach and Rescorla stated that distinguishing between children whose reported problems stem mainly from internalizing or externalizing may be clinically valuable for selecting approaches to interventions, testing hypotheses about etiology, uncovering co-morbidity, and evaluating responsiveness to particular treatments. Achenbach and suggested general guidelines to classifying children as having primarily internalizing or externalizing problems. The criteria include: only if (a) their Total Problem T score is at or more than 60, and (b) the difference between their Internalizing and Externalizing T scores is at least 10 points on one of the school-age forms or at least 5 points on two of the three forms. On the Internalizing and Externalizing scales, T scores of 60 through 63 are considered in the borderline clinical range, and scores of 64 or above are considered in the clinical range.
On the 2001 version of the CBCL/6-18, the *DSM*-oriented scales were constructed in order to view children’s behavioral problems from the perspective of a formal diagnostic system. The *DSM*-oriented scales consist of six scales: Affective Problems (related to Dysthymia and Major Depressive Disorder); Anxiety Problems (related to Generalized Anxiety Disorder, Separation Anxiety Disorder, and Specific Phobia); Attention-Deficit/Hyperactivity Problems (related to ADHD); Oppositional-Defiant Problems (related to Conduct Disorder and Oppositional-Defiant Disorder); and Somatic Problems (related to Somatization Disorder and Somatoform Disorder). In this scale, T scores of 65 through 69 are considered in the borderline clinical range, and the clinical range is at or above T scores of 70 (Achenbach & Rescorla, 2000b).

Internal consistency of the CBCL/6-18 was calculated using the intra-class correlation coefficient (ICC) from one-way analysis of variance. Inter-rater reliability of the CBCL was 0.93 for the 20 competence items and .96 for the 118 specific behavior problem items ($p<.001$), a finding that indicates high levels of inter-rater reliability on this instrument. The test-retest coefficient of reliability yielded values 1.00 for the 20 competence scales and .95 for the 118 specific behavior problem items ($p<.001$). Internal consistency of scale scores of the CBCL are displayed with Cronbach’s alpha. Alpha coefficient for competence ranged from .63 to .79. Relatively low alpha scores are generally related to fewer items in the scale (e.g., CBCL school scale has only four items, resulting in .63 alpha) (Achenbach & Rescorla, 2000b). The Syndrome scale produced alpha coefficient ranges from .78 through .94. Alpha coefficient for Internalizing Behaviors was .90, for Externalizing Behaviors .94, and for Total
Problems .97 (Achenbach and Rescorla, 2000a, 2000b), indicating high reliability for this instrument.

The Child Behavior Checklist 1½-5 (CBCL/1½-5) is a revision of the Child Behavior Checklist/2-3 (CBCL/2-3). The CBCL/1½-5 obtains parents’ ratings of 99 problem items and descriptions of problems, disabilities, and concerns, as well as the parents’ perceptions of their child's best attributes. The scoring profile of the CBCL/1½-5 includes: (a) Syndrome Scale, (b) Internalizing, Externalizing, and Total Problem Scale, and (c) DSM-oriented Scale. The Syndrome Scale is comprised of seven scales; Emotionally Reactive, Anxious/Depressed, Somatic Complaints, Withdrawn, Attention Problems, and Aggressive Behavior. T-scores between 65 and 69 are considered to be in the borderline clinical range, and T scores at or above 70 are considered to be in the clinical range (Achenbach & Rescorla, 2000a).

The CBCL/1½-5 utilizes the same definition of the Internalizing and Externalizing problems as the CBCL 6-18. It also employs the same cut-off point of T scores of 60 through 63 for the borderline clinical range and at or above T scores of 64 for the clinical range (Achenbach & Rescorla, 2000a).

The CBCL/1½-5 2001 version also includes the DSM-oriented Scale. This scale consists of five scales: Affective Problems (Dysthymia and Major Depressive Disorder); Anxiety Problems (Generalized Anxiety Disorder, Separation Anxiety Disorder, and Specific Phobia); Pervasive Developmental Problems (Asperger’s and Autistic Disorders); Attention Deficit/Hyperactivity Problems (related to ADHD); and Oppositional Defiant Problems (Oppositional-Defiant Disorder). T scores of 65 through 69 are
considered in the borderline clinical range, and the clinical range is at or above T scores of 70 (Achenbach & Rescorla, 2000a).

Inter-rater reliability for the CBCL/1½-5 is not reported in the manual. However, inter-rater agreement on the CBCL/1½-5 was obtained by calculating Pearson r's between scale scores completed by mothers and fathers. The mean r was .61, indicating that there was no significant bias for either gender of parents. The test-retest reliability of the CBCL/1½-5 was computed by test-retest Pearson correlations (r's). A mean r was .85 over the average of 8 days (Achenbach & Rescorla, 2000a).

Notwithstanding the existence of Japanese versions of both the PSI and CBCL instruments, the decision to utilize the English versions was made for this study for the following reasons: (a) The Japanese version of the PSI has not been tested for its validity and reliability utilizing Japanese subjects; (b) the newest Japanese translated version of CBCL is the 1991 version for children aged 4 -18, whereas the most current English version is 2001. Although the reliability and validity of the 1991 Japanese version of the CBCL (JCBCL) was tested (Itani, Kanbayashi, & Nakata, 2001), the assessment was conducted on old data; (c) About half of the participants in this study were biracial children having one Japanese parent and one non-Asian parent whose native language was English. Most of the families in the study have been living in the United States for more than five years, and the parents have enough command of English to read and understand the questionnaires. This researcher is not aware of any assessments that have been standardized on Japanese minorities in the United States and that are appropriate to assess the effectiveness of play therapy with this population.
It is difficult to develop a standardized instrument on a minority group in the United States due to extensive within-group differences.

Participant Selection

Human subjects approval was obtained from the University of North Texas Internal Review Board prior to the recruitment of subjects for this study. The volunteer research participants were recruited from The Japanese School of Dallas. The school is an enhancement school serving as an addition to public school education, and it holds classes every Saturday, teaching all subjects in Japanese utilizing Japanese textbooks. In addition, the school provides a place for children in the United States to experience Japanese tradition and customs. The students are in attendance between 40 and 50 days annually.

The Japanese School of Dallas was established in 1970. The school currently holds about 300 students in total from kindergarten to high school, and there are 25 teachers and one principal, all of whom are Japanese. The principal is an experienced Japanese school principal who was selected by the Japanese Ministry of Education, Culture, Sports, Science, and Technology to serve a Japanese school abroad. A principal’s term is usually limited to 3 to 5 years. There are no specific criteria or entrance examinations required for a student to be accepted by The Japanese School of Dallas, but students are expected to have enough Japanese language ability to follow the classes conducted in Japanese. The principal conducts interviews with applicants and their families to determine whether the child is an appropriate candidate for acceptance into the school. In order to respond to the diversity in Japanese children in
Dallas, The Japanese School of Dallas established an international class that accommodates Japanese children whose Japanese language abilities are not well enough developed to keep up with the regular classes at the school. By 2004, there were 186 Japanese Schools (Saturday Schools) in 56 countries in the world, with 84 in the United States (CLALINET, n/d).

Participants were recruited from the kindergarten through third grades, and ages ranged from 4 to 9 years. Recruitment for this research was advertised in the school newsletter in February, 2006. Flyers that explained the study goals were also distributed to students in the kindergarten through fifth-grade classes by the teachers (see Appendix A). All parents who were interested in this study contacted the researcher through e-mails. The researcher met parents individually in order to explain the process of play therapy and the purpose of the study before the parents consented to participation. Handouts explaining play therapy (see Appendix B) and the objectives and process of play therapy (see Appendix C) were provided to the parents at the initial meeting; the handouts were written in Japanese. The flyers and handouts were written based on the researcher’s understanding of play therapy.

In order to be eligible to participate, the children must have met the following criteria: (a) parent or guardian consent was obtained, (b) parent agreed for child to participate in eight 30-minute sessions of culturally responsive child-centered play therapy, (c) child’s main language was either English or Japanese, (d) parents must be literate in English, (e) child was not currently receiving any form of psychotherapy, (f) child was between 4 and 9 years old, and (g) child attended the Japanese School of Dallas once a week in addition to weekly local school.
A total of 16 children originally participated in the research. Of 16 children, 4 children were unable to complete eight play therapy sessions because they left the country to go to Japan during the summer break. One parent failed to complete the third and fourth assessments for her 2 children in the study although they completed all eight sessions. Therefore, for a total of 10 children, each child participated in all eight sessions, and the child's parents completed all the assessments required. Data from those 10 children were utilized for analysis.

Table 1 presents demographic information on the participants in the study. The number of female participants was 7, and that of male was 3. In regard to ethnicity, four children were Japanese American, having a Japanese mother and an American father. Six children were Japanese, meaning both parents were Japanese. The participant group was composed of four kindergarten children, one first-grade child, three-, second-grade children, and two third grade children. The mean age of the participants was 6.7 years. The mean length of U.S. residency of children was 5.15 years. Four children were born in Japan and moved to Texas, five children were born in Texas, and one child was born in Illinois before she moved to Texas. One child had an anxiety problem and was receiving psychotropic medication but no psychological treatment while she participated in the study.
Table 1

Demographic Information for Child Participants

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<tr>
<td>Second</td>
<td>3</td>
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<tr>
<td>Third</td>
<td>2</td>
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| Average Age   | 6.7   |
| Average Length of U.S residency | 5.15 |

Collection of Data

The parents of the child participants in this study completed the PSI and the CBCL at four different points; baseline (4 weeks prior to the first child-centered play therapy (CCPT) session); pretest assessment point (following 4 weeks of no treatment prior to CCPT); the second assessment point (following 4 sessions over 4 weeks of CCPT); and the third assessment point (following 8 sessions over 8 weeks of CCPT). Graphically, this design takes the following form:

\[ 0_1 \times 0_2 \times 0_3 \times 0_4 \]

Baseline pretest 2 3

Any change between data obtained at baseline and at pretest was utilized as a baseline. The baseline measures the natural frequency of subjects’ targeted behaviors before the introduction of the experimental variable. This design allowed the researcher to avoid
some threats to internal validity such as history, maturation, statistical regression, and experimental mortality; hence, the outcome of the study may be attributed to treatment effects. Baseline measurements help to establish high internal validity.

The researcher met the parents of child participants at The Japanese School of Dallas 4 weeks prior to the first play therapy sessions in order to distribute the assessment for the baseline, child background information forms (see Appendix E), and informed consent forms (see Appendix D). Although the researcher had obtained signed consent forms from the parents at the initial meeting, an additional informed consent form, which included more detailed information about the research, was provided at the baseline assessment distribution. The parents were informed verbally and also in writing that if they had any difficulty understanding questions on the assessments, they were welcome to call or e-mail this researcher or to inquire on the following week when the baseline assessments were collected.

Prior to the first play therapy session, a storybook that explains play therapy for children in Japanese (see Appendix F) was provided to parents either in a hard copy or in presentation software that was sent via e-mail. This researcher directed the parents to read this handout with their children before the children received their first play therapy sessions.

Followed by the distribution of the baseline assessment, assessment instruments were provided to parents at the pretest point (when the child attended the initial play therapy session); the second assessment point (when the child had completed four sessions); and the third assessment point (when the child had completed eight sessions); The parents were asked to bring the completed assessments in the following
week when their children returned for their weekly sessions. Each time parents completed the assessments, a compensation of gift certificates was offered.

Qualitative data regarding child participants’ behaviors were obtained through three methods: parent consultation, child background information forms, and play therapy session summary forms (see Appendix G). Parent consultations were held at the initial meeting and at the end of the 8 week play therapy treatment. The child background information form included open-ended questions on parenting difficulties and behavioral concerns for each participating child. The researcher completed play therapy session summary forms immediately following each session for each child. Significant verbalizations, happenings, or changes in the child’s play or behavior were recorded on this form.

Description of Treatment

During the treatment phase of the study, Japanese children whose parents signed the consent form received 30 minutes of child-centered play therapy (CCPT) once a week for 8 weeks based on the principles and procedures of CCPT (Landreth, 2002).

Landreth (2002) defines child-centered play therapy as a dynamic interpersonal relationship between a child and a play therapist who provides selected play materials and facilitates the development of a safe relationship for the child to fully express and explore self through play. The materials for play therapy are considered to act as the child’s words; therefore, they should be selected with caution to provide the child with freedom and a variety of expression. Landreth (2002) recommended the following toys for CCPT:
A child-centered play therapist is equipped with both nonverbal and verbal skills in order to respond to any of a child’s expressions in play therapy in a manner that conveys a “being with” attitude. The “being with” attitude is conveyed through four basic messages sent to the child: “I am here, I hear you, I understand, and I care” (Landreth, 2002). The child-centered play therapist conducting this study incorporated both nonverbal and verbal skills as identified by Ray (2004). The nonverbal skills included (a) maintaining an open posture and leaning forward; (b) appearing interested in the child; (c) appearing comfortable and relaxed; (d) matching the child’s affect through tone and...
rate of speech; and (e) conveying a sense of genuineness by matching words and affect. The child-centered play therapists’ reflective verbal responses included: (a) utilizing short, interactive, and personalized responses at an appropriate rate of responses while matching the energy level of the child; (b) tracking the child’s play behavior; (c) reflecting content; (d) reflecting feeling; (e) facilitating decision making and returning responsibility; (f) using esteem-building responses; and (g) incorporating relationship facilitating responses (Ray, 2004).

Modifications and adaptations were made in order to create a culturally responsive play therapy environment including playroom/toys, the therapist, and the play therapy structure.

*Playroom/toys*

A corner of an empty classroom at the school was utilized as a play therapy room. The playroom was equipped with the aforementioned toys recommended by Landreth (2002). However, traditional toys were adapted and additional toys were utilized in order to facilitate the communicative process of Japanese children in play therapy. Culturally sensitive toys for Japanese children were selected based on a discussion with Japanese child therapists, Japanese mothers, and Japanese school teachers. Following is a list of Japanese toys included in this study.

- Japanese masks (*omen*)
- Japanese Emergency Cars
- Japanese traditional costume
- Japanese juggling ball (*otedama*)
- Asian doll families
- Japanese toy money
- Plastic food toys (fish and rice)
- Chopsticks
- Japanese kaleidoscope
- Paper balloon (*Kami fusen*)
Japanese beads                     Asian baby doll
Japanese music Instrument       Japanese standard school back pack (*Randoseru*)
(Japanese little drum; *Taiko*)

The Japanese School in Dallas provides strict classroom curricula in order to condense academic materials that are usually taught in 5 days at a school in Japan into 1 day per week. In addition, according to the custom of schools in Japan in general, it is rare for a student to leave a classroom to receive any special services. Therefore, the researcher conducted all play therapy sessions after-school (after 12:30 pm for students in kindergarten and the international class and after 3:10 to 4:30 for other students). In addition to this time restraint, there were other limitations such as having only one play therapist and one room available (see Appendix H) to conduct play therapy at the school. Consequently, the researcher met some of the participants outside of the school on weekdays at private practice offices in the participants’ neighborhoods in Texas. Those offices were owned by child-centered play therapists who were Licensed Professional Counselors (LPC) in Texas. The offices included similar toys and play materials as described in Landreth’s list (Landreth, 2002). The researcher created a kit of culturally sensitive Japanese toys (the same toys used in play therapy at the Japanese School in Dallas) and added the Japanese toys to the private practice offices whenever a session was conducted in those settings in order to maintain a culturally responsive play therapy environment and maintain consistency throughout the different playrooms.
Therapist

All CCPT sessions were conducted by a Japanese child-centered play therapist proficient in Japanese and English. The therapist was the present researcher, a doctoral candidate specializing in play therapy in the counseling program at the University of North Texas. She is a Registered Play Therapist (RPT) with advanced play therapy training at the doctoral level, including supervised training in CCPT, principles and application of CCPT, and child psychological assessment. She has completed more than 600 hours of CCPT sessions. Play therapy was facilitated in the language chosen by the child, either English or Japanese. For example, when a child spoke in Japanese, the therapist responded in Japanese, and if a child spoke in English, the therapist responded in English.

Play Therapy Structure

In this study, each CCPT session was conducted for 30 minutes. Each participant had a weekly play therapy schedule and received sessions at a set day and time each week. The parents were informed that childcare would be provided for the children who were waiting for their play sessions following school so that the parents could delay school pickup until their child finished their session. However, no parents requested childcare.

Statistical Analysis of Data

After the treatment phase was completed and all assessment instruments were scored, data were analyzed in order to explore the impact of child-centered play therapy (CCPT) on child participants by examining a decrease in scores on the PSI and the
CBCL throughout the treatment phase (from the pretest point to the third assessment point) comparing with the baseline phase (from the baseline point to the pretest point). Single-group repeated measures analysis of variance (ANOVA) was performed on this data analysis using Statistical Package for the Social Sciences for Windows (2001). A repeated measures ANOVA design provides researchers the ability to measure change over time. Repeated measures analysis requires subjects to be measured on two or more occasions (Girden, 1992). According to Maxwell (1998), repeated measures analysis can yield significant results with as few as 6 participants, provided there are at least three time points of data collection. This economy of number of subjects is one of the advantages of repeated measures analysis, especially for research with ethnic minorities because of the overall small population size. Because small samples often lead to results that do not reach the conventional level of statistical significance (– p value of less than 0.05; Kraemer & Rosenthal, 1999), an eta squared effect size was computed to measure the practical significance of the treatment effect. Whereas statistical significance answers the question “Is there a difference?” an effect size answers the question “How much of a difference?” (Thompson, 2002). The guidelines for an eta squared proposed by Cohen (1988) were utilized to interpret the data. Suggested values of eta squared were following; 0.01 = small, 0.06=medium, and 0.14= large (Cohen, 1988).

In addition to the group analysis, individual analyses were conducted on individual participants’ Child Behavior Checklist (CBCL) Total Scores, utilizing linear regression. Linear regression describes the growth patterns of individuals (Ware, 2006), in this case, the relationship between four assessment points and a dependent variable.
CBCL Total Scores were selected to be examined because these scores include Internalizing and Externalizing problems and reflect the full range of presenting behavioral problems for each child. Additional qualitative data generated from the researcher’s observations of play therapy sessions as well as parents’ feedback are also presented in the following chapter.
CHAPTER 3
RESULTS AND DISCUSSION

This chapter presents the results of the analysis of data to examine the research question investigating the impact and the use of child-centered play therapy (CCPT) with Japanese children in the United States. Also included is the individual analysis of behavioral change utilizing linear regression. The analysis of quantitative data, both group analysis and individual analysis, a discussion of the possible meaning of the results, implications and limitations of the findings, and recommendations for future research are also presented in this chapter.

Results

Group Analysis.

Single-group repeated measures ANOVA was performed on the Internalizing Problems, the Externalizing Problems, and the Total Problems in the Child Behavior Checklist (CBCL), and the Child Domain, the Parent Domain and the Total Stress Domain in Parenting Stress Index (PSI). Two separate ANOVAs were conducted for each syndrome scale of CBCL and PSI. The first ANOVA examined differences between the baseline and the pretest. The second ANOVA examined differences between the pretest, assessment point 2 and assessment point 3. The alpha .05 level of statistical significance was used as a criterion to assess the effectiveness of child-centered play therapy (CCPT) with Japanese children in the United States as evidenced by a reduction of scores in aforementioned subscales. Because the study is under-
powered due to the small sample size, the partial eta squared was computed for each analysis of six subscales to determine the practical significance.

Prior to conducting repeated measures ANOVA, analysis of the outliers was performed. For the Parent Domain and the Total Stress Domain on the PSI, 2 cases were identified as outliers. Therefore, those 2 cases were omitted from further analysis, resulting in the total 8 cases for the analysis of the data from the PSI. There was no outlier identified on the CBCL subscales. Hence, a total of 10 cases were utilized for the CBCL analysis. All the assumptions for repeated measures ANOVA were met for further analysis.

Table 2 presents the means and standard deviations of the data from the four assessment points on the Internalizing Problems subscale on the CBCL.

Table 2

*Mean Scores and Standard Deviations for the Internalizing Problems on the Child Behavior Checklist (CBCL)*

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>49.60</td>
<td>10.94</td>
</tr>
<tr>
<td>Pretest</td>
<td>47.40</td>
<td>12.35</td>
</tr>
<tr>
<td>Second assessment</td>
<td>50.00</td>
<td>10.69</td>
</tr>
<tr>
<td>Third assessment</td>
<td>46.90</td>
<td>7.14</td>
</tr>
</tbody>
</table>

Total Cases = 10

*Note. A decrease in the mean score indicates a decrease in Internalizing Problems.*
Table 3

Repeated Measures ANOVA on Internalizing Problems on the CBCL from the Baseline to the Pretest

<table>
<thead>
<tr>
<th>Source</th>
<th>SS</th>
<th>df</th>
<th>MS</th>
<th>F</th>
<th>p</th>
<th>Partial Eta Squared</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals</td>
<td>2235.00</td>
<td>9</td>
<td>248.33</td>
<td></td>
<td></td>
<td>0.10</td>
</tr>
<tr>
<td>Time</td>
<td>24.20</td>
<td>1</td>
<td>24.20</td>
<td>1.02</td>
<td>0.34</td>
<td></td>
</tr>
<tr>
<td>Error</td>
<td>213.80</td>
<td>9</td>
<td>23.76</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>2473.00</td>
<td>19</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Computed using p = .05

Table 4

Repeated Measures ANOVA on Internalizing Problems on the CBCL from the Pretest to the Third Assessment

<table>
<thead>
<tr>
<th>Source</th>
<th>SS</th>
<th>df</th>
<th>MS</th>
<th>F</th>
<th>p</th>
<th>Partial Eta Squared</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals</td>
<td>2106.03</td>
<td>9</td>
<td>234.00</td>
<td></td>
<td></td>
<td>0.07</td>
</tr>
<tr>
<td>Time</td>
<td>55.40</td>
<td>2</td>
<td>27.70</td>
<td>0.66</td>
<td>0.53</td>
<td></td>
</tr>
<tr>
<td>Error</td>
<td>753.27</td>
<td>18</td>
<td>41.85</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>2914.70</td>
<td>29</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Computed using p = .05
Figure 1. Marginal means of Internalizing Problems on the CBCL.

As shown in Table 3, the $F$ ratio was not statistically significant at the .05 level ($F(1, 9) = 1.02, p=0.34$), indicating that there was no statistically significant change during the no treatment period (from the baseline to the pretest) on the Internalizing Problem subscale on the CBCL. However, the partial eta squared was determined as medium ($\eta^2=0.1$) based on Cohen’s guidelines (1988). Table 4 indicates that the $F$ ratio was also not statistically significant at the .05 level ($F(2, 9) = 0.66, p=0.53$) during the treatment period (from the pretest to the third assessment point). The results demonstrated that there was no statistically significant change during the treatment period on the Internalizing Problems syndrome scale on the CBCL. However, the partial eta squared was determined as medium ($\eta^2=0.07$) based on Cohen’s guidelines (1988).

Figure 1 shows the marginal means of Internalizing Problems Score on the CBCL across the 4 measurement points.
Table 5 presents the means and standard deviations of the data from the four assessment points on the Externalizing Problems subscale on the CBCL.

**Table 5**

*Mean Scores and Standard Deviations for Externalizing Problems on the CBCL*

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>49.30</td>
<td>11.31</td>
</tr>
<tr>
<td>Pretest</td>
<td>44.90</td>
<td>11.94</td>
</tr>
<tr>
<td>Second assessment</td>
<td>48.00</td>
<td>8.00</td>
</tr>
<tr>
<td>Third assessment</td>
<td>46.90</td>
<td>9.35</td>
</tr>
</tbody>
</table>

Total Cases = 10

*Note. A decrease in the mean score indicates a decrease in Externalizing Problems*

**Table 6**

*Repeated Measures ANOVA on Externalizing Problems on the CBCL from the Baseline to the Pretest*

<table>
<thead>
<tr>
<th>Source</th>
<th>SS</th>
<th>df</th>
<th>MS</th>
<th>F</th>
<th>p</th>
<th>Partial Eta Squared</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals</td>
<td>2180.80</td>
<td>9</td>
<td>242.31</td>
<td></td>
<td></td>
<td>0.28</td>
</tr>
<tr>
<td>Time</td>
<td>96.80</td>
<td>1</td>
<td>96.80</td>
<td>3.43</td>
<td>0.09</td>
<td>0.28</td>
</tr>
<tr>
<td>Error</td>
<td>254.20</td>
<td>9</td>
<td>28.24</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total 2531.80 19

*Computed using p=.05*

**Table 7**

*Repeated Measures ANOVA on Externalizing Problems on the CBCL from the Pretest to the Third Assessment*

<table>
<thead>
<tr>
<th>Source</th>
<th>SS</th>
<th>df</th>
<th>MS</th>
<th>F</th>
<th>p</th>
<th>Partial Eta Squared</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals</td>
<td>2428.00</td>
<td>9</td>
<td>269.76</td>
<td></td>
<td></td>
<td>0.19</td>
</tr>
<tr>
<td>Time</td>
<td>49.40</td>
<td>2</td>
<td>24.70</td>
<td>2.04</td>
<td>0.16</td>
<td>0.19</td>
</tr>
<tr>
<td>Error</td>
<td>217.93</td>
<td>18</td>
<td>12.11</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total 2695.33 29

*Computed using p=.05*
As shown in Table 6, the $F$ ratio was not statistically significant at the .05 level ($F(1, 9) = 3.43, p=0.09$), indicating that there was no statistically significant change during the no treatment period (from the baseline to the pretest) on the Externalizing Problem subscale on the CBCL. However, the partial eta squared was determined as large ($\eta^2=0.28$) based on Cohen’s guidelines (1988). Table 7 indicates that the $F$ ratio was also not statistically significant at the .05 level ($F(2, 9) = 2.04, p=0.16$) during the treatment period (from the pretest to the third assessment point). Results demonstrated that there was no statistically significant change during the treatment period on the Externalizing Problem syndrome scale on the CBCL. However, the partial eta squared was determined as large ($\eta^2=0.16$) based on Cohen’s guidelines (1988).

Table 8 presents the means and standard deviations of the data from the four assessment points on the Total Problems subscale on the CBCL.
Table 8

Mean Scores and Standard Deviations for Total Problems on the CBCL

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>49.30</td>
<td>8.96</td>
</tr>
<tr>
<td>Pretest</td>
<td>45.50</td>
<td>11.13</td>
</tr>
<tr>
<td>Second assessment</td>
<td>47.60</td>
<td>8.39</td>
</tr>
<tr>
<td>Third assessment</td>
<td>45.40</td>
<td>7.52</td>
</tr>
</tbody>
</table>

Total Cases = 10

Note. A decrease in the mean score indicates a decrease in Total Problems

Table 9

Repeated Measures ANOVA on Total Problems on the CBCL from the Baseline to the Pretest

<table>
<thead>
<tr>
<th>Source</th>
<th>SS</th>
<th>df</th>
<th>MS</th>
<th>F</th>
<th>p</th>
<th>Partial Eta Squared</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals</td>
<td>1579.80</td>
<td>9</td>
<td>175.53</td>
<td></td>
<td></td>
<td>0.22</td>
</tr>
<tr>
<td>Time</td>
<td>72.20</td>
<td>1</td>
<td>72.20</td>
<td>2.53</td>
<td>0.15</td>
<td></td>
</tr>
<tr>
<td>Error</td>
<td>256.80</td>
<td>9</td>
<td>28.53</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total 1908.80 19

*Computed using p = .05

Table 10

Repeated Measures ANOVA on Total Problems on the CBCL from the Pretest to the Third Assessment Point

<table>
<thead>
<tr>
<th>Source</th>
<th>SS</th>
<th>df</th>
<th>MS</th>
<th>F</th>
<th>p</th>
<th>Partial Eta Squared</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals</td>
<td>1986.83</td>
<td>9</td>
<td>220.76</td>
<td></td>
<td></td>
<td>0.10</td>
</tr>
<tr>
<td>Time</td>
<td>30.87</td>
<td>2</td>
<td>15.43</td>
<td>1.04</td>
<td>0.38</td>
<td></td>
</tr>
<tr>
<td>Error</td>
<td>268.45</td>
<td>18</td>
<td>14.92</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total 2286.15 29

*Computed using p = .05
As shown in Table 9, the $F$ ratio was not statistically significant at the .05 level ($F(1, 9) = 2.53, p=0.15$), indicating that there was no statistically significant change during the no treatment period (from the baseline to the pretest) on the Total Problem subscale on the CBCL. However, the partial eta squared was determined as large ($\eta^2=0.22$) based on Cohen’s guidelines (1988). Table 10 indicates that the $F$ ratio was also not statistically significant at the .05 level ($F(2, 9) = 1.04, p=0.38$) during the treatment period (from the pretest to the third assessment point). The result demonstrates that there was no statistically significant change during the treatment period on the Total Problem subscale on the CBCL. However, the partial eta squared was determined as medium ($\eta^2=0.1$) based on Cohen’s guidelines (1988).
Table 11 presents the means and standard deviations of the data from the four assessment points on the Child Domain on the PSI.

Table 11

Mean Scores and Standard Deviations for Child Domain on the Parenting Stress Index (PSI)

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>108.63</td>
<td>7.29</td>
</tr>
<tr>
<td>Pretest</td>
<td>110.00</td>
<td>10.04</td>
</tr>
<tr>
<td>Second assessment</td>
<td>103.38</td>
<td>12.75</td>
</tr>
<tr>
<td>Third assessment</td>
<td>104.38</td>
<td>7.01</td>
</tr>
</tbody>
</table>

Total Cases = 10

Note. A decrease in the mean score indicates a decrease in child-parent relationship stress.

Table 12

Repeated Measures ANOVA on Child Domain on the PSI from the Baseline to the Pretest

<table>
<thead>
<tr>
<th>Source</th>
<th>SS</th>
<th>df</th>
<th>MS</th>
<th>F</th>
<th>p</th>
<th>Partial Eta Squared</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals</td>
<td>786.94</td>
<td>7</td>
<td>112.42</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>7.56</td>
<td>1</td>
<td>7.56</td>
<td>0.18</td>
<td>0.68</td>
<td>0.03</td>
</tr>
<tr>
<td>Error</td>
<td>290.94</td>
<td>7</td>
<td>41.56</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total 1085.44 15

*Computed using p = .05
Table 13

Repeated Measures ANOVA on Child Domain on the PSI
from the Pretest to the Third Assessment Point

<table>
<thead>
<tr>
<th>Source</th>
<th>SS</th>
<th>df</th>
<th>MS</th>
<th>F</th>
<th>p</th>
<th>Partial Eta Squared</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals</td>
<td>1566.50</td>
<td>7</td>
<td>223.79</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>204.08</td>
<td>2</td>
<td>102.04</td>
<td>2.3</td>
<td>0.14</td>
<td>0.25</td>
</tr>
<tr>
<td>Error</td>
<td>621.25</td>
<td>14</td>
<td>44.38</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>2391.83</td>
<td>23</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Computed using p =.05

Figure 4. Marginal means of Child Domain Scores on the PSI.

As shown in Table 12, the F ratio was not statistically significant at the .05 level ($F (1, 7) = 0.18, p=0.68$), indicating that there was no statistically significant change during the no treatment period (from the baseline to the pretest) on the Child Domain on the PSI. The partial eta squared was determined as small ($\eta^2 =0.03$) based on Cohen's guidelines (1988). Table 13 indicates that the F ratio was also not statistically significant at the .05 level ($F (2, 7) = 2.3, p=0.14$) during the treatment period (from the pretest to
the third assessment point). The result demonstrates that there was no statistically
significant change during the treatment period on the Child Domain on the PSI.
However, the partial eta squared during this period was determined as large ($\eta^2=0.25$)
based on Cohen’s guidelines (1988).

Table 14 presents the means and standard deviations of the data from the four
assessment points on Parent Domain score on PSI.

Table 14

Mean Scores and Standard Deviations for
Parent Domain on the PSI

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>126.63</td>
<td>7.87</td>
</tr>
<tr>
<td>Pretest</td>
<td>125.00</td>
<td>13.48</td>
</tr>
<tr>
<td>Second assessment</td>
<td>121.50</td>
<td>11.53</td>
</tr>
<tr>
<td>Third assessment</td>
<td>124.63</td>
<td>11.92</td>
</tr>
</tbody>
</table>

Total Cases = 10

Note. A decrease in the mean score indicates a decrease in child-parent relationship stress.

Table 15

Repeated measures ANOVA on Parent Domain on the PSI
from the Baseline to the Pretest

<table>
<thead>
<tr>
<th>Source</th>
<th>SS</th>
<th>df</th>
<th>MS</th>
<th>F</th>
<th>p</th>
<th>Partial Eta Squared</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals</td>
<td>1446.94</td>
<td>7</td>
<td>206.56</td>
<td></td>
<td></td>
<td>0.04</td>
</tr>
<tr>
<td>Time</td>
<td>10.56</td>
<td>1</td>
<td>10.56</td>
<td>0.28</td>
<td>0.61</td>
<td>0.04</td>
</tr>
<tr>
<td>Error</td>
<td>259.94</td>
<td>7</td>
<td>37.13</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total 1717.44 15

*Computed using $p = .05$
Table 16

Repeated Measures ANOVA on Parent Domain on the PSI from the Pretest to the Third Assessment Point

<table>
<thead>
<tr>
<th>Source</th>
<th>SS</th>
<th>df</th>
<th>MS</th>
<th>F</th>
<th>p</th>
<th>Partial Eta Squared</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals</td>
<td>2122.29</td>
<td>7</td>
<td>303.19</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>59.08</td>
<td>2</td>
<td>29.54</td>
<td>0.39</td>
<td>0.69</td>
<td>0.06</td>
</tr>
<tr>
<td>Error</td>
<td>1073.58</td>
<td>14</td>
<td>76.69</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>3254.95</td>
<td>23</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Computed using p = .05

Figure 5. Marginal means of Parent Domain Scores on the PSI.

As shown in Table 15, the F ratio was not statistically significant at the .05 level (F(1, 7) = 0.28, p=0.61), indicating that there was no statistically significant change during the no treatment period (from the baseline to the pretest) on the Parent Domain on the PSI. The partial eta squared was determined as small (η²=0.04) based on Cohen’s guidelines (1988). Table 16 indicates that the F ratio was also not statistically significant at the .05 level (F(2, 7) = 0.39, p=0.69) during the treatment period (from the
pretest to the third assessment point). Results demonstrated that there was no statistically significant change during the treatment period on the Parent Domain on the PSI. However, the partial eta squared during this period was determined as medium \((\eta^2=0.06)\) based on Cohen’s guidelines (1988).

Table 17 presents the means and standard deviations of the data from the four assessment points on Total Stress score on PSI.

### Table 17

**Mean Scores and Standard Deviations for Total Stress on PSI**

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>235.25</td>
<td>11.95</td>
</tr>
<tr>
<td>Pretest</td>
<td>235.00</td>
<td>18.18</td>
</tr>
<tr>
<td>Second assessment</td>
<td>224.88</td>
<td>17.40</td>
</tr>
<tr>
<td>Third assessment</td>
<td>229.00</td>
<td>15.90</td>
</tr>
</tbody>
</table>

Total Cases = 10

*Note. A decrease in the mean score indicates a decrease in child-parent relationship stress.*

### Table 18

**Repeated Measures ANOVA on Total Stress on the PSI from the Baseline to the Pretest**

<table>
<thead>
<tr>
<th>Source</th>
<th>SS</th>
<th>df</th>
<th>MS</th>
<th>F</th>
<th>p</th>
<th>Partial Eta Squared</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals</td>
<td>2965.75</td>
<td>7</td>
<td>423.68</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>0.25</td>
<td>1</td>
<td>0.25</td>
<td>0.05</td>
<td>0.95</td>
<td>0.001</td>
</tr>
<tr>
<td>Error</td>
<td>347.75</td>
<td>7</td>
<td>49.68</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Total** 3313.75  15

*Computed using \(p=.05\)*
Table 19

Repeated Measures ANOVA on Total Stress on the PSI from the Pretest to the Third Assessment Point

<table>
<thead>
<tr>
<th>Source</th>
<th>SS</th>
<th>df</th>
<th>MS</th>
<th>F</th>
<th>p</th>
<th>Partial Eta Squared</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals</td>
<td>4259.63</td>
<td>7</td>
<td>608.52</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>414.75</td>
<td>2</td>
<td>207.36</td>
<td>1.49</td>
<td>0.26</td>
<td>0.18</td>
</tr>
<tr>
<td>Error</td>
<td>1943.25</td>
<td>14</td>
<td>138.80</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>6617.63</td>
<td>23</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Computed using p=.05

Figure 6. Marginal means of Total Stress Scores on the PSI.

As shown in Table 18, the $F$ ratio was not statistically significant at the .05 level ($F(1, 7) = 0.01, p=0.95$), indicating that there was no statistically significant change during the no treatment period (from the baseline to the pretest) on the Total Stress subscale on the PSI. The partial eta squared was determined as small ($\eta^2=0.001$) based on Cohen’s guidelines (1988). Table 19 indicates that the $F$ ratio was also not statistically significant at the .05 level ($F(2, 7) = 1.5, p=0.29$) during the treatment period (from the pretest to the third assessment point). The result demonstrates that there was
no statistically significant change during the treatment period on the Total Stress on the PSI. However, the partial eta squared during this period was determined as large ($\eta^2=0.18$) based on Cohen’s guidelines (1988).

Individual Analysis.

In order not to perpetuate unnecessary stereotyping or useless categorization by grouping individuals together in this study and not to underestimate within-group heterogeneity, linear regression was performed on individual scores of Total Problems on the CBCL across the four assessment points. The impact of the CCPT with the individual participant child was inferred by the change pattern of CBCL Total Problem scores.

**Figure 7.** Linear regression chart of Case 1.

Figure 7 presents a linear regression chart of a child (case 1) who was a 5-year-old Japanese American female student in the kindergarten class. Her Total Problem scores on the CBCL at the baseline and the pretest were 63, which fell in the borderline clinical range. At the second assessment point, her score increased one point, to 64,
reaching into the clinical range. However, at the last third assessment point, her score dropped to 56, which is within the range of normal.

Figure 8. Linear regression chart of Case 2.

Figure 8 presents a linear regression chart of a child (case 2) who was a 9-year-old Japanese American female student in the third grade. Throughout the baseline to the second assessment point, her Total Problem score on the CBCL was 54. However, at the last third assessment point, her score decreased to 43. All of her scores were within the normal range.

Figure 9. Linear regression chart of Case 3.

Figure 9 presents a linear regression chart of a child (case 3) who was a 5-year-old Japanese American female student in the kindergarten. Her Total Problems score was 43 at the baseline. At the pretest, her score increased to 49 and maintained the
same score at the second assessment point. At the last third assessment point, her scored fell to 47. All of her four scores were within the normal range.

Figure 10. Linear regression chart of Case 4.

Figure 10 presents a linear regression chart of a child (case 4) who was a 7-year-old Japanese American male student in the second grade. His Total Problems scores at the baseline and the pretest were both 53. At the second assessment point, it decreased to 52, and at the last third assessment point, it increased to 58. However, all of his four scores were within the normal range.

Figure 11. Linear regression chart of Case 5.
Figure 11 presents a linear regression chart of a child (case 5) who was a 9-year-old Japanese female student in the third grade. Her Total Problems score was 53 at the baseline, 50 at the pretest, 45 at the second assessment point, and 49 at the last third assessment point. All of the four scores of hers were within the normal range.

![Linear regression chart of Case 5](image)

*Figure 12. Linear regression chart of Case 6.*

Figure 12 presents a linear regression chart of a child (case 6) who was a 5-year-old Japanese female student in the kindergarten class. Her Total Problems score was 35 at the baseline, 34 at the pretest, 39 at the second point, and 38 at the last third assessment point. All of the four scores were within the normal range.

![Linear regression chart of Case 6](image)

*Figure 13. Linear regression chart of Case 7.*
Figure 13 presents a linear regression chart of a child (case 7) who was a 7-year-old Japanese female student in the first grade. Her Total Problems score was 57 at the baseline, 42 at the pretest, 49 at the second assessment point, and 44 at the last third assessment point. All of the four scores were within the normal range.

Figure 14. Linear regression chart of Case 8.

Figure 14 presents a linear regression chart of a child (case 8) who was a 5-year-old Japanese male student in the kindergarten class. His Total Problems score was 36 at the baseline, 31 at the pretest, 35 at the second assessment point and 34 at the last third assessment point. All of his four scores were within the normal range.

Figure 15. Linear regression chart of Case 9.

Figure 15 presents a linear regression chart of a child (case 9) who was a 7-year-old Japanese female student in the second grade. Her Total Problems score was 48 at
the baseline, 29 at the pretest, 40 at the second assessment point, and 40 at the last third assessment point. All of her four scores were within the normal range.

Figure 16. Linear regression chart of Case 10.

Figure 16 presents a linear regression chart of a child (case 10) who was an 8-year-old Japanese male student in the second grade. His Total Problems Score was 51 at the baseline, 50 at the pretest, 49 at the second assessment point, and 45 at the last third assessment point. All of his four scores were within the normal range.

Nine out of ten cases demonstrated the same scores or the decrease in the scores from the baseline to the pretest assessment point. Seven cases demonstrated the same scores or the increase in scores from the pretest to the second assessment point. Eight cases demonstrated the same scores or a decrease of scores from the second assessment to the third assessment point. Finally, seven cases out of ten revealed lower scores from baseline to third assessment point.

Discussion

The convergence of traditional scientific methodology and the ecological view of the person has been a primary focus in the area of multicultural counseling. The
ecological view of the person emphasizes the use of multiple and diverse methods to gain complementary lenses to understand ethnic minorities by valuing within-group differences while examining the inner cultural experiences of individuals. The quantitative data from this study, along with parents’ feedback and this researcher’s subjective observations, are reviewed for comprehensive and rigorous analysis in order to examine the use of child-centered play therapy (CCPT) with Japanese children in the United States.

Results of this study highlight the benefit of CCPT with this population. The benefits are demonstrated in the large effect size obtained on the Externalizing Problems subscale and medium effect size on Internalizing and the Total Problems scores on the Child Behavioral Checklist (CBCL). These mixed results indicated that child problematic behaviors increased then decreased during the therapeutic intervention. The large effect sizes on the Child Domain and the Total Stress subscales on the Parenting Stress Index (PSI) demonstrated that parent-child relationship stress decreased and maintained a lower score during the therapeutic intervention. None of the scores on the six aforementioned subscales achieved statistical significance. However, this study carried 10 children for data analysis of CBCL scores and 8 for PSI scores; it is likely that the study is under-powered due to small sample size. This seems a logical explanation for the fact that statistical significance was not obtained (Armstrong & Henson, 2004).

Furthermore, the utility of statistical significance as the sole criterion for testing treatment effects has been severely questioned (Henson & Smith, 2000). Statistical significance tests do not (a) evaluate replicability of the results, (b) speak to the
importance of findings, or (c) report the magnitude of group differences, relationship, or other effects (Armstrong & Henson, 2004). Effect sizes provide the research consumer the ability to better understand the magnitude of effects of a provided treatment and interpret the practical significance of results of empirical research (Trusty, Thompson, & Petrocelli, 2004). The large and medium effect sizes obtained in this study indicate a considerable impact of CCPT on Japanese children in this study.

Child Behavior Checklist (CBCL)

As Figures 1, 2, and 3 show, a similar pattern of the estimated marginal means across the four measurement points was repeated in the Internalizing Problems, Externalizing Problems, and Total Problems scores on the CBCL. In general, from the baseline to the pretest assessment point, the scores decreased. However, from the pretest to the second point, the scores increased, and then scores dropped again at the last third assessment point.

The decrease in the participants' CBCL scores from the baseline to the pretest assessment point led the researcher to postulate that the decline in scores during this period may reflect alleviated concerns on the part of the child participants' parents. Although no CCPT treatment was provided for the children during this period of time, the researcher frequently contacted their parents through phone calls and e-mails to arrange play therapy sessions (e.g., the location of the office, time to provide the service). In addition, during this phase, parents were instructed to read to their children a storybook on play therapy provided by the researcher to prepare them for their initial play therapy session. This assignment for the parents may have increased their
interaction with their children as well as provided a topic to share. As Agatsuma (2003) reported, Japanese parents in the United States tend to experience difficulty communicating with English-speaking mental health and educational professionals, and it is often a struggle for them to obtain sufficient information to support their children. It is possible that some parents involved in this study experienced a degree of relief or hope as a result of their frequent contacts with the therapist; this sense of relief may have increased the parents’ tolerance of their children’s behavioral problems. As an alternative explanation, the parents’ sense of relief or hope may have affected their children in positive ways, resulting in decreased behavioral problems.

The pattern of score changes between the pretest and the third assessment point illustrates a common process of play therapy. Moustakas (1955) observed and analyzed the process of play therapy in young children, identifying several stages in the therapeutic process: (a) diffuse negative feelings, expressed everywhere in the child’s play, (b) ambivalent feeling of anxiety and hostility, (c) direct negative feelings targeted toward parents, siblings, or others, or some forms of regression, (d) ambivalent feelings that are both negative and positive directed toward parents, siblings, or other; and (e) distinct and realistic positive and negative attitudes with a prevalent positive attitude in a child’s play. The pattern of child participants’ behavior changes in this study (based on CBCL scores) also coincided with the results of a study by Ray (in review). She reported that upon completion of 3 to 7 sessions of play therapy, parent-child relationship likely deteriorated due to child behaviors; however, significant beneficial effects began at 11 sessions. Garza & Bratton (2005) conducted 15 weeks (15 sessions) of culturally responsive CCPT with 15 Hispanic children at an elementary
school. A result from her study revealed a statistically significant decrease in the culturally responsive CCPT groups’ Externalizing problems measured by the Behavior Assessment Scale for Children-Parent Report Scale (BASC) compared to the comparison group, which was a curriculum-based small group. Meta-analysis of 93 research studies on the effectiveness of play therapy conducted by Bratton et al. (2005) also concluded that 35 to 40 sessions tend to have a peak effect.

Landreth (2002) stated that CCPT facilitates children’s free and open expression of their emotions. Child participants may have transferred this experience of direct self-expression from the play therapy setting to their home and school environments; parents involved in the study may have perceived this shift as their children’s behaviors being “worse.” According to Shibusawa (2001), Japanese mothers tend to expect their children to acquire self-control, cooperation with group members, and emotional maturity, whereas American parents expect their children to be socially and verbally assertive and expressive and to stand up for their rights. Because all the participant parents were Japanese females who were born and raised in Japan, it can be speculated that the parents in the study sustained the expectations common in Japanese parents. Freer self-expression of the children may have contradicted parents’ expectations, resulting in parents rating their children as having increased behavioral problems on the CBCL.

**Parenting Stress Index (PSI)**

There were no statistically significant changes in parents’ PSI scores in the Child Domain, the Parent Domain, or the Total Stress Domain. However, results of a partial
eta squared did reveal large effect sizes in the Child Domain and the Total Stress Domain, and a medium effect size in the Parent Domain. As Figures 4, 5, and 6 show, estimated marginal means of the three subscales over the four assessment points also followed a similar shift pattern except for the phase between the baseline and the pretest assessment point. During this period, the score of the Child Domain increased whereas the Parent Domain decreased; however, the scores in all three subscales of the CBCL exhibited a declining trend during the same time. This result led the researcher to speculate that positive change in child behavior may have encouraged the parents in their parenting skills, resulting in the reduction of stress regarding their perceived ability to be a parent. As another postulated explanation, the parents' decision to participate in this research may have brought some increased feelings of pride that they were making an effort to seek a beneficial service for their children. The contradictory result that the Child Domain score in the PSI increased while all three subscales on the CBCL decreased may indicate that the Japanese parents in this study may have rated higher scores on the items on the PSI that do not infer the child's behavioral problems. In fact, more parents obtained scores in the clinical range on the Reinforces Parent and the Acceptability scales that do not necessarily inquire into a child's behavior. For instance, some of the questions in the Acceptability scale on the PSI are “My child doesn’t seem to learn as quickly as most children,” and “In some areas, my child seems to have forgotten past learnings and has gone back to doing things characteristic of younger children.” Considering the reports from the existing literature that Japanese and Japanese American parents hold higher educational expectations for their children than do European American parents (Shibusawa, 2001),
those questions may have been contributed to higher scores by the Japanese parents. As a result, the parents may have reported higher stress on the Child Domain despite the fact that they perceived an improvement in the child’s behavior.

From the pretest to the second assessment point, the scores decreased, followed by an increase in the scores at the third assessment point but remaining below the scores of the baseline. It can be postulated that the decrease in scores between the pretest and second assessment points is an indication of parents’ sense of relief or hope related to their children having begun the CCPT treatment. However, CCPT is designed to provide therapeutic intervention for children, not for parents. Therefore, it is not surprising that the decrease in the scores on the Parent Domain did not have a sustained effect.

Most of the local schools that the children in the study attended began the summer break between the second and the last third assessment point. Therefore, the parents were spending more time together with their children and, as a result, the parents may have been feeling more challenged in their parental roles at this period of time, resulting in higher stress. This is an additional explanation for the escalation of the score from the second assessment point to the last third assessment point on the Parent Domain of the PSI.

The estimated marginal mean scores on the Child Domain of the PSI were observed to increase between the second and the last third assessment point; however, there was a 1-point elevation, and the score at the last third assessment point was still 4.25 below the score at the baseline point. Meanwhile, there was a 3.13 score increase between the second and the last third assessment point. The score at the third
assessment point was 2 points below that of the baseline on the Parent Domain of the PSI. However, the interpretation of the Child Domain scores on the PSI requires caution when compared with the results of the CBCL. The Child Domain on the PSI measures parents’ experiences of their children’s behavioral problems, including hyperactivity, adaptability, demandingness, and mood (Adibin, 1995). Despite the fact that the parents reported decreased parental stress levels between the pretest and the third assessment point (as measured by the PSI), the same parents reported an increase in child behavior problems (as measured by the CBCL) during the same time period. These results indicate that the parents in the study may have become more tolerant and accommodating of their children’s behavioral problems.

Abidin (1995) noted that the Child Domain score is typically elevated above the Parent Domain score for parents of children with emotional disturbance, hyperactivity, and behavioral problems. However, the results of this study revealed the reverse trend; the Parent Domain scores were consistently higher than the Child Domain scores. One possible explanation for this finding is that some of the children in the study were engaged in play therapy for preventive purposes; hence, they were not experiencing emotional or behavioral problems at the clinical level. Cote and Bornstein (2001) conducted a study of parenting cognitions among immigrant groups, and stated that parenting cognitions are believed to acculturate exceptionally gradually, if at all. They also reported that Japanese mothers are significantly more likely to attribute their lack of success in parenting to their own efforts and that they rated themselves as being less satisfied with their parenting than those in other immigrant groups. One Japanese parent in the study reported to this researcher that the values and priorities that she
inherited from her parents often seemed not to apply to her son because he is a “biracial child.” Additionally, Kazui, Muto, and Sonoda (1996) reported that Japanese mothers who have no involvement in social activities outside of their family tend to develop stronger feelings of anxiety and stress related to parenting. A mother in the study mentioned that it is difficult to enjoy engaging in social interactions with the other mothers at her child’s local school due to the limitations of her English language skills; however, she also feels anxious with mothers at the Japanese School of Dallas because the local Japanese community is so small that rumors and gossip circulate quickly within the community. It is notable that the Parent Domain scores were elevated above the Child Domain scores in this study; it can be postulated that this finding is due to Japanese mothers’ struggle to adapt their traditional parenting style to their biracial children. Another possible explanation is that the children in the study have acculturated to the United States faster than their mothers have. Yet another possible explanation is that Japanese mothers tend to personalize their unsuccessful experiences in parenting. Finally, lack of opportunity for social interactions may have contributed to the Japanese mothers’ elevated Parent Domain scores on the PSI.

**Individual Analysis.**

Most of the individual linear regression data on the Total Problems scale of the CBCL followed a common pattern of decline between the baseline and the pretest assessment point, followed by elevation between the pretest and second assessment points, then a decrease to scores below the scores from last third assessment point. The average slope of a score curve across the four assessment points is -0.24. The
small average drop rate may be attributed to the fact that 9 out of 10 individuals’ scores on the Total Problems scale of the CBCL fell within the normal range throughout the assessment points.

A few individuals’ data exhibited a different curve from the aforementioned general trend. One of the challenges in applying the quantitative research paradigm to multicultural counseling is the frequent assumption that diversity, or being different, is problematic (Shorter-Gooden, 2002). Further investigation for the exceptional curves was conducted in order to address this challenge.

The CBCL Total Problems domain scores from 3 children did not exhibit elevation between the pretest and second assessment points; instead, their scores continued to decline. These children were 7, 8, and 9 years old, respectively, in the older age group of the participating children. According to Piaget’s (1972) theories of cognitive development, children at these ages are in the concrete operational stage. In this stage, their egocentric thoughts diminish and they acquire more socialized forms of play. In addition, children at this period not only use symbols representationally but can manipulate those symbols logically. Therefore, the focus of their play shifts from symbolic expression to rules and games (Piaget, 1972). The 3 children whose scores varied from the rest of the group were encouraged toward free and open expression of self through their CCPT as well as the other children. However, it is possible that the parents had a better understanding of their children’s expression because their expression was more logical and mature, and was less symbolic. Therefore, the parents may not have experienced the children’s more liberated expressions as problematic, especially in light of the fact that none of the 3 children scored in the clinical range on
the CBCL. Dougherty (2006) conducted a study to explore the impact of the CCPT on children within Piaget’s preoperational and concrete operational stages. Among her results, children in the preoperational developmental stage did not obtain a statistically significant decrease in the Child Domain on the PSI, whereas children in the concrete operational stage did. She postulated that children in the concrete developmental stage might be better able to express verbally, and, therefore, they were perceived as more adept, resulting in the decreased score on the stress in the parent-child relationship.

Two of the 3 aforementioned children also did not follow the general declining curve between the second and the last third assessment point; instead, their scores increased during this period. The mother of the child whose scores increased between the second and the last third assessment point recalled that during this period the child’s grandmother came from Japan to visit them for several weeks. After the grandmother’s arrival, the mother noticed that the child seemed more dependent and egocentric in her efforts to occupy the grandmother’s attention. At the feedback session the mother of the other child who also had elevated scores between the second and the last third assessment point did not recall any specific change in the child’s behaviors or the environment. It is noteworthy to mention that none of the scores of the children whose data did not follow the general data trend fell within the clinical range. Therefore, the increase in Internalizing and Externalizing behaviors may be interpreted as a positive change. Lastly, the CBCL measures parents’ experiences and perceptions of their children’s behaviors. Thus, the elevation or decline in the scores on the CBCL may have been influenced by parents’ emotional, physical, and cognitive status.
Researcher’s Subjective Observations of a Play Therapy Session

In this section, the researcher addresses qualitative data from her observations of participating children’s play therapy sessions. Anecdotal information can be beneficial in discussing unique happenings during play therapy which were not reflected in quantitative data. Information includes; (a) children’s first reaction to a play therapy setting, (b) motivations of the parents and children’s play behaviors, (c) children’s reactions to Japanese toys (d) identity issues exhibited during play therapy sessions, (e) sibling rivalry, and (f) children’s tendency to clean the playroom.

In the first play therapy session, some of the children appeared to be perplexed when they first experienced the nondirective structure of the time. When they encountered the unfamiliar experience of freedom in the playroom at the initial session, the children frequently requested to bring their friends or siblings to the playroom. Although a puzzled feeling was observed in some children at the beginning of the treatment, none of them expressed strong discomfort or anxiety; that is, no children cried or requested to leave the playroom. The most frequent concepts that are cited as cultural differences between the United States and Japan are the concepts of individualism and collectivism (Azuma, 2001). The Japanese are often described as a nation that places priority on group interests over personal interests, on attending to and fitting in with others, and on the importance of harmonious interdependence with others (Markus & Kitayama, 1991). Landreth and Sweeney (1999) outlined some of the benefits of adding one or more another child to the therapeutic relationship; other children present in the play therapy room may help mitigate threatening feelings as children enter a new environment. They may also help children reevaluate their
behaviors in the light of peer reactions. Considering the group-oriented cultural value among the Japanese, it seems that group play therapy may be utilized to help Japanese children familiarize themselves with the permissive play therapy environment as a prior step to individual play therapy.

The parents of the child participants in this study seemed to be motivated to participate in the research for one of two reasons: that is, to prevent future child behavior problems or to intervene in existing child behavior problems. One parent expressed concerns about the impact of an upcoming out-of-state move on her children. Another parent seemed to have anticipatory anxiety about parenting, based on her previous experience of parenting difficulty with an older child. Parents who were motivated to participate with the hope of intervening in current child behavior problems expressed concerns about ongoing anxiety issues, current struggles in the parent-child relationship, lack of attention, and somatic symptoms. In play therapy, the children whose parents seemed motivated to participate based on a desire to prevent child behavior problems appeared to engage in higher levels of mastery play, whereas the children whose parents had been motivated to participate in order to intervene in current child behavior problems seemed to absorb themselves into fantasy and imaginative play.

The majority of child participants exhibited interest in the Japanese toys added to the playroom. It appeared that the Japanese toys often evoked family stories. For instance, a child who found Japanese juggling balls (Otedama) talked about her grandmother who is skilled at playing with the toy; the child expressed her feeling of sadness as she talked about how she missed her grandmother who lives in Japan. Another child who tried a Japanese cup and ball game (Kendama) started talking about
his father, who is good at playing with it, and expressed his admiration for his father. For children who are bilingual in Japanese and English, the Japanese toys seemed to stimulate their Japanese language skills. Some of the bilingual children who spoke in English the majority of a play therapy session began verbalizing in Japanese when they played with a Japanese toy. Some children distinguished the sounds of vehicles (an ambulance car and a police car) depending on whether they were using a Japanese or an American toy car. A female child created animals with Origami and decided to give them to her American friends because “they like those because they do not know how to do Origami!”

The Japanese toys included in this study were traditional and classic toys. When some children brought a paper balloon (Kamifusen) with them from the playroom, their parents expressed excitement to see a familiar toy from their childhood; the toys seemed to evoke nostalgic feelings in the parents. Some of the parents started tossing the balloon with their children in the waiting room. Existing literature on play therapy in a multicultural setting highlights the importance of the playroom environment, including modifications and the addition of culturally responsive toys (Chang, Ritter, & Hays, 2005; Garza & Bratton, 2005; Gil, & Drewes, 2005). It was observed in this study that culturally specific toys can address some of the unique experiences of culturally diverse children.

Identity issues were also observed in one session. A 5-year-old Japanese American male was excited to find an American flag among the army man figures. He expressed his excitement, then said with a disappointed tone of voice, “But I am a Japanese American” and put the flag back in the box. A 7-year-old female complained
that she has to write in English when she makes something for her father and in Japanese when she makes something for her mother.

Three pairs of siblings participated in the study, and competition between siblings was often observed. Due to the limited time schedule, the researcher conducted sessions with siblings consecutively. It was often observed that a brother or a sister who came to a session after their sibling was curious what the sibling had done in a session. A 5-year-old male who was scheduled to be in play therapy before his older brother often hid some toys he liked so that his older brother would not be able to play with them. A 5-year-old female often engaged in the same art project as her older brother had created in a previous session, but she tried to make it more elaborate. According to Hunter (1993), when a family is experiencing extreme stress, a positive relationship between siblings can prevent some of the more devastating consequences. Siblings of minority children can function as a support in order to overcome some of the unique issues to them, such as acculturation, language acquisition, and prejudice. In the meantime, intense relationships between siblings can engender conflict and competition. Therefore, minority siblings can benefit from sibling group play therapy, which provides a common framework for resolving conflicts and removing impediments to mutually supportive relationships.

The researcher did not observe any difference in play behaviors based on playroom location. However, children who attended play therapy sessions at The Japanese School of Dallas were apt to utilize the Japanese language more compared with the children seen outside of the school. It is speculated that a rule at the Japanese School that students as well as teachers are discouraged to use English while they are
attending the school on Saturdays may have influenced the choice of language of the participating children who were seen at the school. Despite the freedom to choose to clean or not to clean the playroom after a session, the majority of the children voluntarily cleaned the room before they left at all three playrooms. Cleaning behaviors appeared to have occurred more frequently with Japanese children in this study than with European children based on the researcher’s personal experience.

Case Reports

In order to fill the gap between research and the practice of counseling, two case reports are presented. The cases chosen from the 10 child participants portrayed individual differences in presenting issues and reactions to play therapy as well as differences in parents’ feedback. Although valid inferences cannot be drawn, anecdotal reports provide a glimpse of the impact of CCPT on individual Japanese children in the United States.


At the initial meeting with the researcher, the mother reported that several months prior Akiko started frequently reporting somatic and panic symptoms and refusing to go to school in the morning. The mother also reported that Akiko became obsessed with trivial things, and her frustration was expressed through sobbing. Akiko became hypervigilant with others’ moods and feelings and said that she felt sad if everybody was not smiling.

The mother mentioned that she “knew” the cause of Akiko’s change. She remorsefully confessed that she had been imposing extremely high expectations on
Akiko to live as a biracial child. The mother reported that she had been trying to accept Akiko as she was, and, as a result, she was experiencing some improvement in Akiko’s behaviors. However, the mother expressed her concerns over Akiko’s occasional intense emotional reactions and some regressed behaviors.

In play therapy, Akiko seemed excited but restricted at the beginning of the therapy process. During this period of time, she mostly engaged in mastery play, using art and craft materials. She often drew “a smiley face.” In the middle phase of therapy, her play became more athletic, and she tried something that her “brothers do.” Interestingly, when she was attracted to a specific toy but not feeling comfortable enough to try it, she used a flashlight and manipulated the light to pretend that the light was playing with the toy. Toward the end of the session, Akiko’s play became more symbolic, and she either engaged in role play or she used a doll family to play out scenes.

At the feedback session, the mother reported significant improvement in Akiko’s behaviors; she reported that she had observed fewer emotional outbursts and somatic symptoms. However, the mother reported that Akiko started denying being part Japanese and that she became hesitant about coming to The Japanese School in Dallas.

This child’s Externalizing, Internalizing, and Total Problems scores on the CBCL at the last third assessment point were all lower than the scores obtained at the three previous assessment points. On the PSI, the scores on the Demandingness and Mood subscales in the Child Domain were in the clinical range across the four assessment
points. However, the scores of those subscales at last third assessment point were lower than at the baseline point.


At the initial meeting, Jun’s mother reported concerns about Jun’s lack of attention, day dreaming, and his struggles with learning Japanese. The researcher also serves as a mental health consultant at The Japanese School of Dallas, and the teachers of the school occasionally consult with her regarding students of concern. Jun’s second-grade teacher at The Japanese School of Dallas reported to the researcher that Jun had been destructive to the class by humming, playing with pens and erasers, biting his nails, and hiding behind textbooks that he set up on the desk. The teacher also reported her struggle with the mother’s defensiveness.

In play therapy, Jun used mainly Japanese, but he often stuttered when he was searching for words in Japanese, and eventually English words were spoken. From the first session, he was interested in the sand tray, setting out toy soldiers and creating battle scenes. As the session progressed, he started playing the role of “soldier” and fought with Bobo (the punching bag). He usually carried two swords, one of which seemed a Japanese Samurai style and another that seemed a Western medieval style. In his play, he was confident with his swordsmanship and explained a variety of techniques he knew. Often he was so absorbed in his fantasy play that he had difficulty with leaving the playroom at the end of the session. However, the more sessions he had, the more able he became to prepare himself for ending the session when the 5 minute warning was given.
The results of the CBCL did not reveal any clinical scores. His PSI scores were excluded from the group analysis as a result of an outlier analysis showing that both scores in the Parent Domain and the Total Stress Domain were extremely low. However, only scores in the Reinforces Parent subscale of the Child Domain on the PSI reached the clinical range across the four assessment points. It is also noteworthy that the PSI, from the baseline and the pretest assessment, exhibited low Defensive Responding scores, indicating that the mother may have been responding in a defensive manner (Adibin, 1995). However, the Defensive Responding score of the PSI at the second and last third assessment point increased, indicating that the mother became less defensive to responding. The researcher also observed that the mother became more open to the researcher as the sessions progressed and shared her conflict about having her son go to the Japanese School in Dallas. According to the mother, Jun started using English predominantly in daily conversation, and, accordingly, he began struggling at the Japanese school. Nonetheless, Jun’s second-grade teacher reported her surprise and excitement that she had started observing more self-control, longer attention span, and motivation in Jun during class than ever before.

Limitations of the Study

Limitations inherent to the procedure of this study are as follows:

1. Due to the small sample size, this study was not able to establish comparison or control group. This lack of comparison group made it difficult to attribute any change reflected in the scores solely to the result of CCPT.
2. The use of an English version of the assessments may have prevented parents from fully comprehending the meaning of the questionnaires. Some of the words in the questions may be inexact when there is no direct correspondence between the words and concepts originating in Western culture and those of Japanese culture.

3. Assignments of playrooms in multiple locations may have impacted the children’s play behaviors and their choice of language during a session.

4. The internal validity of this study was threatened by within-group differences, such as acculturation levels and ethnicity.

5. Among the parents of participant children, some sought intervention for their children’s existing behavioral problems, and others were motivated to participate with the goal of preventing child behavior problems. The different levels of participant children’s presenting issues may also have further threatened the internal validity of this study.

6. Some parents sought advice from the researcher or began sharing their stress and struggles with the researcher during the study. Although the researcher attempted to refrain from any consultation type of interaction with the parents, some communication that the parents had with the researcher may have had an impact on how the parents interacted with their children which, as a result, may have brought about some behavioral change in the children.

7. Small sample size affected the power of the statistical procedures, thus compromising the possibility of obtaining statistical significance.
8. Selection of the subjects for this study was completely limited to volunteer participants from The Japanese School of Dallas. The small number of participants restricted the ability to generalize the results to other populations.

9. Due to the lack of English-Japanese bilingual play therapists in this area, the researcher functioned as the play therapist in this study, which may have introduced a degree of researcher bias.

10. A couple of child participants could have benefited from continuing play therapy; however, because there was no Japanese therapist in this area, the researcher could not make any referrals.

11. The researcher had to order culturally specific toys for Japanese children through overseas shipping; therefore, available toys were limited.

12. Use of the term, play therapy may have created some resistance in parents to having their children participate in this study due to the stigma that this population in general has toward mental health services.

13. The total of eight sessions may not have been enough to promote behavioral changes in children obvious enough to be noticed by parents.

Contribution and Strengths of the Study

Although the generalizability of the results of this study is limited due to the small sample size, this study has augmented the play therapy literature well as the field of multicultural counseling. One of the major contributions of the present study is that it examined a treatment method for Japanese children in the United States to improve or maintain their psychological well-being. The existing literature has identified the
struggles and conflicts unique to this population, but few research studies have scrutinized the effectiveness of mental health services for them. Careful consideration in implementing culturally responsive play therapy is an additional strength of this study. Qualitative data evidenced the importance of toy modification and flexibility in language responsiveness to serve minority children in the United States. Additionally, an asset of the present study is that it holds emic perspectives. Asian Americans are distinguished by their extremely low admission rate to mental health services as well as their high drop-out rate after an initial session; nevertheless, mental health care providers with similar ethnic minority backgrounds are apt to treat ethnic minority clients and succeed in retaining them in treatment (Sue, Fujino, Hu, Takeuchi, & Zane, 1991). Although this researcher believes from her own experiences that differences in ethnicity between a therapist and a client are rarely definite detrimental factors in providing therapeutic services, the fact that the treatment provider was of similar ethnicity as the child participants in this study seemed to contribute to a deeper understanding of the children’s play behaviors.

Lastly, the research methodology employed in this study may be viewed as a strength of the study; the use of both quantitative data and case study analyses provided rich information related to the use of CCPT with minority children in the United States. This combined approach responds to the call for micro-level analyses in the multicultural counseling field to develop more sensitivity to within-group differences and individual factors among an ethnic group as well as the demand to establish a scientifically supported mental health treatment modality.
Recommendations for Future Research

1. Conduct a replication of this study utilizing a control group and a comparison group which employs an evidence-based treatment. The addition of a control group would enhance the possibility of the attribution of the research results to the CCPT treatment effect. The addition of a comparison group would help to establish the effectiveness of CCPT treatment.

2. Conduct a replication of this study with a larger sample size. This would increase the power of statistical measures and make it more feasible to generalize the results to the targeted population.

3. Conduct a replication of this study with Japanese children from other areas in the United States in order to better generalize the results.

4. Conduct a replication of this study with Japanese children in Japan in order to address the lack of empirically supported research on the effectiveness of play therapy in Japan as well as to further examine the unique characteristics and issues related to Japanese children in the United States.

5. Conduct a replication of this study extending the length of time the treatment is provided. More than eight sessions may be required in order to observe measurable changes in children. In addition, research should not be conducted during the first semester based on the Japanese School year (from April to July), because it is common for Japanese families in the United States to visit Japan for 2 to 3 months after the spring semester at local schools end in order for the children to have more exposure to Japanese culture. Consideration for scheduling will help decrease the drop-out rate in future studies.
6. In a replicated study, utilize an assessment tool that measures more objective variables. Parent reports as utilized in the current study can be subjective. Direct observation of children’s behaviors would add more unbiased information to results.

7. Conduct a replication of this study utilizing more thorough single-case study research design in order both to explore within-group differences and to assess the treatment effects on children. Collaborating with the local schools that Japanese children attend will be crucial because they are present at a Japanese school only on Saturdays.

8. Conduct a follow-up study of the children in this study to determine the long-term effectiveness of the CCPT treatment.

9. Conduct group play therapy in order to follow the cultural value of collectivism.

Conclusion

In spite of the growing awareness of multiculturalism in counseling, the level of sensitivity and practicality of the mental health services continues to be called into question. In light of this criticism, increasing need exists for culturally conscientious research that examines and identifies effective mental health treatment modalities targeted for discrete minority groups.

In attempting to address this need, the current study investigated the impact of child-centered play therapy (CCPT) with Japanese children in the United States. The effectiveness of CCPT was measured by a decrease of child behavioral problems in Internalizing, Externalizing, and Total Problem Scores on the Child Behavioral Checklist (CBCL), and by a decrease of parent-child relationship stress in the Child Domain, the
Parent Domain, and the Total Stress on the Parental Stress Index (PSI). Data from a total of 10 children were included in this study, four of whom were Japanese and 6 were Japanese Americans. PSI and CBCL were completed by the parents at four measurement points; (a) baseline, four weeks before the first play therapy session, (b) pretest assessment point, right before the first treatment started (c) second assessment point, after four play therapy treatment sessions were completed, and (d) third assessment point, after eight play therapy treatment sessions were completed. These assessments provided four total points of measurement.

Single-group repeated measures ANOVA was exercised to determine the impact of CCPT. Unfortunately, due to the small sample size, statistically significant results (at the 0.05 alpha level) were not obtained for the Internalizing, Externalizing, and Total Problem subscales on the Child Behavior Checklist (CBCL), and the Child Domain, the Parent Domain and the Total Stress on the Parental Stress Index (PSI). However, the Externalizing Problems subscale on the CBCL and the Child Domain, and the Total Stress subscales achieved large effect sizes and the Internalizing Problems, and the Total Problems subscales on the CBCL and the Parent Domain on the PSI attained medium effect sizes respectively during the treatment intervention.

The analysis of the results of the CBCL indicated wave-like behavior of the scores over the four assessment points: from the baseline to the pretest assessment point, the score declined, then it increased from the pretest to the second assessment point, finally decreasing to the point below the baseline at the last third assessment point. The deterioration of the child behavior at the beginning of the play therapy process observed in this study coincides with the results from previous research.
The analysis of PSI results exhibited the opposite trend, showing a decline from the pretest to the second assessment point, then decreasing from the second and the third assessment point. These results warrant a note of caution, considering that the CCPT is not designed for treating parents and that some of the questions on the PSI assess parental stress that may not have been provoked by the child’s behavior.

The analysis of the CBCL Total Problems, utilizing linear regression, revealed that most of the individual scores followed the same aforementioned trend of the CBCL. Explanations of the exceptions include a child’s developmental stage, school schedule change, and family environmental change. Subjective observation of play therapy sessions and case reports by the researcher provided additional consideration for existing within-group differences.

Rogers (1961) stressed that true empathy rests in a therapist’s ability to see the world of another individual by assuming the internal frame of reference of that person, and sensing it as if it were the therapist’s very own. This study -- featuring the effectiveness of child-centered play therapy (CCPT) with Japanese children in the United States -- indicates that CCPT holds promise to provide a multicultural framework for mental health professionals who strive to better understand the unique characteristics of this population.
APPENDIX A

ADVERTISEMENT ON PLAY THERAPY PROJECT
お子さんにプレイセラピーの体験をさせてみませんか？

“セラピー”と聞くと「おかしな子」「問題児」を対象にするものというイメージがあるかもしれません。しかし、過去の研究からプレイセラピーは子どもの自尊心、友人関係、自己表現の向上、乱暴な行動、落ち着きのなさの減少、環境変化（引越し、家族メンバーの死別、離婚など）への適応力の向上などの効果があることが実証されています。プレイセラピーが、なんらかの心理的問題に向き合っている子だけでなく、いわゆる「普通の子」にとってもなんらかのかたちでプラスになる経験になることは少なくありません。近年日本でもプレイセラピーは、学校や教育相談所で子どもへの心理的サポートの一方法としてよく行われているようになっています。

3月(予定)から週一回、12週間にわたってプレイセラピーを実施するプロジェクトを開始します。セラピーは無料で提供されます。場所・時間は主に補習校の放課後、プレイセラピー用に設定された部屋で行われますが、ご都合によっては、補習校以外の場所でも実施することは可能ですので、場所・日時については御相談可能です。セッションは週一回、30分です。

参加者は以下の条件を満たす方に限ります。
1. お子さんの年齢が3歳から10歳までの方
2. お子さんが日本語または英語（又は両方）が話せる
3. 12回プレイセラピーにお子さんを参加させることができる方
4. 現在お子さんがなんらかの専門家による心理的サポートを受けていない方

守秘義務は必ず守られますので、お子さんのプレイセラピーについて、又はご両親がご報告なさったことは、他のご両親または補習校の先生き方を含め、他人の方にご本人の許可なく伝わることは一切ありません。

プレイセラピー実施前、中、後で、ご両親に2つの簡単な質問紙を記入していただきます。質問紙の結果は、ご希望のあるご両親にお伝えします。また12週間のプレイセッション終了後、ご両親にセッションについてフィードバックを提供することも可能です。

異文化の中で、又はマイノリティとして生活していくことは、大人にとっても大きなチャレンジです。このプレイセラピーが、そんな大きなチャレンジを体験している子ども達の支えになれば・・・と思っています。

このプロジェクトに参加ご希望の方、またはご興味のある方は個別に詳細をご説明しますので、以下までご連絡ください。

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APPENDIX B

WHAT IS PLAY THERAPY?
プレイセラピーって何？

この冊子、プレイセラピーのプロジェクトまたはプレイセラピーについてご質問がありましたら、お気軽に下記までご連絡ください。

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プレイセラピーってなんですか？
「遊びは子ども達の国語、そして、おもちゃは彼らの言葉」("Play is children's language and toys are their words.")とLandreth（1991）は定義しています。例えばおしゃべりなお子さんでも、言葉よりも遊びによっての方が自分自身を表現しやすいものです。これは子どもの発達段階に見合った考え方であり、スイスの児童発達心理学者のビアジェは、7歳くらいまでは子どもは言葉よりもイメージで情報を処理する傾向があり、12歳くらいからやっと抽象的な思考、または「もし〜であれば」といった、仮説演繹的思考が行えるようになると言っています。

例えば・・・公の場での発言で恥じをかいたとか、喧嘩しているときに何も言い返せなかったとか、大切な事を告白したかったのについ臆病になってしまいどうでもいい会話を始めていたんだ・・・そんな時に、言いたかったことをぶつぶつと後で一人で言いながら「場面再生」劇を一人でやって、ちょっと気が楽になっている自己を経験したことのある方も少なくなって思います。「いいたかったのに言えなかった・・・」というモヤモヤ感を言葉で表現または修復できない代わりに、子どもは「遊び出す（Play out）」という手段を使うのです。

その子が普段経験していること、自分自身のイメージ、そして「こうなって欲しい・・・」という希望を含むことを子どもは遊びを通して表現します。このような遊びの働き、効果に基づいてプレイセラピーが生まれました。プレイセラピーとは、遊ぶことを媒体にして行う子どもとの「会話」なのです。お子さんは遊びの中で、自分のことや今困っていることなどについて表現し、カウンセラーは遊びを通してお子さんを理解し、応対していきます。このようなコミュニケーションを積み重ねていくことで、お子さんの本来持っている力を発揮できるようになることを目的としています。

一回のセッションはどれくらいですか？また何セッション必要なのでしょうか？

今回のプロジェクトでは1回30分のセッションに12回参加することをお願いしています。Ray(in print)の研究結果から、プレイセラピーの効果は12〜15セッション辺りから見られるようになることが報告されています。どうしてそんなにかかるのか・・・と不思議に思われている方もいらっしゃるかもしれません。プレイセラピーでは一般的に「関係作り」の期間、子どもがカウンセラーの事を「信頼できる人、自分自身のことをあるがままに受け入れてくれる人」という信頼感と安心感を築くとしても重要な期間、遊びを通して自由な表現をする期間、そしてさらに遊びを通して自分なりに問題解決をしていく期間があります。

子どもの性格、その子がいる環境状態、その子がむきあって問題の深刻さなどによりそれぞれの期間にかかる時間は色々で、セラピーをはじめる前から「何回のセッションが必要ですか」と断言することは難しいです。最近はマニュアル化されたプレイセラピーもあります。「全部で15セッションです」とカウンセラーが初めから言うこともあり得ます。私自身はどの子にも同じ関わりをするマニュアル化されたプレイセラピーを信じていません・・・）。今回のプレイセラピープロジェクトでは、プロジェクトと学校のスケジュール上計12回のセッションとしてありますが、とお子さんが1
２回のセッションを終えた時点で「もうすこしプレイセラピーを続けたほうがいいかも・・・」とご両親が思わわれた場合には、継続は可能ですのでお気軽にご相談ください。

どんなおもちゃがプレイルームにあるのですか？

プレイルームに置かれているおもちゃは色々な配慮の上厳選されたものが置かれています。

- 発達段階にあった安全なおもちゃ
- 色々な感情が表現できるバラエティに富んだおもちゃ
- 想像力を駆り立てるおもちゃ

今回のプロジェクトでは年齢制限を4歳から10歳までにしているため、プレイルームにはこの年齢層のお子さんが自分を表現するのに使いやすいおもちゃが用意されています。年齢の高いお子さんが、プレイルームにある基本的なおもちゃを使ってとても創造的に遊ぶことも少なくありません。また、プレイルームにはいくつかの工作用具なども用意されます。年齢の高いお子さんの中には、そのようなものをして楽しむ子もいます。また、もしお子さんが遊びに話がしたいと決めたらなら、言語のやり取りが中心となった時間を過ごすことになります。その子の子で自分がやりやすく感じる自己表現の方法が違うので、このプレイセラピーのアプローチでは、その子が一番やりやすい方法を選べるような環境をつくります。

カウンセラーはプレイセラピー中どんなことをするのですか？

どの子どもも更に成長していくための自己治癒力という力を本来持っています。その力を発揮する為に、どのような事にどのような形で（どのようなおもちゃを使って）取り組みたいのかはその子自身が一番よく知っていることです。ですから、プレイセラピーではカウンセラーが「今日はこれをしましょう」とセッションを構成することはありません。遊びという子ども自身の自由な表現にカウンセラーはついていきながら、その遊びにこめられた表現、メッセージを理解し、応答していきます。

カウンセラーは、子どもの自信、独立心、「やってみよう！」という新しいことに挑戦する気持ちを高める、自己表現・想像力を促進する、子どもが自分の行動・衝動をコントロールできるようになることを目的とした言葉かけ・対応をします。

セッションを見学することはできますか？

自分の子どもがプレイセラピー中どんなことをしているのか・・・とても興味があることと思います。しかし、カウンセラーにはカウンセリングの中で知りえたプライベートのプライバシーを守る義務があります。これをカウンセラーの守秘義務といいます。お子さんの自由な表現を促すために、プレイセラピーにおいてもこの守秘義務をできるだけ守るようにしているため、ご両親がお子さんのプレイセラピーを見学
することは遠慮していただいています。しかし、なんといってもお子さんが未成年、ご両親の保護にある存在ですので、セッションの様子はセラピストからご両親に報告し共有するようにしています。また、セッション中にセラピストが気なることが見られた場合には、即時ご両親と相談するようにしています。

プレイセラピーってどんなことにいいんですか？

「セラピー」と聞くと、精神障害などといったなにかとても深刻な問題に対するものというイメージが浮かぶかもしれません。しかし、友達とうまく遊べない、いろいろなことを気にしたり怖がったり、そうでないことを表現するのが苦手、学習面での遅れ、食べられない・眠れない、学校や園に行きたがらない、嫌だめだめとしたり乱暴な行動をとりやすい、などといった所謂「普通の子」が直面する問題のサポートとしてプレイセラピーが提供されることも大変よくあります。日本におけるプレイセラピー（遊戯療法）の認識は年々高まっており、現在では学校、教育相談所などでプレイセラピーが一般的に行われています。

アメリカではプレイセラピーの効果を実証的に証明する研究が数多くなされています。ここにいくつかの研究をご紹介します。

- Ashby, J., Kottman, T., & Martin, J. L. (2004) は、完璧主義の子どもがリラックスし、より良い判断・選択ができるようになるためのプレイセラピーアプローチについて報告しています。

- Axline, V (1948) は場面緘黙症（ある特定の場所で一切人と話しきしない）の一人の男の子にプレイセラピーを通して触れ合い、次第に男の子が話すようになり、社会性をつけ友達をつくり、さらにはIQを高める過程を報告しています。

- Bills, R. E. (1950) の研究では、読解力が劣っている8人の小学3年生にプレイセラピーを実施したところ、8人とも読解力が上がったことを報告しています。

- Clatworthy, S. (1981) は計14の入院中の5－12歳の子どもを対象に、プレイセラピーを受けるグループと受けないグループに分けて、グループ間での子どもの不安感の強さの違いを研究しました。プレイセラピーを受けた子どもは、受けなかった子どもに比べて、入院中不安感を高まらせることが少ないことが報告されています。


- Garza & Bratton (2005) は対象をヒスパニックの子ども限定し、ヒスパニックの家庭に特有のおもちゃをプレイルームに導入して、小学校でプレイセラピーを実施しました。15週間（15セッション）終了後、プレイセラピーに参加した子どもの両親は
子どもの乱暴な行動と子どもの心配性、不安感が一般的に減少したことを報告しています。

- Milos, M. E. & Reiss, S. (1982) の研究では、プレイセラピーが分離不安（お母さん、お父さんと離れることを極端に怖がる）の緩和に役立ったことを報告しています。

- Schumann(2003) の研究では、5 - 12 歳の乱暴な行動をとりやすい20人の小学生に学校でプレイセラピーを行った結果、両親、先生ともに、生徒の乱暴な行動の現象を認めている事を報告しています。
APPENDIX C

HANDOUT ON OBJECTIVES AND PROCESS OF THE PLAY THERAPY PROJECT
プレイセラピープロジェクトについて

今回のプレイセラピープロジェクトは、補習校のご理解とご協力のもと、補習校に通っている生徒さんの様々な面における適応（異文化体験、学習面、友人関係、自信など）を高めることを目的にしたものです。

・ご両親がお子さんのプレイセラピープロジェクトへの参加を決めた場合、お子さんは12回（週一回 30分）のプレイセラピーを体験します。

・スケジュール上、お子さんが放課後プレイセラピーを受けるまでに待ち時間ができた場合、こちらで日本人の付き添いの方（ベビーシッター）を準備しますので、ご両親がお子さんと一緒に待ってくださらなくても結構です。

・ご両親には4回にわたって2つの簡単な質問紙に回答していただきます（毎回同じ2種類の質問紙です）。一回目はお子さんがプレイセラピーを受ける前、二回目はお子さんが4回目のセッションを終了した直後、三回目はお子さんが8回目のセッションを終了した直後、そして、四回目はお子さんが12回目のセッションを終了した後に記入していただきます。これは、お子さんの適応がプレイセラピーを経験することによって高まっているかを客観的に見極めるための大切な情報となります。質問紙の結果は4回すべての記入が終わった時点で、ご希望のあるご両親にお伝えします。また12週間のプレイセッション終了後、ご両親にお子さんのプレイセッションについてフィードバックを提供することも可能です。

・守秘義務は必ず守られますので、お子さんのプレイセラピーについて、又はご両親がご報告なさったことは、他のご両親または補習校の先生方、校長先生を含め、他人の方にご本人の許可なく伝わることは一切ありません。

・お子さんが12回のプレイセラピーセッションに参加し、ご両親が4回の質問紙記入を終了してくださった際には、謝礼として合計$30.00の映画券をお渡します。
APPENDIX D

INFORMED CONSENT
この研究へのお子さんの参加に同意される前に、この研究の目的、利点、そして過程についての下記の説明を必ず読んで、理解なさるようにしてください。

研究課題: アメリカ在住日本人児童へのチャイルドセンタードプレイセラピー(児童中心遊戯療法)の実施とその効果の実証的検討研究 Effectiveness of Child-Centered Play Therapy on Japanese Children in the U.S.

主研究者: 小川裕美子 Yumiko Ogawa, MA, M.Ed., NCC, RPT, LPC, JCCP
University of North Texas (UNT) Department of Counseling

研究の目的: この研究ではプレイセラピーがアメリカに在住する日本人児童の適応向上に貢献するかどうかを検討することを目的としています。

研究の過程
あなたのお子さんは一週間に一回30分のプレイセラピーに8回参加します。プレイセラピーは遊びを通じて自分自身を表現することを促進することを目的とした子どもの発達段階に見合ったカウンセリングの一方法です。小学生くらいまでの年齢の子どもは、自分が向き合っている問題を言葉で表現しながら解決していく認知力と言語力が発達的に十分備わっていません。異文化体験、またはアメリカに住むマイノリティとしての経験から生ずるさまざまな困難、またその困難が及ぼす学業、社交関係の問題などに対して、お子さんが遊びという媒体を通して取り組み、改善していく場をプレイセラピーは提供します。プレイセラピーでは、どのようなおもちゃでどのように遊ぶか、またどのような話をセッション中にしたいかはお子さんが主導をとって自由な環境が提供されます。セラピストが提供する特定な方法で遊ぶことを強制したり、特定の質問に答えることを強いたりすることはありません。

また、参加に同意なさったご両親には、the Child Behavior Checklist (CBCL) the Parenting Stress Index (PSI) 4回に渡って記入していただくことになります。1）一回目はお子さんがプレイセラピーを受けられる数週間前、2）お子さんがプレイセラピーを受ける直前、3）お子さんがプレイセラピーを4回受けた時点、そして、4）お子さんがプレイセラピーを8回受けた時点の計4回において、同じ質問紙（CBCLとPSI）を記入していただきます。ご要望があれば、プロジェクト終了後、4回の質問紙の結果をプレイセラピー・セッションのフィードバックと一緒に伝えていきます。

この研究における予測できるリスク
この研究への参加はまったくのボランティアベースとなっています。そのため、いつでも途中で参加を辞退することが可能です。この研究に参加することによる直接の危害は全くありませんが、以下に記したようなちょっとした不快な状況をお子さんが経験することもあるかもしれません。

1. プレイセラピーにおいてお子さんが話したこと、または遊んだことは守秘義務のもとにあるため、セラピストがその内容を第三者や学校関係者（Local, 補習校共に）に伝
えることはありません。しかしながら、もしあなた自身またはあなたのお子さんが虐待、ネグレクト、または他人に危害を与える可能性を明らかにした場合には、セラピストは適切な機関にそのことを報告することが法的に義務付けられています。

2. プレイセラピーはカウンセリングの一形態のため、セッション中にお子さんが自分の気持ちを表現することがあります。セラピストはお子さんの適宜な自己表現力を促進するような場を提供しますが、お子さんの感情があまりに強くなり、感情表現がお子さんためになっていないと判断した場合には、その日のセッションを中断し、プレイセラピーとは違ったかかわりでお子さんが落ち着くのを待つような場合もあります。

研究参加者に期待できるメリット
あなたのお子さんがこの研究に参加することにより、異文化への適応、自信、学業面での向上、そして行動問題、情緒問題の緩和がある程度みられることが期待しています。また、お子さんがこの研究に参加することにより、あなたが日々経験している保護者としてのストレスが多少でも減り、よりよいお子さんとの関係が形成されることも期待しています。この研究の結果は今後、日本人児童を対象にしているメンタルヘルスの専門家にとって、お子たちがより幸せになり、より成功していくことをサポートするための役に立つ情報を提供することになると思っています。プレイセラピーは、情緒的、心理的、または問題行動のある子どもに対する主要なアプローチとして近年日本でも、幅広く受け入れられてきています。しかしながら、日本人児童を対象にしたプレイセラピーの効果を測定した実証学的研究が皆無のため、この研究がアメリカ、また日本における精神保健の領域に貢献できることは多大であると思っています。

参加者への報酬
お子さんがこの研究に参加している保護者の方には、3週間毎に計4回、2種類の質問紙（Parenting Stress Index, Child Behavior Check List）を記入することをお願いしています。2種類の質問紙を記入してくださったご両親には、毎回（計4回）AMC movie theaters か、Burns and Novels のギフトカードをお礼としてお渡しすることになっています。ギフトカードの金額は回によって異なります。

守秘義務の守られ方
この研究に関するすべての個人情報は Center for Play Therapy at the University of North Texas 内の鍵のかかるキャビネットに保管されます。この研究結果を一般に報告することができる場合は、ご両親、お子さんのお名前などの個人情報は一切公開されることはありません。ご記入してくださった質問紙もお名前は個人番号に変えて情報を処理します。この研究の第一研究者、小川裕美子のみがこの研究への参加者リストを所持することになっています。すべてのお子さんに対してのプレイセラピーが一貫しているかどうかを確かめるために、お子さんのプレイセッションをビデオ録画する場合があります。第一研究者の小川裕美子とその教授 Dr. Dee Ray 以外にビデオが公開されることはありません。また、ビデオは研究終了後一年以内に破棄されます。
この研究についての質問
この研究について、ご質問のある場合は、小川裕美子 940-380-9385 又は Yogawa@coe.unt.edu（日本語可）までご連絡ください。

研究参加者の権利
以下に署名することによって、あなたはこの書類を読み以下の件について確認したこと
を証明します。

この研究第一責任者の小川裕美子はこの研究について説明し、あなたからの質問に全て答えました。また、この研究に参加することによって期待されるメリットと、予測されるリスクについても説明を受けました。

あなたのお子さん、そしてあなた自身もこの研究に参加することはボランティアベースであり、参加を義務づけられていないことを承知しています。この研究に参加しない、または途中で参加を辞退すると決めた場合も不利益になりえるようなこと（罰則など）は一切ありません。また研究者がこの研究参加が何らかのかたちで参加者に不利になっていると判断した場合は、研究参加を辞退していただくことをお願いすることもあります。

この研究がおこなわれる目的と、この研究の過程についての説明を受けました。

あなたとあなたの子さんがこの研究にボランティアとして参加することをここに同意します。

保護者署名

日付

第一研究者に対して:
この同意書を上記に署名された両親とともに見直したことをここに証します。この研究
参加によって生じることが期待されるメリットとリスクについて参加者保護者に説明
をしました。研究参加の保護者の方はこの研究についての説明をご理解されたと思われ
ます。

第一研究者署名

日付

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APPENDIX E

CHILD BACKGROUND INFORMATION
あなたのご家庭環境とお子さんについて少し教えてください・・・

お子さんのお名前：__________________________________________

記入者のお名前：__________________________________________
お子さんと記入者の関係：母親・父親・その他（__________）

住所：____________________________________________________ City _______________ Zip Code ________

電話番号(自宅) __________________________ (携帯) __________________________

電話に出やすい時間帯：__________________
留守電にメッセージを残してもいいですか？ はい・いいえ

お子さんのお誕生日：_______年_______月_______日 現在満_______才

お子さんの出生地：_______________________________________
お子さんのエスニシティ：日本人・日系アメリカ人・その他（__________）

お子さんが主に話す言語はなんですか？英語・日本語・その他（__________）
お家で主に話している言語はなんですか？英語・日本語・その他（__________）

お母さんの出生国はどこですか？：___________________________
お父さんの出生国はどこですか？：___________________________

お母さんの母国語（日常よく使う言葉）はなんですか？____________________
お父さんの母国語（日常よく使う言葉）はなんですか？____________________

お母さんのエスニシティ：日本人・アメリカ人・その他（__________）
お父さんのエスニシティ：日本人・アメリカ人・その他（__________）
現在の家族構成を記入してください。（お子さんが一緒に住んでいる方々）

名前_________________________ 年齢________ 関係（義母、養親など）詳しく記述してください。

例：荒川 恵子_________________________ 42 母親
荒川 準_________________________ 44 義父

お子さんの在米生活は何年目ですか？________年
以前にあなたのお子さんは海外生活を経験していますか？
はい：_________________________ 年から_________________________年 国・都市______________
いいえ

一番最近、日本に一時帰国したのはいつですか？________年 月 約________日間

お子さんは現在、なんらかの心理的サポート（カウンセリング、精神科医の診察など）を受けていらっしゃいますか？
はい：（どこで、どのような専門家からか記述してください）________________________
いいえ

過去にお子さんがなんらかの心理的サポートを受けたことはありますか？
はい：（どこで、どのような専門家からか記述してください）________________________
いいえ

お子さんは現在、学校でスペシャルエデュケイションやテュータリングを受けていらっしゃいますか？
はい：（内容、頻度を記述してください）________________________
いいえ
• お子さんはなんらかの身体的障害（Physical Disability）がありますか？
はい：障害名とお子さんが何歳の時からかを記してください。__________________________
いいえ

• お子さんはなんらかの慢性疾患（Chronic Illness）がありますか？
はい：障害名とお子さんが何歳の時からかを記してください。__________________________
いいえ

• お子さんは定期的になんらかの薬をのんでいますか？
はい：薬の名前と服用目的を記してください。__________________________
いいえ：

• このお子さんについて、あなたが一番たのもしく思うところはどんなところですか？
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

• このお子さんについてあなたが一番「難しい・・・」と思うところはどんなところですか？
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
このお子さんについての心配事、お子さんの性格、など、なんでも知っておいてもらいたいと思うことを自由に記述してください。

ご協力ありがとうございました

ご協力ありがとうございました

Happy!
花ちゃんへ

プレイルームへの招待状

こんにちは。
わたしのおうちを知ってる？
みんながプレイルームってよくにあるところ。
わたしのおうちはプレイルームのたなの、一番下のはしっこ。

たくさんのおもちゃはわたしの友達。
いつもいつも同じメンバーが、いつもいつも同じ場所にいる。
それと･･･

お姉さんもいる。
お姉さんはプレイルームの管理人さんみたいないひとで、花ちゃんと一緒にプレイルームに来てくれるひと。
花ちゃんと初めて会ったときに･･･

「ここが花ちゃんのプレイルームよ。花ちゃんがしたいことをして過ごしていいのよ」とお姉さんは言う。
あ、そうそう、お姉さんのことは花ちゃんが好きなようによくっていいんだって。

花ちゃんがしたいことはなんに？自分が好きなように過ごしてごらん。
後かたづけだってしたくなったら、しなくていいんだ！
イライラ、モヤモヤ、心配事がどんどん小さくなっていって、そのかわり、毎日楽しいことがふえてから、「プレイルームに「さようなら」を言うとき。

その時がきたら、お姉さんは「また来週ね」といつものように言わないで、そのかわり「さようなら」って言う。

花ちゃんプレイルームに来るって聞いたよ。

花ちゃんがプレイルームに来るのを楽しみにしているね。

今度の金曜日にプレイルームで会おうね。

花ちゃん、プレイルームってそんなところ。

でも、覚えておいてほしいの。

いつかまた、プレイルームと、プレイルームのお姉さんと、ぼくたちに会いたくなったら、お母さんやお父さんにそう言えいいことを。

けんちゃんも、まりちゃんも、「じゃ～ね、バイバイ」って、もうこない。

なおやくんも、さやかちゃんも、「プレイルーム、バイバイ」って、もうこない。

どうしているのかな～。

でも、覚えておいてほしいの。

いつかまた、プレイルームと、プレイルームのお姉さんと、ぼくたちに会いたくなったら、お母さんやお父さんにそう言えいいことを。

花ちゃん、プレイルームってそんなところ。

けんちゃんも、まりちゃんも、「じゃ～ね、バイバイ」って、もうこない。

なおやくんも、さやかちゃんも、「プレイルーム、バイバイ」って、もうこない。

どうしているのかな～。

でも、覚えておいてほしいの。

いつかまた、プレイルームと、プレイルームのお姉さんと、ぼくたちに会いたくなったら、お母さんやお父さんにそう言えいいことを。

花ちゃんプレイルームに来るって聞いたよ。

花ちゃんがプレイルームに来るのを楽しみにしているね。

今度の金曜日にプレイルームで会おうね。

まってるよ！
APPENDIX G

PLAY THERAPY SESSION NOTE
### PLAY THERAPY SESSION NOTES

Effectiveness of Child-Centered Play Therapy with Japanese Children in the U.S.

**CHILD'S NAME:**

**AGE:**

**DATE:**

**SESSION#:**

**LOCATION:**

### SUBJECTIVE: (Feelings Expressed)-Underline all that apply.

- **HAPPY:** relived, content, satisfied, pleased, delighted, excited, surprised, silly
- **SAD:** disappointed, hopeless, pessimistic, lonely
- **ANGRY:** impatient, annoyed, frustrated, mad, mean, jealous
- **AFRAID:** vulnerable, helpless, distrustful, anxious, fearful, scared, terrified
- **DISTRUSTFUL/OVERLY TRUSTING**
- **CONFIDENT:** proud, strong, powerful, determined, free
- **HESITANT:** uncertain, timid, confused, nervous, embarrassed
- **CURIOUS:** interested, focused
- **FLAT:** restricted, contained, ambiguous

### TOYS/PLAY BEHAVIORS (Underline all that apply-briefly describe play)

| ____animals: domestic/zoo/alligator/dinosaurs/shark/snake | ____vehicles (Japanese emergency cars)/planes |
| ____musical instruments/ Japanese little drum | ____games/bowling/balls/cup and ball |
| ____puppets/theater | ____cash register/money ( $ / ¥ )/phone/camera/flashlight |
| ____kitchen/cooking/food (Asian foods) | ____doll house/doll family (Caucasian dolls, Asian dolls) |
| ____dress up (Yukata/Japanese school backpack) | ____medical kit/bandages |
| ____jewelry/hats/masks (Japanese Masks: Omen) | ____easel/chalkboard/eraser |
| ____constructive toys | ____crafts/clay/markers/play-doh/Paper Balloon/Others |
| ____hammer | ____soldiers/guns/knife/sword/handcuffs/rope |
| ____bop bag.bean bag | ____other Japanese toys (juggling balls, Japanese beads, Japanese Kaleidoscope) |

### SIGNIFICANT VERBALIZATIONS:

### CULTURALLY SIGNIFICANT INCIDENTS:

**ENGLISH** %: **JAPANESE** %

### LIMIT SETTING:

- Protect child:
- Protect counselor/Promote counselor’s acceptance:
- Protect playroom/toys:
- Structuring:
- Socially Unacceptable Behavior:

### THEMES:

- Exploratory
- Constructive
- Relationship Building
- Mastery
- Good vs. Bad
- Sexualized
- Healing
- Dependency
- Power/Control
- Regression
- Reality Play
- Repetitive
- Safety/Danger
- Aggressive/Violence
- Perfectionist
- Nurturing
- Limit Testing
- Protection
- Victimization/Helpless/Trauma
- Cleansing/Wash
- Symbolic Play
- Grief/Loss
- Order vs. Chaos
- Soothing
- Cultural

### CONCEPTUALIZATION/PROGRESS/GOALS:

<table>
<thead>
<tr>
<th>Counselor's Signature</th>
<th>Date</th>
</tr>
</thead>
</table>

originally developed by Bratton, S. & Homeyer, L.
APPENDIX H

PICTURE OF A PLAYROOM AT SCHOOL
REFERENCES


Miyama, T., & Tsushima, T. (1960). On the variables significant in terms of the therapeutic results in play therapy (No. 2). Kyoto furitsu daigaku gakuzyutu houkoku, 3 (2), 165-170.


