INTENSIVE SHORT-TERM CHILD CENTERED PLAY THERAPY AND
EXTERNALIZING BEHAVIORS IN CHILDREN

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Play therapists use children's natural symbolic play as a method of mental health treatment (Landreth, 2012). Meta-analysis research has demonstrated the effectiveness of treating children with play therapy (Bratton, Ray, Rhine, & Jones, 2005), and child-centered play therapy (CCPT) has proven to be an effective treatment for children with externalizing behaviors such as aggression and other disruptive behavior (Bratton & Ray, 2000; Bratton et al., 2005). Some studies have demonstrated the effectiveness of brief and short-term CCPT, such as twice weekly within two to three months (Blanco & Ray, 2011; Shen, 2002) and when delivered in an intensive format, conducting 12 sessions within three weeks (Jones & Landreth, 2002). In this current study, I sought to determine the effectiveness of intensive CCPT with children identified as having externalizing problem behaviors.

Participants were recruited from public schools in the urban area of Darwin, Northern Territory, Australia area. A total of 24 participants completed the study: 18 boys and 6 girls aged 6 to 9 years old ($M = 7$); 17 Australian Caucasians, 1 English (UK) Caucasian, 1 Asian, 3 Hispanic/Latino, and 2 Biracial. Participants were randomly assigned: 12 to the experimental group and 12 to the wait-list control group. Children in the experimental group received 20 intensive CCPT sessions: twice daily for 10 days. For each child participant, a parent completed the Child Behavior Checklist (CBCL) and a teacher completed the CBCL Teacher's Report Form (TRF) three times: at pretest, posttest, and one-week follow-up.

Mixed between-within ANOVAs were conducted applying an alpha level of .05 to interpret statistical significant and η^2 calculation to assess practical significance. Follow-up results indicated a statistically significant interaction effect on CBCL Externalizing score, $F(2, 44) = 14.747, p < .001$, with a large effect size of $\eta^2 = .277$. Results also indicated a statistically significant interaction effect on the TRF Externalizing score, $F(2, 44) = 4.042, p = .024$, with a large effect size of $\eta^2 = .135$. Therefore, both parents and teachers indicated that children with externalizing behaviors who received intensive CCPT showed a significant decrease in those behaviors. The results of this study indicate that when time and financial resources call for short-term, intensive CCPT for children with problematic externalizing behaviors, practitioners may use it with confidence that its effectiveness has been demonstrated through this research.

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"Courage does not always roar. Sometimes it is a quiet voice at the end of the day, saying... "I will try again tomorrow." - Author unknown

The long and winding road that led me to this point has been filled with many loving and supportive people. Words are not enough to truly express my appreciation to everyone who invested so much into my life, but thank you. Dee, my major professor, through your unconditional acceptance of me, I had courage to grow and heal. To Sue, I wish I could bottle your encouragement and hugs. To Leslie, your nurturing is always perfect timing. To Brandy, my mentor and friend, thank you for believing in me when I did not yet believe in myself. To my committee as a whole, I could not have been in more knowledgeable or supportive care for this research than the four of you. It has been my privilege to learn from each of you. To the Australia crew, Jo, Joanne, Carmen, and Tim, and the American and Australian play therapists, this could not have happened without your dedication and love for children. To my cohort, the Tenacious Ten. I cannot imagine my life without each of you in it. We did it! To the TOTS crew, past and present, thank you. It is an honor to prize children together. Lastly, but most importantly, to Keilani Alana, my "baby girl," who has no memory of me not working while being a full time student and mom. You are my entire world and I prize you for who you are. You give me the courage to remain on the long and winding road because you are with me. As promised, I finished. I am finally done.

This dissertation is dedicated to every child in every nook and cranny on earth who needs to feel they are prized and unconditionally accepted for exactly who they are. With them, and my mentors before me, I tread both chartered and uncharted waters to promote a world that will prize all children, for each one has a story.

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INTENSIVE SHORT-TERM CHILD CENTERED PLAY THERAPY AND EXTERNALIZING BEHAVIORS IN CHILDREN

Introduction

Individuals predictably receive counseling once a week; however, there is little research regarding the relationship between frequency of mental health services received and effectiveness. Instead, the decision to increase or decrease the number of sessions per week tends to depend on factors such as time restraints and finances rather than treatment outcome (Fiorentine, 2001; Fiorentine & Anglin, 1996). Landreth (2012) suggested the frequency of counseling is often scheduled to meet the needs of therapists, rather than the emotional needs of clients who might benefit from more frequent services than once a week. Some studies have demonstrated improved effectiveness when increasing the number of counseling sessions, whether talk or play therapy, in the same or less amount of time (Blanco & Ray, 2011; Fiorentine, 2001; Fiorentine & Anglin, 1996; Grskovic & Goetze, 2008; Kot, Landreth, & Giordano, 1998; Ray, Henson, Schottelkorb, Brown, & Muro, 2008; Shen, 2002). More research is needed to explore the benefits and positive effects of increasing the number of therapy sessions in the same or shorter amount of time than typically delivered.

Play has been identified as critical in healthy development and growth in children (Piaget & Inhelder, 1996/1969). Piaget emphasized the connection between children's symbolic play and their social, emotional, and cognitive development. Play therapy has been identified as an effective treatment modality due to its use of children's natural symbolic play as a method of treatment (Landreth, 2012). Child Centered Play Therapy (CCPT) emphasizes genuine, deep empathy and unconditional positive regard from

therapists to their clients, and that the therapeutic relationship between play therapists and their client is the healing factor in CCPT (Axline, 1969; Landreth, 2012).

Play therapy has been used with children who struggle with various problems, such as externalizing behaviors (Ray, Bratton, Rhine, & Jones, 2001). CCPT is a well-researched and widely used method of play therapy that has proven to be an effective treatment for children with externalizing behaviors (Bratton & Ray, 2000; Bratton, Ray, Rhine, & Jones, 2005). Kaduson and Schaefer (2006) expressed the need to offer play therapy that meets the length restrictions of managed care. Ultimately, typical delivery of play therapy, regardless of the method of delivery, appears to be provided once a week for about 10 to 15 weeks, leaving children and their families to struggle for months.

CCPT

CCPT is a developmentally appropriate intervention utilizing play, the natural language of children, to offer a therapeutic relationship evident through responding with empathy, setting limits, returning responsibility to the child, and facilitating emotional expression (Axline, 1969; Landreth, 2012; Ray, 2011). Landreth (2012) stated that CCPT is a complete therapeutic system, describing it as more than just the application of a few rapport-building techniques, and that CCPT is rooted in the belief in the capacity and resiliency of children to self-direct constructively.

CCPT originated from the philosophy of Carl Rogers' person-centered therapy (1951). According to Rogers (1980), individuals innately have the internal resources they need for growth and to reach their potential. He viewed individuals as the best authority on their experiences and fully capable of fulfilling their own potential for growth

when presented with a facilitative environment (Rogers, 1951). Moreover, he stated that under adverse conditions, individuals will not grow and develop in healthy ways (Rogers, 1951, 1980).

The core belief in CCPT is that all children possess an innate tendency to self-actualize, which instinctively moves them toward growth. In CCPT, the therapist believes the relationship is healing agent and facilitates this innate tendency in children by offering the core conditions of empathy, genuineness, and unconditional positive regard (Axline, 1969; Landreth, 2012). Through understanding and accepting children's perceptions of their world, the play therapist facilitates a therapeutic relationship and offers children a freeing environment that releases their potential to move toward self-actualizing and self-enhancing ways of being (Landreth, 2012).

CCPT is supported by experimental research (see Lin & Bratton, 2015; Ray, Armstrong, Balkin, & Jayne, 2015) and by recent research in interpersonal neurobiology (Rossouw 2011, 2012; Siegel, 2010). Therapeutic relationships formed within the context of CCPT provide children with safe and caring environments characterized by unconditional acceptance (Landreth, 2012). Badenoch and Kestly (2014) stated the field of neuroscience supports the safety emphasized in child-therapist relationships in play therapy. Children are freed through the experience of these relationships, enabling them to move towards growth (Axline, 1969; Landreth, 2012). Because the human brain is a system of complex interconnected neural networks (Badenoch, 2008; 2011; Siegel, 2010; Dahlitz & Rossouw, 2012), repeated and intense experiences within a child's social environment create opportunities for health and growth (Rossouw 2011,

2012; Siegel, 2010). CCPT, especially intensive CCPT, may give children an opportunity for repeated and intense experiences.

CCPT Session Structure

CCPT is typically delivered once a week (Landreth, 2012). Muro, Ray, Schottelkorb, Smith, and Blanco's (2006) analyzed weekly sessions to measure problematic behaviors reported by teachers. Their study revealed a large effect size indicating practical significance regarding effectiveness. Nordling and Guernsey (1999) compared a twice-weekly session structure with a once-weekly session structure in order to examine the typical stages in CCPT. They concluded that the twice-weekly session frequency, as opposed to the more common once per week model replicated the progress made in the same number of sessions delivered weekly, demonstrating that intense levels of therapeutic relational support facilitate children to respond with intense levels of change.

Ray, Henson, Schottelkorb, Brown, and Muro (2008) explored the effect of both short- and long-term CCPT on teacher–student relationship stress. Children in the short-term intensive play therapy group participated in twice-weekly play therapy over eight weeks, and the children in the long-term play therapy group participated in 16 sessions over 16 weeks. The results demonstrated that both groups showed significant improvement in teacher–student relationship stress from pre to posttest. Jones and Landreth (2002) examined the effectiveness of CCPT in an intensive format, 12 sessions within three weeks, with children diagnosed with insulin-dependent diabetes, compared to children who did not receive CCPT. The results demonstrated significant effectiveness of the treatment on anxiety and depression; however, there was no

statistical difference between the experimental and control group concerning behavior problems. Still, the results indicated an intensive format was effective in diabetes treatment compliance. Kot, Landreth, and Giordano (1998) examined the effectiveness of intensive CCPT with children who witnessed domestic violence. The results indicated that children in the experimental group experienced significant improvement.

Externalizing Behaviors and CCPT

CCPT has been effective in treating problematic externalizing behaviors (Bratton & Ray, 2000; Bratton et al., 2013; Bratton et al., 2005). In CCPT, the therapist's task is to provide a safe therapeutic environment where children are able to explore feelings, behaviors, and consider other ways of being (Landreth, 2012). The therapeutic relationship is essential in that it assures emotional and physical safety as children explore their behaviors, such as aggressiveness and rule breaking. Therapists must be able to first accept children's need to be disruptive because the children may feel as though therapists want to change them. In CCPT, a safe and unconditionally accepting environment and relationship is provided for children to be free to accept themselves (Landreth, 2002).

Children exhibiting aggressive problem behaviors typically reach a peak of aggressive acts at an early age, providing evidence that early intervention for aggression is needed (Peterson & Flanders, 2005). Ray, Blanco, Sullivan, and Holliman (2009) demonstrated that CCPT was effective in treating externalizing behaviors in a twice-weekly format. Results demonstrated that children assigned to CCPT intervention demonstrated statistically significant decreases in aggressive behaviors and the control group made little improvement.

Garza and Bratton (2005) investigated effects of twice-weekly CCPT on elementary aged Hispanic children exhibiting externalized behavioral problems compared to an active curriculum-based control group with the same twice-weekly schedule. The results indicated that children who received CCPT sessions demonstrated statistically significant decreases in externalizing behaviors problems compared to the active control group. Schumann (2010) conducted her study on the effectiveness of once-weekly CCPT with children who exhibited aggressive behaviors. Participants were age 5 to 12, kindergarten to fourth grade, and identified as aggressive. Schumann compared the randomly assigned treatment group, children who received 20 weekly sessions of CCPT, with an active control group of 17 children who participated in an evidence-based violence prevention guidance program. Results demonstrated that both groups showed a statistically significant decrease in aggression behaviors among participants.

Purpose

The purpose of this study was to explore the effectiveness of CCPT in a brief and intensive structure, specifically the impact of intensive CCPT on reduction of externalizing problem behaviors of children. Through experimental design, I examined the effect of CCPT delivered in a very brief but intensive format on reducing problematic externalizing behaviors. The current study is based on the following research question: What impact does intensive short-term Child Centered Play Therapy have on reduction of externalizing problem behaviors of children identified as disruptive?

Methods

Participants

A priori power analysis using G*Power software determined that a minimum sample of 28 participants would be necessary to find a statistical difference between groups over time (pre to post to follow up). G*Power calculation was based on alpha level .05, minimum power established at .80, and a moderate treatment effect size ($f = .30$) based on Cohen's (1988) guidelines. The sample consisted of 18 boys and 6 girls between the ages of 6 and 9 years old ($M = 7$) in the Darwin, Northern Territory, Australia area. Children were recruited from public schools in the urban Darwin area where the racial composition consists of Australian Caucasian (31%), English (27%), Irish (9%), Scottish (7%), Chinese (5%), German (4%), Filipino (4%), other (13%), and Australian Aboriginals make up about 2% of the population (Australian Bureau of Statistics, 2011). There were 25 total participants: 13 in the experimental group and 12 in the control group. One child did not complete the intervention due to illness; therefore, 24 total participants completed the study.

In order to participate in this study, children had to meet the following criteria: a) were between the ages of 6 and 9 years old; b) described as demonstrating high levels of problematic externalizing behaviors by one or more caregivers; c) identified as having borderline or clinical levels of externalizing behaviors according to the CBCL or TRF assessment measure; d) spoke English; e) had parental or guardian consent; f) parent or guardian agreed to complete pre, post, and follow up assessments; g) child's teacher agreed to complete pre, post, and follow assessments; h) child assented to participate;

i) did not receive play therapy or other counseling services anywhere else during the duration on the study.

Instrumentation

Two instruments were used to measure outcome, the Child Behavior Checklist-Parent Version (CBCL) and the Teacher Report Form (TRF).

CBCL

The CBCL was used to measure Externalizing Behaviors. The CBCL (Achenbach & Rescorla, 2001) was administered to participants' caregivers. The CBCL for ages 6 to 18 years measured caregiver reports of a child's scores on externalizing behaviors. The CBCL is composed of 120 items. For each item, the caregiver chooses the best response from among three possibilities, 0 for not true, 1 for sometimes true, and 2 for very true. The items describe various problem behaviors displayed by their children, including externalizing behaviors such as excessive arguing and hitting others. The CBCL also includes several open-ended questions to allow respondents to report any observed behaviors. The CBCL requires approximately 20 minutes to complete and was scored with a computer software program designed to score the CBCL.

According to the manual, the normative population for the CBCL was based on a diverse sample, which included children referred for clinical and special education services, as well as children attending diverse childcare and school settings. The children of the normative sample were residents of the United States, Canada, Australia, and Jamaica (2001). The test-retest reliability of the CBCL is strong ($r = .85$). The test-retest reliability coefficients for the syndrome subscales of the CBCL are: (a) Anxious/Depressed, $r = .68$; (b) Withdrawn, $r = .80$; (c) Somatic Complaints, $r = .84$; (d)

Attention Problems, $r = .78$; (e) Rule Breaking Behavior, $r = .85$; (f) Aggressive Behavior, $r = .87$; (g) Internalizing Problems, $r = .90$; (h) Externalizing, $r = .87$; and (g) Total Problems, $r = .85$ (Achenbach & Rescorla, 2001). The content validity of the problems scales is strong and supported by research. Achenbach and Rescorla reported that the criterion-related validity of the problem scales has been supported by the instrument's capability to differentiate between referred and non-referred children.

TRF

The TRF was used to measure Externalizing Problems and was administered to the study participants' teachers. The TRF is a teacher report instrument used to assess children's academic performance, adaptive functioning, and behavioral and emotional functioning (Achenbach & Rescorla, 2001). The TRF form is for use with children between the ages 6 and 18 years. It is a self-administered instrument and takes approximately 20 minutes to complete. The instrument requires teachers to rate each student's academic performance and behavior compared to other children in the class on a 118-problem item form. The student's behavior is rated on a three-point scale of 0 to 2 indicating: not true = 0, sometimes true = 1, or very true = 2.

Achenbach and Rescorla (2001) reported adequate internal consistency for the TRF as follows: (a) an alpha of .90 on the TRF Total Adaptive scale; (b) alphas .72 to .95 for the Problem scores; and (c) alphas ranging from .73 to .94 for the DSM-oriented scores. The authors reported the test-retest reliability for the TRF was high, and scaled scores were stable. The TRF content, criterion-related and construct validity is strongly supported by research (Achenbach & Rescorla, 2001).

Procedures

This study was conducted in collaboration with an international team of play therapists. Primary researchers included three play therapists who were residents of Australia and 4 play therapists who were residents of the US. US researchers communicated with Australian researchers to plan and implement CCPT intervention research in Australia. I served as the lead researcher for the project. The data opportunity was due to an internship program being offered at a university in the US for students to gain experience in conducting play therapy internationally. Because the recruitment and data collection was in Australia, an Australian play therapist communicated and aided in the coordination of recruitment of participants. Also, a local Australian university offered support by means of providing training facilities and logistical support pre/during/post intervention phase, including providing services for the control group post follow-up phase.

Human subjects approval was attained through a university located in the southwest US. Participants were recruited through local primary (elementary) schools in the Darwin, Northern Territory, Australia area through a flyer distributed to the caregivers of each child via email and hardcopy. Each school also attached the flyer to their weekly bulletin that was emailed and/or mailed to students' homes. Principals, teachers, local clinics, and private practices also referred children to the study. Upon demonstrating interest in participation, I communicated with the parent or guardian of each potential participant to explain study procedures. Parents/guardians completed the CBCL, and teachers completed the TRF, for participating children prior to the study and for screening and pretest purposes.

Interested parents/guardians were administered the CBCL using the assessment author's encrypted and confidential Achenbach System of Empirically Based Assessment (ASEBA) Web-Link as a pretest measure. Web-Link fulfills Health Information Protection and Accountability Act (HIPAA) requirements through several security measures (Achenbach, 2010). Encryption of data and password protection are utilized to physically and electronically secure electronic "protected health information" against unauthorized retrieval, to reliably store electronic data, and provide for emergency access to the data. Also, all identifying data stored in Web-Link is encrypted using private key technology.

Parents/guardians and teachers were offered to remotely complete their respective assessments from their home, work, child's school using a school computer, or at a key research member's private practice using her computer. The ASEBA Web-Link immediately scored the assessments and a key member of the research team informed the parent of their child's inclusion of the study if their scores demonstrated a Borderline and Clinical score on the Externalizing Problems Domain on either or both the CBCL or TRF. Parents/guardians of children who did not qualify were also immediately notified and offered referrals to local play therapists. Participants who qualified were randomly assigned using a random table of numbers to either the play therapy treatment group or waitlist control group.

Local key members of the research team were available during the collection of pretest and follow up data collection to answer any questions and assure integrity of procedures. I was accessible through email and phone during the initial data collection phase (recruitment and pretest), and during the follow up assessment phase. I was

present for the treatment and posttest phases to answer questions and ensure integrity of data collection. Also, demographic data reported on the CBCL was collected and examined using SPSS. The US team of play therapists arrived in Australia to assist in delivering the CCPT protocol.

Upon completion of the CCPT protocol, the end of ten-day period, parents of children in the intervention and control groups completed a CBCL posttest. Teachers were also asked to complete a post-TRF at the end of the CCPT protocol. In order to assess post-therapy effectiveness, parents and teachers of all participating children completed a CBCL or TRF one week after the posttest.

Parents and teachers who requested information regarding their child's progress were immediately referred to the lead researcher. Logistical, general study, and play therapy information was given; however, specific individual progress was not given to protect the fidelity of the study. At the end of the follow up assessment phase, the lead researcher communicated with interested parents and teachers to discuss their child's progress and to offer additional resources, such as individual play therapy to a local play therapist.

The lead researcher organized a one-day training for cultural sensitivity and to standardize the delivery of CCPT among the play therapists before the intervention began. The one-day training consisted learning differences between American English and Australian English, such as "mom" in American English and "mum" in Australian English. The basic tenets of CCPT were also reviewed and then practiced with children to ensure the integrity of delivery of CCPT. During the treatment phase, all play therapists received one hour of triadic supervision, and two 30-minute individual

supervision sessions per week by a Registered Play Therapist or a Registered Play Therapist Supervisor, as certified by the Association for Play Therapy (APT) or Australasia Pacific Play Therapy Association (AAPTA).

To achieve optimal treatment fidelity, each session was video-recorded. CCPT protocol adherence was assessed through fidelity checks of video-recorded sessions utilizing the Play Therapy Skills Checklist (PTSC; Ray, 2011). Five sessions per counselor were randomly selected and reviewed in its entirety by a University of North Texas doctoral student trained in CCPT. Sessions adhered to CCPT protocol over 90% of the time with an average of 95.89% adherence to protocol per session.

Experimental Group

CCPT was conducted at four different locations. One location was at a private practice, and three locations were at local primary schools. Each location provided an unoccupied room that allowed for uninterrupted daily use throughout the duration of the intervention. The first week of the intervention was conducted during the week of a school semester break, and the second week was conducted during the first week classes resumed. The treatment group received CCPT in an intensive structure.

CCPT intensive structure included two sessions daily for 10 days. Adjustments were made to allot for varying school/class schedules, clean up between sessions, and number of children in the treatment group at each location. During the first week, sessions were scheduled to allow for three to three and one half hours between the twice-daily sessions. During the second week, due to unforeseen scheduling conflicts within the schools, sessions were modified to allow between thirty minutes and three hours between sessions.

Waitlist Control Group

The waitlist control group received no treatment during the intervention phase and resumed their typical daily schedules as usual. After completion of the intervention phase (2 weeks from pretest), the parents/guardians and teachers of the control group were administered a CBCL and TRF posttest. Following one week post-protocol, parents and teachers completed a follow-up CBCL or TRF. Control group children were then offered play therapy services in the form of modified filial services with at least one individual observation of parent and child, or individual play therapy services at a local university clinic.

Data Analysis

For each dependent variable (teacher and parent report on Externalizing Problem behaviors), a two by two split plot ANOVA was performed in SPSS to analyze group differences, changes in time, and possible interaction effect. The independent variable was type of group, intervention or control, and the dependent variable consisted of pre and post test Externalizing Problems behavior scores on the CBCL/TRF. In the analysis, the experimental group served as the between-subjects variable and time (pretest to posttest to follow up) served as the within-subjects variable (Pallant, 2013). Data met assumptions of normality. Following analysis, I interpreted the results to determine statistical significance and practical significance. Statistical significance was interpreted according to .05 alpha level. Eta squared (η^2) effect sizes were calculated to assess the magnitude of difference between the two groups over time due to treatment. In the interpretation of η^2 , the guidelines used were .01 equals a small effect, .06 equals a moderate effect, and .14 equals a large effect (Cohen, 1988).

I decided that if analyses of externalizing scores yielded significant effects with meaningful effect sizes, I would explore pre-post data for the subscales making up the Externalizing Problems score (i.e., Aggression and Rule-Breaking).

Results

A two-factor repeated measures spilt plot ANOVA was performed in SPSS for each dependent variable (Externalizing Problems score on parent and teacher report) to determine whether the intensive CCPT and the wait list control groups performed differently across three points of time (pretest, posttest, and follow up). The assumptions of random sampling, independence of observations, homogeneity of variance, normal distribution, homogeneity of intercorrelations, and sphericity were all analyzed and reasonably met.

The CBCL and TRF were administered prior to treatment, immediately after treatment, and one week after treatment to assess treatment effects on Externalizing Problems. A reduction in scores on the dependent variables indicated an improvement in the targeted behavior. In order to address potential effects of cultural differences regarding the delivery of play therapy by both Australian and US therapists with children who were native to Australia, an analysis was conducted to determine if there was a difference between American play therapists and Australian play therapists on Externalizing Behaviors over time. Out of the 12 children in the intervention group, American therapists saw six children, and Australian therapists saw six children. Results of the analysis revealed no statistically significant difference between American and Australian therapists, $F(2, 10) = 1.865$, $p = .18$, $\eta^2 = < .001$, indicating a small effect size (see Table 1). These results indicate that according to scores for Externalizing

Behaviors on the CBCL, there was no difference between children of therapists who were trained and lived in America compared to therapists who were trained and lived in Australia. Hence, results of all analyses can be interpreted with limited concern related to differences between therapists. However, due to low number of participants included in the analysis, results should be interpreted with caution.

CBCL Results

Children in the treatment group demonstrated a statistically significant decrease in scores on Externalizing Problems as compared to children in the waitlist control group over time, as reported by the parents on the CBCL. Results of the analysis of the dependent variable Externalizing Problems on the CBCL revealed a statistically significant interaction effect between treatment group and time, $F(2, 44) = 14.747$, $p < .001$, with a large effect size of $\eta^2 = .277$. There was also a statistically significant effect for time, $F(2, 44) = 15.204$, $p < .001$, $\eta^2 = .286$. The main effect for group was not statistically significant, $F(1, 44) = .215$, $p = .647$, $\eta^2 = .022$. Because a statistical and practical effect was found for externalizing problems as reported by parents, I further explored the externalizing problems subscales of the CBCL.

Children in the treatment group demonstrated a statistically significant decrease in scores on the subscale Aggressive Behavior as compared to children in the waitlist control group over time, as reported by the parents/guardians on the CBCL. Results of the analysis of the dependent variable Aggressive Behavior on the CBCL revealed a statistically significant interaction effect between treatment group and time, $F(2, 44) = 18.396$, $p < .001$, with a large effect size of $\eta^2 = .322$. There was also a significantly

significant effect for time, $F(2, 44) = 16.423$, $p < .001$, $\eta^2 = .287$. The main effect for group was not statistically significant, $F(1, 44) = .055$, $p = .816$, $\eta^2 = .006$.

Children in the treatment group demonstrated a statistically significant decrease in scores on the Rule-Breaking subscale compared to children in the waitlist control group, as reported by the parents/guardians on the CBCL. Results of the analysis of the dependent variable Rule-Breaking on the CBCL revealed a statistically significant interaction effect between treatment group and time, $F(2, 44) = 7.250$, $p = .002$, with a large effect size of $\eta^2 = .157$. There was also a statistically significant effect for time, $F(2, 44) = 14.374$, $p < .001$, $\eta^2 = .310$. The main effect for group was not statistically significant, $F(1, 44) = .363$, $p = .553$, $\eta^2 = .061$.

TRF Results

Children in the treatment group demonstrated a statistically significant decrease in scores on Externalizing Problems as compared to children in the waitlist control group over time, as reported by the teachers on the TRF. Results of the analysis of the dependent variable Externalizing Problems on the TRF revealed a statistically significant interaction effect between treatment group and time, $F(2, 44) = 4.042$, $p = .024$, with a large effect size of $\eta^2 = .135$. There was also a statistically significant effect for time, $F(2, 44) = 3.754$, $p = .031$, $\eta^2 = .126$. The main effect for group was not statistically significant, $F(1, 44) = .030$, $p = .864$, $\eta^2 = .001$. Because a statistical and practical effect was found for externalizing problems as reported by teachers, I further explored the externalizing problems subscales of the TRF.

Children in the treatment group demonstrated a statistically significant decrease in scores on the subscale Aggressive Behavior as compared to children in the waitlist

control group over time, as reported by the teachers on the TRF. Results of the analysis of the dependent variable Aggressive Behavior on the TRF revealed a statistically significant interaction effect between treatment group and time, $F(2, 44) = 4.907$, $p = .012$, with a large effect size of $\eta^2 = .130$. There was also a statistically significant effect for time, $F(2, 44) = 9.958$, $p < .001$, $\eta^2 = .264$. The main effect for group was not statistically significant, $F(1, 44) = .170$, $p = .685$, $\eta^2 = .022$.

Children in the treatment group did not demonstrate a statistically significant decrease in scores on the Rule-Breaking subscale over time compared to children in the waitlist control group, as reported by the teachers on the TRF. Results of the analysis of the dependent variable Rule-Breaking on the TRF did not show a statistically significant interaction effect between treatment group and time, $F(2, 44) = 2.445$, $p = .098$; however, there was a moderate effect size of $\eta^2 = .068$. There was a statistically significant effect for time, $F(2, 44) = 11.554$, $p < .001$, $\eta^2 = .320$. The main effect for group was not statistically significant, $F(1, 44) < .001$, $p = 1.000$, $\eta^2 = .004$.

Discussion

This current study sought to determine the effectiveness of intensive CCPT with children who have been identified as having externalizing problem behaviors. This study was the first collaborative study between the United States and Australia on CCPT. Results of this study indicated intensive CCPT was an effective intervention in reducing problematic externalizing behaviors. Intensive CCPT appears to be an appropriate intervention to decrease problematic externalizing behaviors in young

children aged 6 to 9 years old and demonstrated that intensive CCPT was an effective modality cross-culturally.

The children who participated in the intensive CCPT group demonstrated statistically significant improvement compared to children who participated in the waitlist control group. Both parents and teachers reported a statistically significant decrease in externalizing behaviors compared to the waitlist control group. The statistical and practical significance revealed for problematic externalizing behaviors demonstrates the level of effectiveness of intensive CCPT for young children who were identified as displaying externalizing problem behaviors. Mean differences on all subscales, except for Rule-Breaking on the TRF, indicated that children who participated in intensive CCPT demonstrated a trend of improvement while children in the waitlist control group demonstrated deterioration of symptoms. The small number of participants could be a reason for the lack of statistical significance on the Rule-Breaking subscale; however, there was a moderate interaction effect showing that it was practically effective.

The results of this study are consistent with other intensive play therapy studies that demonstrated improved effectiveness when increasing the number of counseling sessions in the same or less amount of time. Blanco and Ray (2011), Ray et al. (2008) and Shen (2002) demonstrated the effectiveness of brief and short-term CCPT, such as twice weekly within two to three months. Jones and Landreth (2002) demonstrated the effectiveness of 12 sessions within three weeks. Kot, Landreth, Giordano (1998), and Tyndall-Lind and Landreth (2001) demonstrated effectiveness with daily sessions within about two weeks.

The results of this current study are consistent with other play therapy studies that demonstrated the effectiveness of CCPT as an effective treatment for children with externalizing problems (Bratton & Ray, 2000; Bratton et al., 2013; Bratton et al., 2005). Both play therapists and parents in this study conveyed they perceived notable decreases in observed problematic externalizing behavior. For example, the mother of a seven-year-old boy initially reported that her son demonstrated aggressive behavior at home and at school, hitting his siblings and peers when frustrated, and using defiant behavior leading to being sent home from school on several occasions. However, after the seventh session, which was first session on the fourth day of the study, the mother reported a notable decrease in aggressive behavior and stated that her son appeared happier and less defiant.

Favorable outcomes of this current study appeared to demonstrate that the fundamental tenets of CCPT, rooted in the healing factor of the relationship between therapist and child, is effective in helping children with problematic externalizing behavior. Therapists who utilize the core CCPT tenets (empathy, unconditional positive regard, and genuineness), offer children materials that allow for expression of aggressive feelings and behaviors (Landreth, 2012). In this study, aggressive materials were offered in the playrooms to provide distance from difficult emotional problems in order for children to freely express their aggression (Ray, 2011). The intensive CCPT provided in this research offered materials traditionally labeled as aggressive, such as knives, guns, bop bags, handcuffs, and aggressive animals, along with other materials such as nurturing and realistic toys. In addition to the materials, the play therapists facilitated the child's freedom of expression of aggression and other emotions. Limits

were also set to protect the child, play therapist, and the room and to structure the session.

Landreth (2012) stated the task of a child centered play therapist is to provide a safe therapeutic environment where children can explore feelings, behaviors, and consider other ways of being. The relationship between therapist and child in CCPT is most important for children to heal and grow (Axline, 1969; Landreth, 2012; Moustakas, 1959). The therapeutic relationship is essential in that it assures emotional and physical safety as children explore their behaviors, such as aggressiveness and breaking rules. In CCPT, a safe and unconditionally accepting environment and relationship is provided for children to be free to accept themselves (Landreth, 2012). For example, one play therapist noted that her 6-year-old male client yelled, broke toys, and threw objects throughout the first 10 sessions. Using play therapy skills, such as reflecting feelings and limits, while offering unconditional acceptance and trusting the child's ability to resolve his problems and use effective coping skills, the therapist created an environment for the child to explore his frustrations. The play therapist reported that beginning on the eighth session, she began seeing a significant decrease in aggressive behaviors toward her (the play therapist) and more aggression toward the bop bag, such as punching and kicking. By the 12th session, the play therapist reported less aggressive behavior and more relationship play, such as creating artwork for the therapist. This example supports the effectiveness of when children are provided with intense levels of relational support, they will respond with intense levels of change.

International Collaboration

This international collaborative study may help to increase awareness of the benefits of mental health counseling in Australia, especially for young children. Burgess et al. (2009) reported that after reviewing the findings for the National Survey of Mental Health and Wellbeing in relation to the number of mental health problems reported, Australians do not appear to typically utilize mental health support. According to the Australian Institute of Health and Welfare (AIHW; 2012), there were approximately 45,000 reported cases of behavioral and emotional problems among children ages birth to 14 years old. The AIHW also reported that about 2.5% of the total child population reported long-term conditions of psychological disabilities between 2007-2008. According to the Australian Bureau of Statistics (ABS; 2006), in 2004-05, 7% of people aged birth to 17 years reported mental or behavioral problems. In 2004-05, problems of psychological development (2.8%) and emotional and behavioral problems with usual onset in childhood/adolescence (3.0%) were most prevalent among those aged birth to 17 years.

Several researchers have investigated and reported the growing development of counseling and other mental health professions (Brown, 2013; Schofield, 2013). The AIHW and ABS statistics demonstrate the need to provide effective interventions earlier to Australian children, such as in primary schools, to help them gain effective coping skills and emotional regulation. Although there have been studies to explore the mental health needs in young children in Australia (Anticich, Barrett, Gillies, & Silverman, 2012; Eickelkamp, 2008; Hays, 2007), more studies, such as this current research, are needed to inform caregivers and educators of the unique developmental needs of

children and how to meet them. This current study, along with the Australasia Pacific Play Therapy Association's (AAPTA) advocacy and training of play therapy, are important to increase developmentally appropriate services to children.

Limitations

A major limitation of the current study was the small sample size recruited from a single geographical area; therefore, the results may not be generalizable to children living in other settings. A larger sample size selected from multiple regions would broaden the generalization of the results. Also, a small sample size leads to tentative conclusions regarding the overall data analysis. Another limitation is the lack of standardization of delivery regarding time between sessions. However, the outcome demonstrated that as long as the children were able to receive the conditions of CCPT, the time periods between sessions did not affect the outcome. Another limitation is that the repeated completion of the CBCL over short intervals can lead to test-retest attenuation effect (Achenbach & Rescorla, 2001). However, according to the Achenbach and Rescorla, the instrument used in this study remains sensitive to short intervals when using control groups that will receive the same or different assessment schedules but no intervention to control for such effects. Ideally, random assignment to experimental groups also controlled for test-retest attenuation effect by having the waitlist control group on the same assessment schedule as the intervention group.

Implication for Practice and Future Research

The results of this study demonstrated that intensive CCPT is effective and therefore presents important implications for practice of CCPT. Practitioners should consider using intensive CCPT when working with children with externalizing behaviors

and when time and financial resources permit. However, there may be times when intensive CCPT is not practical. Some settings may not lend to such an intensive format. Some clinics or practices may not have the available space or therapists for twice-daily sessions. It also may not be practical for parents regarding the time commitment and finances. In this current study, some parents initially committed to the intensive format; however, after several days the schedule became problematic due to other obligations.

Although this study demonstrated evidentiary support for effects of intensive CCPT on clinical levels of externalizing behaviors, further research in this area is needed in order to offer this intervention as an evidence-based modality for similar populations. It is important to conduct further studies with children identified as having externalizing behaviors to demonstrate that results can be replicated. Intensive CCPT research with other populations, such as children identified as anxious or depressed, should also be conducted to determine whether or not intensive CCPT is effective with different presenting concerns, and to provide more support for intensive CCPT. Research in other settings, such as private practice, crisis centers, hospitals, and camps, should also be explored to determine the practicality of intensive CCPT in the private sector. Once-daily sessions should also be explored to address practicality of intensive therapy. Lastly, more collaborative research should also be conducted between the US and Australia to continue to promote developmentally appropriate interventions to children, especially because play therapy is relatively new in Australia.

Conclusion

The outcome of this research showed intensive CCPT demonstrated a beneficial therapeutic effect on young children aged six to nine years old identified as having clinical levels of externalizing behaviors. Reports from both parents/guardians and teachers indicated they observed marked improvement in the externalizing problems of children who received intensive CCPT when compared to the waitlist control group. The majority of the children receiving intensive CCPT moved from clinical levels of behavioral concerns to normal functioning, demonstrating the clinical use of intensive CCPT on daily functioning for young children.

One strength of this study was that it was conducted in a school setting, adding to the relevance for this population and its potential for replication. Another strength is the researcher's use of three measures of assessment, pretest, posttest, and follow up. Few CCPT studies have used a follow up assessment to measure progress retention. Results of this study are promising, specifically in light of opportunities such as summer camps, schools, crisis centers, and other environments where children are readily accessible to provide intensive levels of CCPT to allow for intense levels of change.

References

- Achenbach, T. M., & Rescorla, L. A. (2001). *Manual for the ASEBA school-age forms & profiles*. Burlington, VT: University of Vermont, Research Center for Children, Youth, & Families.
- Anticich, S., Barrett, P., Gillies, R., & Silverman, W. (2012). Recent advances in intervention for early childhood anxiety. *Australian Journal of Guidance & Counselling*, 22(2), 157-172. doi:10.1017/jgc.2012.24

- Australian Bureau of Statistics 2004. (2006). *Mental health in Australia: A snapshot, 2004-5*. Cat. no. 4430.0, ABS, Canberra.
- Australian Bureau of Statistics, Census of Population and Housing (2011). Retrieved from: <http://profile.id.com.au/darwin/population>
- Australian Institute of Health and Welfare 2012. *A picture of Australia's children 2012*. Cat. no. PHE 167. Canberra: AIHW.
- Axline, V. (1969). *Play therapy*. New York, NY: Ballantine Books.
- Badenoch, B. (2008). *Being a brain-wise therapist: A practical guide to interpersonal neurobiology*. New York, NY: W. W. Norton & Co.
- Badenoch, B. (2011). *The brain-savvy therapist's workbook*. New York, NY: W. W. Norton & Co.
- Badenoch, B. & Kestly, T. (2014). Exploring the neuroscience of healing play at every age. In *Play therapy: A comprehensive guide to theory and practice*, D. Crenshaw & A. Stewart. (Eds.). New York, NY: Guilford Press.
- Blanco, P. J., & Ray, D. C. (2011). Play therapy in elementary schools: A best practice for improving academic achievement. *Journal of Counseling & Development*, 89(2), 235-243.
- Bratton, S. C., Ceballos, P. L., Sheely-Moore, A. I., Meany-Walen, K., Pronchenko, Y., & Jones, L. D. (2013). Head start early mental health intervention: Effects of child-centered play therapy on disruptive behaviors. *International Journal of Play Therapy*, 22(1), 28-42. doi:10.1037/a0030318
- Bratton, S., & Ray, D. (2000). What the research shows about play therapy. *International Journal of Play Therapy*, 9(1), 47-88. doi:10.1037/h0089440

- Bratton, S. D., Ray, D., Rhine, T., & Jones, L. (2005). The efficacy of play therapy with children: A meta-analytic review of treatment outcomes. *Professional Psychology: Research and Practice*, 36(4), 376-390. doi: 10.1037/0735-7028.36.4.376.
- Brown, J. (2013). Counseling and psychotherapy in Australia: Championing the egalitarian society? In R. Moodley, U. P. Gielen, R. Wu (Eds.), *Handbook of counseling and psychotherapy in an international context* (pp. 171-181). New York, NY: Routledge/Taylor & Francis Group.
- Burgess, P. M., Pirkis, J. E., Slade, T. N., Johnston, A. K., Meadows, G. N., & Gunn, J. M. (2009). Service use for mental health problems: Findings from the 2007 National Survey of Mental Health and Wellbeing. *Australian & New Zealand Journal of Psychiatry*, 43(7), 615-623. doi:10.1080/00048670902970858
- Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2nd ed.). Hillsdale, NJ: Lawrence Erlbaum Associates.
- Dahlitz, M. J., & Rossouw, P. J. (2014). The consistency-theoretical model of mental functioning: Towards a refined perspective. In Rossouw, P. J. (Ed.), *Neuropsychotherapy: Theoretical underpinnings and clinical applications*. Brisbane, Queensland, AU: Mediros Pty Ltd.
- Eickelkamp, U. (2008). (Re)presenting experience: A comparison of Australian Aboriginal children's sand play in two settings. *International Journal of Applied Psychoanalytic Studies*, 5(1), 23-50. doi:10.1002/aps.136
- Fiorentine, R. (2001). Counseling frequency and the effectiveness of outpatient drug treatment: Revisiting the conclusion that "more is better". *American Journal of*

- Drug and Alcohol Abuse*, 27(4), 617–631.
- Fiorentine, R. & Anglin, M. D. (1996). More is better: Counseling participation and the effectiveness of outpatient drug treatment. *Journal of Substance Abuse Treatment*, 13, 341–348.
- Garza, Y., & Bratton, S. (2005). School-based child centered play therapy with Hispanic children: Outcomes and cultural considerations. *International Journal of Play Therapy*, 14, 51–80.
- Grskovic, J. A., & Goetze, H. (2008). Short-term filial therapy with German mothers: Findings from a controlled study. *International Journal of Play Therapy*, 17(1), 39-51. doi:10.1037/1555-6824.17.1.39
- Hayes, L. (2007). Problem behaviours in early primary school children: Australian normative data using the Strengths and Difficulties Questionnaire. *Australian & New Zealand Journal of Psychiatry*, 41(3), 231-238.
- Jones, E., & Landreth, G. (2002). The efficacy of intensive individual play therapy for chronically ill children. *International Journal of Play Therapy*, 11(1), 117–140.
- Kaduson, H., & Schaefer, C. E. (2006). *Short-term play therapy for children*. (2nd ed.). Guilford Publications.
- Kot, S., Landreth, G. L., & Giordano, M. (1998). Intensive child-centered play therapy with child witnesses of domestic violence. *International Journal Of Play Therapy*, 7(2), 17-36. doi:10.1037/h0089421
- Landreth, G. L. (2002). *Play therapy: The art of relationship* (2nd ed.). New York, NY: Routledge/Taylor & Francis Group.
- Landreth, G. L. (2012). *Play therapy: The art of relationship* (3rd ed.). New York, NY:

Routledge/Taylor & Francis Group.

Lin, Y., and Bratton, S. C. (2015), A meta-analytic review of child-centered play therapy approaches. *Journal of Counseling & Development*, 93: 45–58.

doi: 10.1002/j.1556-6676.2015.00180.x

Moustakas, C. (1959). *Psychotherapy with children*. New York: Harper and Brothers.

Muro, J., Ray, D., Schottelkorb, A., Smith, M., & Blanco, P. (2006). Quantitative analysis of long-term play therapy. *International Journal of Play Therapy*, 15, 35–58.

Nordling, W., & Guerney, L. (1999). Typical stages in child-centered play therapy. *Journal for the Professional Counselor*, 14, 17-23.

Pallant, J. (2013). *SPSS survival manual: A step by step guide to data analysis using IBM SPSS* (5th ed.). Berkshire, England, McGraw-Hill.

Peterson, J., & Flanders, J. (2005). Play and the regulation of aggression. In R. Tremblay, W. Hartup, & J. Archer (Eds.), *Developmental origins of aggression* (pp. 133-157). New York: Guilford Press.

Piaget, J., & Inhelder, B. (1996/1969). *The psychology of the child*. New York, NY: Basic Books.

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

Ray, D. C., Armstrong, S. A., Balkin, R. S. and Jayne, K. M. (2015), Child-centered play therapy in the schools: Review and meta-analysis. *Psychology in the Schools*, 52: 107–123. doi: 10.1002/pits.21798

Ray, D. C., Blanco, P. J. Sullivan, J. M., Holliman, R. (2009). An exploratory study of

- child centered play therapy with aggressive children. *International Journal of Play Therapy*, 18(3), 162-175. doi:10.1037/a0014742
- Ray, D., Bratton, S., Rhine, T. & Jones, L. (2001). The effectiveness of play therapy: Responding to the critics. *International Journal of Play Therapy*, 10(1), 85-108. doi:10.1037/h0089444
- Ray, D. C., Henson, R. K., Schottelkorb, A. A., Brown, A., & Muro, J. (2008). Effect of short- and long-term play therapy services on teacher-child relationship stress. *Psychology in the Schools*, 45(10), 994-1009.
- Ray, D. C., Stulmaker, H. L., Lee, K. R., & Silverman, W. K. (2013). Child-centered play therapy and impairment: Exploring relationships and constructs. *International Journal of Play Therapy*, 22(1), 13-27. doi:10.1037/a0030403
- Rogers, C. R. (1951). *Client-centered therapy*. Boston, MA. Houghton Mifflin.
- Rogers, C. R. (1980). *A way of being*. Boston, MA. Houghton Mifflin.
- Rossouw, P. J. (2011). The triune brain: Implications for neuropsychotherapy. *Neuropsychotherapy*, 5, 2-3.
- Rossouw, P. J. (2012). Effective client focused interventions: The top-down and bottom-up discourse. *Neuropsychotherapy News*, 11, 2–4. Retrieved from <http://mediros.com.au/wp-content/uploads/2012/11/NPTIG-Newsletter-11.pdf>
- Schaefer, C., Landreth G., and Pehrsson, D. E. (n.d.). Play therapy makes a difference. *Association for Play Therapy*. Retrieved from <http://www.a4pt.org/?page=PTMakesADifference>
- Schnyder, U. (2009). Future perspectives in psychotherapy. *European Archives and Psychiatry and Clinical and Clinical Neuroscience*, 259 (Suppl.2), 123-128.

- Schofield, M. J. (2013). Counseling in Australia: Past, present, and future. *Journal of Counseling & Development, 91*(2), 234-239. doi:10.1002/j.1556-6676.2013.00090.x
- Schumann, B. (2010). Effectiveness of child-centered play therapy for children referred for aggression. In J. N. Baggerly, D. C. Ray, S. C. Bratton (Eds.). *Child-centered play therapy research: The evidence base for effective practice* (pp. 193-208). Hoboken, NJ: John Wiley & Sons Inc.
- Shen, Y. (2002). Short-term group play therapy with Chinese earthquake victims: Effects on anxiety, depression and adjustment. *International Journal of Play Therapy, 11*(1), 43-63. doi:10.1037/h0088856
- Siegel, D. J. (2010). *The mindful therapist: A clinician's guide to mindsight and neural integration*. New York: W.W. Norton & Company.
- Tyndall-Lind, A., & Landreth, G. L. (2001). Intensive short-term group play therapy. In G. L. Landreth (Ed.), *Innovations in play therapy: Issues, process, and special populations* (pp. 203-215). New York, NY: Brunner-Routledge.

Table 1

Mean Scores on Externalizing Behaviors by Therapist Country of Origin

<u>Externalizing</u>	<u>American (n = 6*)</u>		<u>Australian (n = 6*)</u>	
	M	SD	M	SD
Pretest	73.50	6.53	70.00	4.05
Posttest	68.83	8.51	58.17	8.93
Follow up	62.50	12.40	57.67	10.38

Note: A decrease in mean scores indicates an improvement in behavior. *Number of children receiving play therapy facilitated by a therapist from this country.

Table 2

Mean Scores on Externalizing Problems Scales and Subscales on the CBCL and TRF.

<u>CBCL Externalizing</u>	<u>Intensive CCPT Group (n=12)</u>		<u>Control Group (n = 12)</u>	
	M	SD	M	SD
Pretest	71.75	5.50	67.00	6.14
Posttest	63.50	10.01	65.08	7.34
Follow up	60.08	11.09	67.50	7.00
<u>CBCL Aggressive</u>	M	SD	M	SD
Pretest	74.67	9.20	66.42	8.90
Posttest	64.92	10.344	65.02	8.59
Follow up	61.67	9.60	67.58	8.94
<u>CBCL Rule-Breaking</u>	M	SD	M	SD
Pretest	68.50	6.74	66.25	6.54
Posttest	61.25	9.08	64.25	8.77
Follow up	60.50	9.04	65.42	8.40
<u>TRF Externalizing</u>	<u>Intensive CCPT Group (n=12)</u>		<u>Control Group (n = 12)</u>	
	M	SD	M	SD
Pretest	66.42	10.62	61.50	9.38
Posttest	59.08	10.35	58.17	9.37
Follow up	60.01	11.19	67.30	6.90
<u>TRF Aggressive</u>	M	SD	M	SD
Pretest	67.08	12.61	60.25	7.25
Posttest	60.25	7.25	59.08	7.30
Follow up	59.00	8.22	61.42	5.94
<u>TRF Rule-Breaking</u>	M	SD	M	SD
Pretest	64.92	8.99	62.33	7.58
Posttest	58.50	8.71	60.17	8.33
Follow up	58.92	8.99	59.83	8.57

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

Table 3

ANOVAs for Externalizing, Aggressive, and Rule-Breaking on the CBCL and TRF.

Source	df	SS	MS	F	p	η^2
CBCL Externalizing Problems						
Group	1	36.125	36.125	.215	.647	.022
Time	2	458.111	229.056	15.204	<.001*	.286
Group*Time	2	444.333	222.167	14.747	<.001*	.277
Within Cells	44	662.889	15.066			
Total	49	1601.458				
CBCL Aggressive Problems						
Group	1	12.500	12.500	.055	.816	.006
Time	2	541.083	270.542	16.423	<.001*	.287
Group*Time	2	606.083	303.042	18.396	<.001*	.322
Within Cells	44	724.833	16.473			
Total	49	1884.499				
CBCL Rule-Breaking Problems						
Group	1	64.222	64.222	.363	.553	.061
Time	2	327.528	163.764	14.374	<.001*	.310
Group*Time	2	165.194	82.597	7.250	.002*	.157
Within Cells	44	501.278	11.393			
Total	49	1058.222				
Source	df	SS	MS	F	p	η^2
TRF Externalizing Problems						
Group	1	5.014	5.014	.030	.864	.001
Time	2	441.333	220.667	3.754	.031*	.126
Group*Time	2	475.111	237.556	4.042	.024*	.135
Within Cells	44	2586.222	58.778			
Total	49	3507.680				
TRF Aggressive Problems						
Group	1	29.389	29.389	.170	.685	.022
Time	2	342.694	171.347	9.958	<.001*	.264
Group*Time	2	168.861	84.431	4.907	.012*	.130
Within Cells	44	757.111	17.207			
Total	49	1298.055				
TRF Rule-Breaking Problems						
Group	1	3.553	3.553	.000	1.0	.004
Time	2	291.861	145.931	11.554	<.001*	.320
Group*Time	2	61.750	30.875	2.445	.098	.068
Within Cells	44	555.722	12.630			
Total	49	912.886				

*Statistically significant at $p < .05$.

APPENDIX A
EXTENDED LITERATURE REVIEW

The majority of counseling services are delivered once a week (Seligman & Reichenberg, 2013). Brief therapy has been defined in the literature as the process of therapy conducted and completed in about 10 to 15 sessions (Kaduson & Schaefer, 2006). Intensive therapy has been described in the literature as increased frequency of therapy, thorough and vigorous, concentrated into a short amount of time (Jones & Landreth, 2002; Kot, Landreth, & Giordano, 1998; Smith & Landreth, 2003; Tyndall-Lind & Landreth, 2001; Tyndall-Lind, Landreth, & Giordano, 2001). In this appendix, literature addressing the topics of Child Centered Play Therapy (CCPT), and weekly and intensive delivery of CCPT will be presented. Because the recruitment and intervention of this study took place in Australia, Australian studies using CCPT and other counseling modalities will be presented. Externalized behaviors will then be addressed in detail, followed with a discussion on the delivery of short-term and intensive CCPT with externalized behaviors.

Play Therapy

On their website, the Association for Play Therapy (APT) defines play therapy as “the systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development” (Schaefer, Landreth, & Pehrsson, 2014; para. 6). As a therapeutic modality, play therapists respond to the individual needs and developmental level of children using play, their natural language (Axline, 1969; Ray, 2011). Numerous studies have been completed and demonstrate the effectiveness of play therapy (Blanco & Ray, 2011; Bratton & Ray, 2000; Bratton, Ray, Rhine and Jones, 2005; Landreth, 2012). Leblanc

and Ritchie (2001) conducted a meta-analysis of play therapy outcomes with children and demonstrated the overall effectiveness of play therapy and the variables related to effectiveness. The data was analyzed and demonstrated an average treatment effect of 0.66 standard deviations. A strong relationship between treatment effectiveness and parental involvement in the therapeutic process was also reported. The authors stated play therapy appeared to be as effective as non-play therapies in treating children experiencing emotional difficulties and recommended future research focus on explaining therapeutic or participant characteristics that are related to treatment effectiveness.

With an emphasis on the effectiveness of play therapy with specific presenting issues and populations, Bratton and Ray (2000) completed a comprehensive literature review of 82 play therapy research studies from 1942 to 2000. The authors included studies only if they clearly identified at least one treatment as consisting of a play therapy intervention and employed pre and post measures. Their analysis found positive outcomes in the areas of self-concept, behavioral adjustment, social skills, emotional adjustment, intelligence, and anxiety/fear, demonstrating that play therapy has been proven as an effective modality to treat children with such problems.

Following the recommendations by Leblanc and Ritchie (2001) and their extensive literature review in 2000, Bratton et al., (2005) conducted a meta-analysis of 93 play therapy outcome studies and further demonstrated the value of play therapy. The outcome of their meta-analysis demonstrated children with various presenting problems, including externalizing behaviors, and at varying ages, functioned better after

receiving play therapy with humanistic nondirective approaches, such as CCPT, yielding significantly larger treatment effects compared to non-humanistic directive approaches.

CCPT

CCPT is a developmentally appropriate intervention utilizing play, the natural language of children, to offer a therapeutic relationship evident through responding with empathy, setting limits, returning responsibility to the child, and facilitating emotional expression (Axline, 1969; Landreth, 2012; Ray, 2011; Schottelkorb, Swan, Garcia, Gale, Bradley, 2014). Landreth (2002) described CCPT as:

... a dynamic interpersonal relationship between a child (or person of any age) and a therapist trained in play therapy procedure who provides selected play material 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. (p.16)

Landreth also stated that CCPT is a complete therapeutic system, describing it as more than just the application of a few rapport-building techniques, and that CCPT is rooted in the belief in the capacity and resiliency of children to self-direct constructively.

CCPT originated from the philosophy of Carl Rogers' person-centered therapy (1951). According to Rogers (1980), individuals innately have the internal resources they need for growth and to reach their potential. He viewed individuals as the best authority on their experiences and fully capable of fulfilling their own potential for growth when presented with a facilitative environment (Rogers, 1951). Moreover, he stated

that under adverse conditions, individuals will not grow and develop in healthy ways (Rogers, 1951, 1980).

Rogers stated if the following six conditions are present and continue over a period of time, these conditions are sufficient for constructive personality change to occur.

1. Two persons are in psychological contact.
2. The first, whom we shall term the client, is in a state of incongruence, being vulnerable or anxious.
3. The second person, whom we shall term the therapist, is congruent or integrated in the relationship.
4. The therapist experiences unconditional positive regard for the client.
5. The therapist experiences an empathic understanding of the client's internal frame of reference and endeavors to communicate this experience to the client.
6. The communication to the client of the therapist's empathic understanding and unconditional positive regard is to a minimal degree achieved.

(Rogers, 1989, p. 221)

Conditions three through five pertain to therapists' attitudes and responsibilities. Condition three states therapists must be congruent. According to Rogers, to be congruent and to offer congruence means therapists are authentic and genuine (1951). Clients do not have to speculate about what their therapist is really like outside of session. Therapists do not present any type of professional façade; instead, they are present and therapeutically transparent with their clients (Rogers, 1980).

Condition four refers to therapists providing unconditional positive regard, and means that therapists accept clients unconditionally and completely without any judgment (Rogers, 1951). Clients are free to explore all thoughts and feelings, positive or negative, without danger of rejection or condemnation. Therefore, clients are free to explore and to express themselves without having to do anything in particular or meet any particular standard of behavior to earn positive regard from their therapist.

The fifth condition is empathic understanding (Rogers, 1989). To offer empathetic understanding means therapists fully attempt to accurately understand their clients' thoughts, feelings, and meanings from their clients' point of views (Freire & Grafanaki, 2013). Therapists must assume their clients' frame of reference, truly attempting to see the world from their perspective (Heppner, Rogers, & Lee, 1984). When therapists perceive what the world is like from their clients' point of views, therapists demonstrate not only that their clients' views have value, but also demonstrate that they are being accepted unconditionally. Finally, condition six states if therapists' empathic understanding and unconditional positive regard is communicated to clients, at least minimally, then clients *will* experience therapeutic change (Rogers, 1961).

Similar to person-centered therapy, the core belief in CCPT is that all children possess an innate tendency to self-actualize, which instinctively moves them toward growth. In CCPT, the therapist facilitates this innate tendency in children by offering the core conditions of empathy, genuineness, and unconditional positive regard (Axline, 1969; Landreth, 2012). Virginia Axline (1969), a student of Rogers, developed nondirective play therapy by applying Rogers' principles of person-centered therapy to

her work with children. Others expanded Axline's model of nondirective play therapy (Ginott, 1961; B. Guerney, 1964; L. Guerney, 1983, Landreth, 2002; Moustakas, 1959). Nondirective play therapy has also been called client-centered play therapy (Ginsberg, 1984; Guerney, 1983), person-centered play therapy (Goetze, 1976, 1984), humanistic play therapy (Bratton & Ray, 2002), and child-centered play therapy (Landreth, 2002; Ray, 2011).

Children are typically limited in their abilities to engage in mature abstract reasoning and thinking until approximately 11 years of age; instead, they are more concrete in their understanding of their worlds (Piaget, 1951; Ray, 2011). Therefore, the vast majority of young children are limited in their abilities to fully express themselves verbally, especially when attempting to communicate their emotions (Ray, 2011). Proponents of CCPT propose that play is the most developmentally appropriate medium of self-expression and the most essential activity of childhood (Landreth, 2012; Ray). Ray explained that developmental research demonstrates that children are not just having fun in their play; their play allows them to experience, explore, and gain awareness of their internal and external worlds. Play also allows children to make connections with people and their environment. Landreth reported that play also serves a cathartic function. Different than adults, who are able to use verbal expression to communicate their emotions, children play out their emotions, needs, and difficulties. Toys become children's words, and play becomes their language (Axline, 1969; Landreth, 2012). According to Ray et al. (2013a) and Ray (2011), therapists carefully select toys in a playroom to match the developmentally appropriate communication style

of children that is play, therefore communicating to the child that the therapist seeks to fully appreciate and comprehend the child in the context of his or her world.

Axline (1969) advocated eight principles to guide play therapists in developing a therapeutic relationship and facilitating a safe environment for children. These principles include the following:

1. The therapist must develop a warm and friendly relationship with the child.
2. The therapist accepts the child as he/she is.
3. The therapist develops a feeling of permissiveness so that the child feels free to express feelings completely.
4. The therapist recognizes and reflects feelings (of the 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 with the child.
6. The therapist does not attempt to direct the child; instead, lets the child lead the way and the therapist follows.
7. The therapist understands that therapy is a gradual process and does not attempt to 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)

CCPT therapists emphasize the greatest importance of the therapeutic relationship (Landreth, 2012; Ray, 2011). Both Landreth and Ray expressed a belief in children's innate tendency towards growth and their capacity for self-realization as a

central component of CCPT. Through understanding and accepting children's perceptions of their world, the play therapist facilitates a therapeutic relationship and offers children a freeing environment that releases their potential to move toward self-actualizing and self-enhancing ways of being (Landreth, 2012). Landreth (2002) described this self-actualization as an active process in which children continually interact with the world and move toward becoming a fully functioning individual through continual growth.

In summary, the assumption of CCPT is that children will change and grow under favorable conditions and CCPT aims to facilitate growth and change through offering a therapeutic relationship (Landreth, 2002). Studies demonstrate that when children are provided with intense levels of relational support, they will respond with intense levels of change (Landreth, 2012).

Neuroscience Support for CCPT

According to Dahlitz (2013), neuroscience research has increasingly informed the field of psychotherapy over the past couple of decades. Examining neuroscience to establish empirical grounds for effective psychotherapy, such as CCPT, has been labeled *social neuroscience* (Cacioppo, Visser, & Pickett, 2006), *brain-based therapy* (Arden & Linford, 2009), and *interpersonal neurobiology* (Siegel, 2010). Therapeutic relationships formed within the context of CCPT provide children with safe and caring environments characterized by unconditional acceptance (Landreth, 2012). Badenoch and Kestly (2014) stated the field of neuroscience supports the safety emphasized in child-therapist relationships in play therapy. Children are freed through the experience

of these relationships, enabling them to move towards growth (Axline, 1969; Landreth, 2012).

Badenoch (2008; 2011), Siegel (2010), and Rossouw (2014) describe the human brain as a system of complex interconnected neural networks. These networks are intricately responsive to an individual's social environment, so that repeated and intense experiences continually create opportunity for health and growth (Rossouw 2011, 2012; Siegel). CCPT, especially intensive CCPT, may give children an opportunity for repeated and intense experiences.

Siegel and Bryson (2011) explained that the *integration* of the numerous parts of the brain is vital to the development of emotional well-being and mental health. According to Siegel (2010), integration is defined as the linking of differentiated components of a system, and in an individual's mind, integration involves linking separate parts of mental processes, such as thoughts with feelings. Therapists who facilitate the integration process, verbally and nonverbally, in ways that take into account their logical, linear left brain and their creative, emotional right brain create an environment that fosters growth and mental health because integration strengthens the connection between the two sides of the brain (Siegel, 2010, 2012a, 2012b). Because the brain exists in relation to its environment, the child-therapist relationship between a skilled and empathic CCPT therapist who fosters a sense of safety in the playroom, can allow the child opportunities of new ways of responding to life experiences.

Similar to Siegel (2010), Rossouw (2014) described replication, consistency, and congruence as important constructs in effective psychotherapy, and as neural underpinings for an application of psychotherapy as established by contemporary

neuroscience. Rossouw's research described that new, intense and/or repeated experiences create and strengthen new neural pathways that facilitate alternate patterns of behaviors, thoughts and feelings. Rossouw's research, like Siegel's, appears to support the use of intensive CCPT.

CCPT Session Structure

According to Landreth (2012), CCPT is typically delivered once a week. The majority of play therapy studies explore the effectiveness of play therapy in a once-a-week format (Baggerly & Jenkins, 2009; Fall, Navelski, & Welch, 2002; Garza & Bratton, 2005; Schumann, 2010). In these studies, play therapy is delivered to children one time a week for 45 minutes. Muro, Ray, Schottelkorb, Smith, and Blanco's (2006) quantitative analysis of frequency long-term play therapy utilized weekly sessions to measure problematic behaviors reported by teachers. Their study revealed a large effect size indicating practical significance regarding effectiveness. After reviewing both short and long term studies regarding play therapy effectiveness, Muro et al. reported studies that provided over 10 sessions appeared to result in more frequent statistically significant findings and stronger positive effects.

Although CCPT is typically delivered once weekly, Landreth (2012) expressed that the frequency of play therapy is often scheduled to meet the needs of counselors, rather than the emotional needs of the children who might feel a week between sessions is too long. Nordling and Guernsey (1999) compared a twice-weekly session structure with a once-weekly session structure in order to examine the typical stages in CCPT. They concluded that the twice-weekly session frequency, as opposed to the more common once per week model replicated the progress made in the same number

of sessions delivered weekly. Nordling and Guerney's study further demonstrated that intense levels of therapeutic relational support allow children to respond with intense levels of change.

Ray, Henson, Schottelkorb, Brown, and Muro (2008) explored the effect of both short- and long-term CCPT on teacher–student relationship stress. Teachers identified 58 students exhibiting emotional and behavioral difficulties who were randomly assigned to one of two treatment groups. Children in the short-term intensive play therapy group participated in twice-weekly play therapy over eight weeks, and the children in the long-term play therapy group participated in 16 sessions over 16 weeks. The results demonstrated that both groups showed significant improvement in teacher–student relationship stress from pre to posttest. According to Ray et al. (2008), the results of post hoc analyses showed the short term intensive intervention demonstrated larger effect sizes when compared to the long-term experimental group in overall total stress, teacher characteristics, and student characteristics, showing the effectiveness of short term CCPT.

Furthermore, Landreth (2012) suggested there are times when the play therapist should consider intensive play therapy, that is, increasing the frequency of services in the same or shorter amount of time as typically delivered. Landreth also stated that intensive play therapy should be considered when a child experiences crisis or trauma like a death in the family, sexual or physical abuse, being attacked by an animal, or in a major car accident. Landreth also suggested that in some cases of psychic trauma, which is an emotional and distressful situation such as abuse, play therapists should consider scheduling play therapy five or six times a week for the first couple of weeks to

allow opportunity for intense level of change, reiterating Nordling and Guernsey's (1999) suggestions.

Landreth (2002, 2012) described several effective variations of modalities of CCPT used in the Center for Play Therapy at the University of North Texas. One such modality described was the delivery of play therapy for three 30-minute sessions for three days to carefully selected children who did not demonstrate significant problems (Landreth, 2012). According to Landreth, the children took a 30-minute break in the waiting area between sessions. Similar to Nordling and Guernsey (1999), Landreth noted an interesting observation was that the play therapy process of the children in this intensive modality appeared similar to the traditional once a week format. Importantly, Landreth stated that the third session in the intensive format seemed similar to what typically occurs in a third session on the third week in the traditional format.

Jones and Landreth (2002) examined the effectiveness of CCPT in an intensive format, 12 sessions within three weeks, with children diagnosed with insulin-dependent diabetes, compared to children who did not receive CCPT. The authors investigated the effects of intensive CCPT on anxiety, depression, behavior problems, and overall adjustment to diabetes. The authors expressed that intensive play therapy was chosen because it provided both psychological and practical benefits for children because a format that allows children to experience the dynamics present in play therapy on a daily basis allows for the opportunity for concentrated and intensive intrapersonal change. The outcome of the study also demonstrated significant effectiveness of the treatment on anxiety and depression; however, no statistical difference between the experimental group and the control group concerning behavior problems. Still, the

results demonstrated that an intensive format was effective in diabetes treatment compliance. The experimental group showed a significant increase ($p < .05$) in diabetes adaptation as indicated by the posttest scores.

Kot, Landreth, and Giordano (1998) examined the effectiveness of intensive CCPT with 22 children, aged 4 to 10 years, who witnessed domestic violence. CCPT was delivered to the experimental group daily for two weeks in a shelter environment, while the control group received no services for the duration of the treatment phase. Analyses of covariance indicated that children in the experimental group experienced a significant increase in self-concept, significant decrease in external and total behavior problems, significant increase in the play behavior of physical proximity to the therapist, and significant increase in the play behavior of nurturing and creative play themes. The outcome of the study resulted in support for utilizing intensive play therapy to treat child witnesses of domestic violence.

Tyndall-Lind and Landreth (2001) and Landreth (2012) stated that when a child has experienced a crisis or trauma, play therapists should consider intensive play therapy two or three times a week for the first couple of weeks in order to facilitate the opportunity for concentrated and focused intrapersonal change. Tyndall-Lind and Landreth investigated intensive sibling group play therapy and intensive individual play therapy with children who witnessed domestic violence. The results demonstrated the treatment group displayed a significant reduction in total behavior problems, externalizing and internalizing behavior problems, aggression, anxiety, and depression, and a significant improvement in self-esteem. The results demonstrated that intensive

sibling group play therapy was found equally effective as intensive individual play therapy with children who have witnessed domestic violence.

Shen (2002) investigated the effectiveness of intensive short-term child-centered group play therapy in elementary school settings with 30 Chinese children in Taiwan who experienced an earthquake in 1999. Shen used a pretest-posttest control group design, with the experimental group receiving the intervention and the control group receiving no treatment. Each group met two to three times per week and received ten 40-minute group play therapy sessions during a four-week span of time. Children in the experimental group scored significantly lower on anxiety level and suicide risk after play therapy compared to children in the control group. The author concluded that the study demonstrated child-centered group play therapy could be effective in anxiety reduction in an intensive model.

Overall, research supports the use of intensive format of CCPT in settings where children are readily available for treatment. Schools, summer camps, shelters, crisis environments are settings where children can access services throughout the day. The use of CCPT intensive structure in settings such as private practice and regular education schools has yet to be explored.

Externalizing Behaviors in Australia

According to the Australian Institute of Health and Welfare (AIHW; 2012), there were approximately 45,000 reported cases of behavioral and emotional problems among children ages birth to 14 years old. The AIHW also reported that about 2.5% of the total child population reported long-term conditions of psychological disabilities between 2007-2008. According to the Australian Bureau of Statistics (ABS; 2006), in

2004-05, 7% of people aged birth to 17 years reported mental or behavioral problems. In 2004-05, problems of psychological development (2.8%) and emotional and behavioral problems with usual onset in childhood/adolescence (3.0%) were most prevalent among those aged birth to 17 years.

According to the findings from the 2007 National Survey of Mental Health and Wellbeing, Australians, in general, do not utilize mental health support (Burgess, 2009). Education about the benefits of counseling is spreading and more Australians are considering using mental health services (Schofield, 2013). Research supporting the effectiveness of counseling is on the rise (Hayes, 2007).

Hayes (2007) examined normative and clinical levels of externalizing problem behaviors from a large community sample ($n = 1928$ ages 5 to 10 years) of Australian early primary school children. The results showed mean scores on total difficulties between this Australian sample and United Kingdom norms were comparable. Australian teacher reports of problem behaviors revealed lower clinical levels of emotional problems, stating that boys had significantly greater problems than girls on the Conduct, Hyperactivity, Peer and Prosocial scales. Overall, 5.3% of boys had scores in the clinical range on four of the five subscales. Comparisons of the factor structure revealed that for boys the Peer scale has two interpretations, with conduct problems associated with greater problem behaviors. For girls, conduct problems were more strongly associated with poorer pro-social skills. Hayes reported the present data is representative of the Australian community and should be used to assess behavior difficulties in early primary school children. Future studies, such as this present study with CCPT delivered in an intensive structure with a similar population, should be

considered to treat children with externalizing problem behaviors in the Australian community.

Externalizing Behaviors and CCPT

CCPT has been effective in treating problematic externalizing behaviors (Bratton & Ray, 2000; Bratton et al., 2013; Bratton et al., 2005). In CCPT, the therapist's task is to provide a safe therapeutic environment where children are able to explore feelings, behaviors, and consider other ways of being (Landreth, 2012). Play therapy authorities have emphasized that the relationship between therapist and child is of utmost importance for children to heal and grow (Axline, 1969; Landreth, 2012; Moustakas, 1959). The therapeutic relationship is essential in that it assures emotional and physical safety as children explore their behaviors, such as aggressiveness and rule breaking. Therapists must be able to first accept children's need to be disruptive because the children may feel as though therapists want to change them. In CCPT, a safe and unconditionally accepting environment and relationship is provided for children to be free to accept themselves (Landreth, 2002). Axline (1969) stressed that therapists should facilitate the expression of all feelings experienced by a child. Therapists' complete acceptance of children's inner feelings, combined with the appropriate reflections of these feelings, facilitates the clarification of feelings and externalizing behaviors for children and insight into their own behavior.

Children exhibiting aggressive problem behaviors typically reach a peak of aggressive acts at an early age, providing evidence that early intervention for aggression is needed (Peterson & Flanders, 2005). In their quasi-experimental study, Ray, Blanco, Sullivan, and Holliman (2009) demonstrated that CCPT was effective in

treating externalizing behaviors in a twice-weekly format. Forty-one elementary school age children were assigned to a CCPT condition or a waitlist control group condition. Nineteen students were assigned to the CCPT group, which consisted of 14 sessions of play therapy scheduled over 7 weeks. Each student received 2 sessions per week of 30-min individual CCPT sessions. The researchers reported that children who participated in 14 sessions of CCPT showed a moderate decrease in aggressive behaviors compared to children in the control group. The results demonstrated that children assigned to CCPT intervention demonstrated statistically significant decreases in aggressive behaviors and children assigned to control group demonstrated no statistically significant difference. However, one limitation of this study was a lack of randomization in assignment of experimental groups.

Garza and Bratton (2005) investigated effects of twice-weekly CCPT on elementary aged Hispanic children exhibiting externalized behavioral problems compared to children randomly assigned to an active curriculum-based control group with the same twice-weekly schedule. Participants were ages 5 to 11 years. The results indicated that children who received CCPT sessions demonstrated statistically significant decreases in externalizing behaviors problems compared to the active control group. The authors concluded the data seemed to indicate that school-based child-centered play therapy is as effective at improving the behaviors of aggressive children and the results of their study demonstrated that CCPT should be considered for treatment of children with externalizing problems.

Schumann (2010) conducted her study on the effectiveness of once-weekly CCPT with children who exhibited aggressive behaviors. Participants were age 5 to 12,

kindergarten to fourth grade, and identified as aggressive. Schumann compared the randomly assigned treatment group, children who received 20 weekly sessions of CCPT, with an active control group of 17 children who participated in an evidence-based violence prevention guidance program. Results demonstrated that both groups showed a statistically significant decrease in aggression behaviors among participants. The results supported CCPT as an effective treatment to treat externalizing problem behaviors such as aggression. The author concluded that the data seems to indicate that school-based child-centered play therapy is effective at improving the behaviors of aggressive children.

Bratton et al. (2013) examined the effectiveness of CCPT with 54 low-income preschool children with externalizing problem behaviors. Children assigned to the experimental group ($n = 27$) received twice weekly, 30-min CCPT sessions for a total of 17 to 21 sessions. Children were assigned to the experimental treatment, CCPT, or to the active control group, reading mentoring. Results from the study demonstrated a statistically significant decrease in externalizing behaviors compared with the control group across 3 points of measurement. According to Bratton et al., children moved from clinical levels of behavioral concern at pretest to normative levels of functioning after treatment. Bratton et al. concluded the outcome of this study demonstrated the effectiveness of CCPT as a important treatment option for children with externalizing behaviors.

Conclusion

Intensive play therapy provides both emotional and practical benefits for children (Landreth, 2002). Past intensive play therapy interventions were based on the premise

that concentrated therapeutic experiences would provide the opportunity for more immediate and long-lasting intrapersonal change (Jones & Landreth, 2002). An intensive format that allows children to experience the dynamics present in CCPT on a twice-daily basis allows for the opportunity for focused change, such as a decrease in externalizing problem behaviors. Although a twice-daily format may not be feasible for all settings, providing intensive play therapy as a part of the regime during summer camps, domestic violence, homeless shelters, and some school settings may be both a practical and creative option to facilitate an intensive therapeutic relationship, and therefore, facilitate intensive growth and change.

APPENDIX B
EXTENDED METHODOLOGY

Introduction

The purpose of this study was to explore the effectiveness of CCPT in a brief and intensive structure, specifically the impact of intensive CCPT on reduction of externalizing problem behaviors of children. Through experimental design, I examined the effect of CCPT delivered in a very brief but intensive format on reducing problematic externalizing behaviors. In this appendix, I discuss my methodological approach to the study. I also describe the procedures I followed, including selection of participants, data collection, and data analysis. I conclude with an acknowledgment of possible limitations.

Research Question

The current study is based on the following research question: What impact does intensive short-term Child Centered Play Therapy have on reduction of externalizing problem behaviors of children identified as disruptive?

Definition of Terms

Child Centered Play Therapy (CCPT): Play Therapy is a developmentally appropriate modality of therapy wherein trained play therapists use the therapeutic powers of play to help children prevent or resolve psychosocial problems and attain optimal development and growth (Landreth, 2012; Ray, 2011). According to Landreth, CCPT is a therapeutic approach for children ages 3–12 that emphasizes the importance of the therapeutic relationship. Landreth and Ray both stated that CCPT is based on the person-centered philosophy of Carl Rogers. Similar to Roger's person-centered theory, the therapeutic relationship is believed to foster children's healthy cognitive, emotional, and social development (Axline, 1969; Landreth, 2012). Like Rogers (1951),

child-centered play therapists utilize unconditional positive regard, empathy, and congruence to create an environment to allow growth and change. For the purposes of this study, CCPT will be operationalized through implementation of the CCPT manualized approach as described in Ray (2011).

Disruptive behaviors: Disruptive behaviors are outward manifestations of internal problems, including aggressive behaviors, conduct problems, rule-breaking behaviors, oppositional behaviors, inattention, hyperactivity, immaturity, and attention seeking (Achenbach & Rescorla, 2001). Disruptive behaviors are actions that violate social norms and are disruptive, and/or violate expected behavior from caregivers or other authority figures in a child's life. For the purposes of this study, disruptive behaviors were operationalized through borderline/clinical scores on the Externalizing Problems subscale of the Child Behavior Checklist (Achenbach & Rescorla, 2001).

Externalizing behaviors: Similar to disruptive behaviors, externalizing behaviors are actions directed out toward others. Externalized behaviors include aggression, hyperactivity, and conduct problems. Behaviors include conflict with other people, particularly behaviors that do not meet adult expectations. For the purposes of this study, externalizing behaviors were operationalized through borderline/clinical scores on the Externalizing Problems domain of the Child Behavior Checklist (Achenbach & Rescorla, 2001)

Intensity: The term intensity has been used in the literature to describe the frequency and duration of counseling services (Fiorentine, 2001; Jones & Carnes-Holt, 2010; Kot, Landreth, & Giordano, 1998). For this present study, the term intensity referred to the frequency and duration of services delivered, not the characteristic of

services rendered. Specifically, the delivery of CCPT in this study was concentrated into two 30-minute sessions per day, delivered within a ten-day period, totally 20 sessions.

Participants

A priori power analysis using G*Power software determined that a minimum sample of 28 participants would be necessary to find a statistical difference between groups over time (pre to post to follow up). G*Power calculation was based on alpha level .05, minimum power established at .80, and a moderate treatment effect size ($f = .30$) based on Cohen's (1988) guidelines. There were 25 total participants: 13 in the experiential group and 12 in the control group. One child did not complete the intervention due to illness; therefore, 24 total participants completed the study. The sample consisted of 18 boys and 6 girls between the ages of 6 and 9 years old ($M = 7$) in the Darwin, Northern Territory, Australia area. Children were recruited from public schools in the urban Darwin area where the racial composition consists of Australian Caucasian (31%), English (27%), Irish (9%), Scottish (7%), Chinese (5%), German (4%), Filipino (4%), other (13%), and Australian Aboriginals make up about 2% of the population (Australian Bureau of Statistics, 2011).

Table B.1

<i>Demographics of Child Participants</i>			
		Intensive CCPT Group (<i>n</i> = 12)	Waitlist Control Group (<i>n</i> = 12)
Gender	Male	9	9
	Female	3	3
Age	Six	4	4
	Seven	4	4
	Eight	3	3
	Nine	1	1
Race/Ethnicity			
	Australian Caucasian	8	9
	English (UK) Caucasian	1	0
	Asian	1	0
	Hispanic/Latino	1	2
	Biracial	1	1

In order to participate in this study, children had to meet the following criteria: a) were between the ages of 6 and 9 years old; b) described as demonstrating high levels of problematic externalizing behaviors by one or more caregivers; c) identified as having borderline or clinical levels of externalizing behaviors according to the CBCL or TRF assessment measure; d) spoke English; e) had parental or guardian consent; f) parent or guardian agreed to complete pre, post, and follow up assessments; g) child's teacher

agreed to complete pre, post, and follow assessments; h) child assented to participate; i) did not receive play therapy or other counseling services anywhere else during the duration on the study.

Instrumentation

Two instruments were used to measure outcome, the Child Behavior Checklist-Parent Version (CBCL) and the Teacher Report Form (TRF).

CBCL

The CBCL was used to measure Externalizing Behaviors. The CBCL (Achenbach & Rescorla, 2001) was administered to participants' caregivers. The CBCL for ages 6 to 18 years measured caregiver reports of a child's scores on externalizing behaviors. The CBCL is composed of 120 items. For each item, the caregiver chooses the best response from among three possibilities, 0 for not true, 1 for sometimes true, and 2 for very true. The items describe various problem behaviors displayed by their children, including externalizing behaviors such as excessive arguing and hitting others. The CBCL also includes several open-ended questions to allow respondents to report any observed behaviors. The CBCL requires approximately 20 minutes to complete and was scored with a computer software program designed to score the CBCL.

The CBCL is comprised of three scales measuring Internalizing, Externalizing, and Total Problems (Achenbach & Rescorla, 2001.) The CBCL ages 6 to 18 years version consists of eight syndrome subscales: (a) Anxious/Depressed, (b) Withdrawn, (c) Somatic Complaints, (d) Social Problems, (e) Thought Problems, (f) Attention Problems, (g) Rule Breaking Behavior, and (h) Aggressive Behavior. The syndrome subscales are categorized into two classifications, Internalizing Problems or

Externalizing Problems. According to Achenbach and Rescorla, Internalizing Problems refer to problems with the self and is measured through the following Internalizing Problem subscales: (a) Anxious/Depressed, (b) Withdrawn, and (c) Somatic Complaints. Achenbach and Rescorla refer to Externalizing Problems as a child's outwardly expressed behavior and the child's behavior conflicting with an adult's expectations. The two Externalizing Problems syndrome subscales for the 6 to 18 year old version are Rule-Breaking Behavior and Aggressive Behavior. The Social Problems, Thought Problems, and Attention Problems subscales are also included in the Total Problems score. The outcome measure used for this study was the Externalizing Problems subscale.

According to the manual, the normative population for the CBCL was based on a diverse sample, which included children referred for clinical and special education services, as well as children attending diverse childcare and school settings. The children of the normative sample were residents of the United States, Canada, Australia, and Jamaica (2001). The test-retest reliability of the CBCL is strong ($r = .85$). The test-retest reliability coefficients for the syndrome subscales of the CBCL are: (a) Anxious/Depressed, $r = .68$; (b) Withdrawn, $r = .80$; (c) Somatic Complaints, $r = .84$; (d) Attention Problems, $r = .78$; (e) Rule Breaking Behavior, $r = .85$; (f) Aggressive Behavior, $r = .87$; (g) Internalizing Problems, $r = .90$; (h) Externalizing, $r = .87$; and (g) Total Problems, $r = .85$ (Achenbach & Rescorla, 2001). The content validity of the problems scales is strong and supported by research. Achenbach and Rescorla reported that the criterion-related validity of the problem scales has been supported by the instrument's capability to differentiate between referred and non-referred children.

TRF

The TRF was used to measure Externalizing Behaviors and was administered to the study participants' teachers. The TRF is a teacher report instrument used to assess children's academic performance, adaptive functioning, and behavioral and emotional functioning (Achenbach & Rescorla, 2001). The TRF form is for use with children between the ages 6 and 18 years. It is a self-administered instrument and takes approximately 20 minutes to complete. The instrument requires teachers to rate each student's academic performance and behavior compared to other children in the class on a 118-problem item form. The student's behavior is rated on a three-point scale of 0 to 2 indicating: not true = 0, sometimes true = 1, or very true = 2.

The TRF provides adaptive scores, problem scores, and Diagnostic and Statistical Manual of Mental Disorders (DSM) -oriented scores (Achenbach & Rescorla, 2001). The authors reported the normative sample of TRF was based upon teachers' reports of 4,437 non-referred children aged 6 to 18 years residing in 40 states of the United States and the District of Columbia. The TRF provides two broad scores for internalizing behavior and externalizing behavior. Three specific scores fall within the internalizing behavior domain: (a) Anxious, (b) Withdrawn-Depressed, and (c) Somatic Complaints. The two subscales of the externalizing domain are Rule Breaking Behavior and Aggressive Behavior (Achenbach & Rescorla).

Achenbach and Rescorla (2001) reported adequate internal consistency for the TRF as follows: (a) an alpha of .90 on the TRF Total Adaptive scale; (b) alphas .72 to .95 for the Problem scores; and alphas ranging from .73 to .94 for the DSM-oriented scores. The authors reported the test-retest reliability for the TRF was high, and scaled

scores were stable. The TRF content, criterion-related and construct validity is strongly supported by research (Achenbach & Rescorla, 2001).

Procedures

This study was conducted in collaboration with an international team of play therapists. Primary researchers included three play therapists who were citizens of Australia and 4 play therapists who were citizens of the US. US researchers communicated with Australian researchers to plan and implement CCPT intervention research in Australia. I served as the lead researcher for the project. The data opportunity was due to an internship program being offered at a university in the US for students to gain experience in conducting play therapy internationally. Because the recruitment and data collection was in Australia, an Australian play therapist communicated and aided in the coordination of recruitment of participants. Also, a local university offered support by means of providing training facilities and logistical support pre/during/post intervention phase, including providing services for the control group post follow-up phase.

Human subjects approval was attained through the University of North Texas. Participants were recruited through local primary (elementary) schools in the Darwin, Northern Territory, Australia area through a flyer distributed to the caregivers of each child via email and hardcopy. Each school also attached the flyer to their weekly bulletin that was emailed and/or mailed to students' homes. Principals, teachers, local clinics, and private practices also referred children to the study. Upon demonstrating interest in participation, a key member of the research team communicated with the parent or guardian of each potential participant to explain study procedures.

Parents/guardians completed the CBCL, and teachers completed the TRF, for participating children prior to the study and for screening and pretest purposes.

Interested parents/guardians were administered the CBCL using the assessment author's encrypted and confidential Achenbach System of Empirically Based Assessment (ASEBA) Web-Link as a pretest measure. Web-Link fulfills Health Information Protection and Accountability Act (HIPAA) requirements through several security measures (Achenbach, 2010). Encryption of data and password protection is utilized to physically and electronically secure electronic "protected health information" against unauthorized retrieval, to reliably store electronic data, and provide for emergency access to the data. Also, all identifying data stored in Web-Link are encrypted using private key technology.

Parents/guardians and teachers were offered to remotely complete their respective assessments from their home, work, child's school using a school computer, or at a key research member's private practice using her computer. The ASEBA Web-Link immediately scored the assessments and a key member of the research team informed the parent of their child's inclusion of the study if their scores demonstrated a Borderline and Critical score on the Externalizing Problems Domain on either or both the CBCL or TRF. Parents/guardians of children who did not qualify were also immediately notified and offered referrals to local play therapists. Participants who qualified were randomly assigned using a random table of numbers to either the play therapy treatment group or waitlist control group.

Local key members of the research team were available during the collection of pretest and follow up data collection to answer any questions and assure integrity of

procedures. I was accessible through email and phone during the initial data collection phase (recruitment and pretest), and during the follow up assessment phase. I was present for the treatment and posttest phases to answer questions and ensure integrity of data collection. Also, demographic data reported on the CBCL was collected and examined using SPSS. The US team of play therapists arrived in Australia to assist in delivering CCPT protocol.

Upon completion of the CCPT protocol, at the end of the ten day period, parents of children in the intervention and control groups completed a CBCL posttest. Teachers were also asked to complete a post-TRF at the end of the CCPT protocol. In order to assess post-therapy effectiveness, parents and teachers of all participating children completed a CBCL or TRF one week after the posttest.

Parents and teachers who requested information regarding their child's progress were immediately referred to the lead researcher. Logistical, general study, and play therapy information was given; however, specific individual progress was not given to protect the fidelity of the study. At the end of the follow up assessment phase, the lead researcher communicated with interested parents and teachers to discuss their child's progress and to offer additional resources, such as individual play therapy to a local play therapist.

Experimental Group

CCPT therapists incorporate play as children's developmentally appropriate and natural form of self-expression. Landreth stated that CCPT is a dynamic interpersonal relationship between a child and therapist (2002). In this study, CCPT principles and procedures provided the framework for conceptualization and practice and were

delivered to participants in the treatment group. CCPT was conducted at four different locations. One location was provided at a private practice, and three locations were provided at local primary schools. Each location provided an unoccupied room that allowed for uninterrupted daily use throughout the duration of the intervention. The first week of the intervention was conducted during the week of a school semester break, and the second week was conducted during the first week after classes resumed. The treatment group received CCPT in an intensive structure.

CCPT intensive structure included two sessions daily for ten days. Adjustments were made to allot for varying school/class schedules, clean up between sessions, and number of children in the treatment group at each location. During the first week, Monday through Friday, sessions were scheduled to allow for three to three and one half hours between the twice-daily sessions. During the second week, due to unforeseen scheduling conflicts within the schools, sessions were modified to allow between thirty minutes and three hours between sessions. See Table B.2 for the schedule of sessions during the first week for all locations.

Table B.2

Week One All Locations and Therapist Schedule

Time	Rm1	Rm2	Rm3	Time	Rm4 (PP)
8:30-9:00 AM	CL1 TH1	CL3 TH3	CL5 TH4	8:30-9:00 AM	CL7 TH5
9:15-9:45 AM	CL2 TH2	CL4 TH3	CL6 TH4	9:05-9:35 AM	CL8 TH6
				9:40-10:10 AM	CL9 TH7
				10:15-10:45 AM	CL10 TH5
				11:25-11:55 AM	CL11 TH7
				12:00-12:30 PM	CL12 TH6
12:15-12:45 PM		CL3 TH3	CL5 TH4	12:35-1:05 PM	CL7 TH5
12:45-1:15 PM	CL1 TH1	CL4 TH3	CL6 TH4	1:10-1:40 PM	CL8 TH6
1:00-1:30 PM	CL2 TH2			1:45-2:15 PM	CL9 TH7
				2:20-2:50 PM	CL10 TH5
				3:20-3:40 PM	CL11 TH7
				3:45-4:15 PM	CL12 TH6

Note. Rm = Room; CL = Client; TH = Therapist; PP = Private Practice.

The twice-daily sessions were originally scheduled to have approximately three hours between them for the duration of the intervention. However, due to varying school activities and parent reported logistical concerns at the private practice during the second week, I needed to modify the schedule to maintain participant retention. Sessions in the schools were rescheduled to have two, three, or three and a half hours between them. See Table B.3 for the schedule of sessions during the second week for the school locations.

Table B.3

Week Two School Locations and Therapist Schedule

Time	Rm1	Rm2	Rm3
8:30-9:00 AM	CL1 TH1	CL3 TH3	
9:15-9:45 AM		CL4 TH3	
10:00-10:30 AM	CL2 TH2		CL5 TH4 CL6 TH4
11:15-11:45 AM		CL3 TH3	
12:00-12:30 PM		CL4 TH3	CL5 TH4
12:45-1:15 PM	CL1 TH1		CL6 TH4
1:30-2:00 PM	CL2 TH2		

Note. Rm = room; CL = Client; TH = Therapist.

Due to scheduling needs of participants, I set up a fifth room, arranged similar to the fourth room, utilizing a second room at the private practice location. One participant was scheduled with 35 minutes between their two daily sessions. Three participants had 40 minutes between their two daily sessions. One participant had two hours and 40 minutes between their sessions. Participants who had less than one hour between their sessions were instructed to leave the building, take a walk and/or have a snack between their sessions to allow the participants an opportunity to disengage from their first session before beginning their second session. See Table B.4 for the schedule of sessions during the second week for the private practice location.

Table B.4

Week Two Private Practice Rooms and Therapist Schedule

Time	Rm4	Rm5
8:30-9:00 AM	CL7 TH5	
9:40-10:10 AM	CL7 TH5	
12:35-1:05 PM	CL12 TH6	
1:25-1:55 PM	CL11 TH7	
2:35-3:05 PM	CL11 TH7	
3:10-3:40 PM		CL10 TH5
3:45-4:15 PM	CL12 TH6	
4:20-4:50 PM		CL10 TH5
4:55-5:25 PM	CL8 TH6	
5:25-5:55 PM		CL9 TH7
6:00-6:30 PM	CL8 TH6	
6:35-7:05 PM		CL9 TH7

Note. Rm = room; CL = Client; TH = Therapist.

Landreth (2012) stated therapists should select specific toys to allow for children in play therapy to express themselves, and each room was set up according to these criteria. The following three categories of toys were provided in each playroom: (a) Real-Life toys to directly represent the real-world, such as doll families, dollhouse, puppets, cars, boats, airplanes, cash register, and play money; (b) Aggressive-Release toys, such as the bop bag, toy soldiers, rubber knives, and toy guns, and items that can be broken or destroyed such as egg cartoons, for the release of emotions that are typically not allowed to be expressed in other settings; and (c) Creative Expression toys, such as paints, butcher paper and an easel, crayons, sand, water, and instruments, to allow for creativity (Landreth, 2002).

Therapists in this study incorporated both nonverbal and verbal skills identified by Ray (2011). The nonverbal skills included maintaining an open posture and leaning forward, appearing interested in the child, appearing comfortable and relaxed, matching the child's affect through rate of speech and tone, and conveying a sense of genuineness by matching affect and words when communicating to the child. The therapists in this study used reflective responses such as: (a) personalizing responses at an appropriate rate of response, matching the energy level of the child; (b) tracking the child's play behavior; (c) reflecting content; (d) reflecting feelings; (e) facilitate decision-making and returning responsibility; (f) using self-esteem building responses; and (g) incorporating relationship facilitating responses (Landreth, 2012).

There were seven play therapists conducting CCPT in the study, four who were trained and lived in the southwest region of the United States, and three who were trained and lived in the Northern Territory of Australia. All therapists had successfully completed an Introduction to Play Therapy course. Also, each therapist had completed at least one other play therapy workshop training such as Family Play Therapy or Child Parent Relationship Training from a Registered Play Therapist-Supervisor. See Table B.5 for supervisor and therapist demographic information.

There was a one-day training for cultural sensitivity and to standardize the delivery of CCPT among the play therapists before the intervention began. The one-day training consisted learning differences between American English and Australian English, such as "mom" in American English and "mum" in Australian English. The basic tenets of CCPT were also reviewed then practiced with children while being observed by a Registered Play Therapist or Registered Play Therapist Supervisor to

ensure the integrity of delivery of CCPT. During the treatment phase, all play therapists received one hour of triadic supervision, and two 30-minute individual supervision sessions per week by a Registered Play Therapist or a Registered Play Therapist Supervisor, as certified by the Association for Play Therapy (APT) or Australasia Pacific Play Therapy Association (AAPTA).

Table B.5

Demographics of Therapists and Supervisors

	Play Therapists (<i>n</i> = 7)	Supervisors (<i>n</i> = 3)
Gender		
Male	0	0
Female	7	3
Race/Ethnicity		
Australian Caucasian	2	1
English (UK) Caucasian	1	0
American (US) Caucasian	4	1
Pacific Islander	0	1
Age		
24-30	4	1
31-35	0	0
36-40	1	1
41-45	1	1
45+	1	0

Treatment fidelity refers to the methodological strategies used to monitor and enhance the reliability and validity of an intervention (Creswell, 2014). To achieve optimal treatment fidelity, each session was video-recorded. CCPT protocol adherence was assessed through fidelity checks of video-recorded sessions utilizing the Play Therapy Skills Checklist (PTSC; Ray, 2011). Five sessions per counselor were randomly selected and reviewed in its entirety by a University of North Texas doctoral student trained in CCPT. Sessions adhered to CCPT protocol over 90% of the time with an average of 95.89% adherence to protocol per session.

Waitlist Control Group

The waitlist control group received no treatment during the intervention phase and resumed their typical daily schedules as usual. After completion of the intervention phase (2 weeks from pretest), the parents/guardians and teachers of the control group were administered a CBCL and TRF posttest. Following one week post-protocol, parents and teachers completed a follow-up CBCL or TRF. Control group children were then offered play therapy services in the form of modified filial services with at least one individual observation of parent and child, or individual play therapy services in a clinic located at CDU.

Data Analysis

For each dependent variable (teacher and parent report on Externalizing Problems), a two by two split plot ANOVA was performed in SPSS to analyze group differences, changes in time, and possible interaction effect. The independent variable was type of group, intervention or control, and the dependent variable consisted of pre and posttest Externalizing Problems scores on the CBCL/TRF. In the analysis,

the experimental group served as the between-subjects variable and time (pretest to posttest to follow up) served as the within-subjects variable (Pallant, 2013). Data met assumptions of normality. Following analysis, I interpreted the results according to statistical significance, practical significance, and clinical significance. Statistical significance was interpreted according to .05 alpha level. Eta squared (η^2) effect sizes were calculated to assess the magnitude of difference between the two groups over time due to treatment. In the interpretation of η^2 , the guidelines used were .01 equals a small effect, .06 equals a moderate effect, and .14 equals a large effect (Sink & Stroh, 2006). Clinical significance was determined according to the percentage of participants who moved from clinical range for problem behaviors to normal range. It was decided that if analyses of externalizing scores yielded significant effects with meaningful effect sizes, I would explore pre-post data for the subscales making up the externalizing score (i.e., Aggressive and Rule-Breaking).

APPENDIX C
UNABRIDGED RESULTS

Results

The following results are intended to answer the following research question:
What impact does intensive short-term Child Centered Play Therapy have on reduction of externalizing problem behaviors of children identified as disruptive?

A two-factor repeated measures spilt plot ANOVA was performed in SPSS for each dependent variable (Externalizing Problems score on parent and teacher report) to determine whether the Intensive CCPT and the wait list control groups performed differently across three points of time (pretest, posttest, and follow up). The assumptions of random sampling, independence of observations, homogeneity of variance, normal distribution, homogeneity of intercorrelations, and sphericity were all analyzed and reasonably met.

The CBCL and TRF were administered prior to treatment, immediately after treatment, and one week after treatment to assess treatment effects on externalizing behaviors. A reduction in scores on the dependent variables indicated an improvement in the targeted behavior. Statistical significance was interpreted according to .05 alpha level, and η^2 was calculated to determine practical significance (small effect = .01; moderate effect = .06; .14 = large effect; Cohen, 1988).

In order to address potential effects of cultural differences regarding the delivery of play therapy by both Australian and US therapists with children who were native to Australia, an analysis was conducted to determine if there was a difference between American play therapists and Australian play therapists on Externalizing Problems over time. Out of the 12 children in the intervention group, American therapists saw six children, and Australian therapists saw six children. Table C.1 presents the pretest,

posttest, and follow up means and standard deviations for the American play therapists ($n = 4$) and Australian play therapists ($n = 3$) on the dependent variable, Externalizing Behavior.

Table C.1

<i>Mean Scores on Externalizing Behaviors by Therapist Country of Origin</i>				
<u>Externalizing</u>	<u>American ($n = 6^*$)</u>		<u>Australian ($n = 6^*$)</u>	
	M	SD	M	SD
Pretest	73.50	6.53	70.00	4.05
Posttest	68.83	8.51	58.17	8.93
Follow up	62.50	12.40	57.67	10.38

Note: A decrease in mean scores indicates an improvement in behavior. *Number of children receiving play therapy facilitated by a therapist from this country.

Results of the analysis revealed no statistically significant difference between American and Australian therapists, $F(2, 10) = 1.865$, $p = .18$, $\eta^2 < .001$, indicating a small effect size. These results indicate that according to scores for Externalizing Behaviors on the CBCL, there was no difference between children of therapists who were trained and lived in America compared to therapists who were trained and lived in Australia. Hence, results of all analyses can be interpreted with limited concern related to differences between therapists. However, due to low number of participants included in the analysis, results should be interpreted with caution.

CBCL Results

Externalizing Problems

Children in the treatment group demonstrated a statistically significant decrease in scores on Externalizing Problems as compared to children in the waitlist control group over time, as reported by the parents/guardians on the CBCL. Table C.2 presents the

pretest, posttest, and follow up means and standard deviations for the treatment group ($n = 12$) and waitlist control group ($n = 12$) on the Externalizing Problems scales on the CBCL.

Table C.2

Mean Scores on Externalizing Problems Scale on the CBCL.

<u>Externalizing</u>	<u>Intensive CCPT Group ($n = 12$)</u>		<u>Control Group ($n = 12$)</u>	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Pretest	71.75	5.50	67.00	6.14
Posttest	63.50	10.01	65.08	7.34
Follow up	60.08	11.09	67.50	7.00

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

Results of the analysis of the dependent variable Externalizing Problems on the CBCL revealed a statistically significant interaction effect between treatment group and time, $F(2, 44) = 14.747$, $p < .001$, with a large effect size of $\eta^2 = .277$. There was also a statistically significant effect for time, $F(2, 44) = 15.204$, $p < .001$, $\eta^2 = .286$. The main effect for group was not statistically significant, $F(1, 44) = .215$, $p = .647$, $\eta^2 = .022$.

Table C.3 presents a summary of the mixed between-within ANOVA results for Externalizing Problems on the CBCL.

Table C.3

Summary for Mixed Between-Within ANOVA for CBCL Externalizing Problems.

<u>Source</u>	<u>df</u>	<u>SS</u>	<u>MS</u>	<u>F</u>	<u>P</u>	<u>η^2</u>
Group	1	36.125	36.125	.215	.647	.022
Time	2	458.111	229.056	15.204	<.001*	.286
Group*Time	2	444.333	222.167	14.747	<.001*	.277
Within Cells	44	662.889	15.066			

Total	49	1601.458
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*Statistically significant at $p < .05$.

Figure C.1 graphically displays the interaction effect of mean group differences for externalizing behavior overtime. Group 1 represents the treatment group and Group 2 represents the waitlist control group. The results indicate that according to the parents/guardians' reports, children who received intensive CCPT ($n = 12$) showed a reduction in externalizing behaviors over time, when compared to the children who received no treatment ($n = 12$). Specifically, the mean scores of the children in the intervention group decreased from pretest to posttest, and from posttest to follow up. The mean scores of children in the waitlist control group decreased slightly from pretest to posttest, then increased again from posttest to follow up. Because a statistical and practical effect was found for externalizing problems as reported by parents, I further explored the externalizing problems subscales.

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

Aggressive Behavior. Children in the treatment group demonstrated a statistically significant decrease in scores on the subscale Aggressive Behavior as compared to children in the waitlist control group over time, as reported by the parents/guardians on the CBCL. Table C.4 presents the pretest, posttest, and follow up means and standard deviations for the treatment group ($n = 12$) and waitlist control group ($n = 12$) on the Aggressive Behavior subscale of the CBCL.

Table C.4

Mean Scores on Aggressive Behavior Subscale on the CBCL.

<u>Aggressive</u>	<u>Intensive CCPT Group ($n=12$)</u>		<u>Control Group ($n = 12$)</u>	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Pretest	74.67	9.20	66.42	8.90
Posttest	64.92	10.344	65.02	8.59
Follow up	61.67	9.60	67.58	8.94

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

Results of the analysis of the dependent variable Aggressive Behavior on the CBCL revealed a statistically significant interaction effect between treatment group and time, $F(2, 44) = 18.396$, $p = < .001$, with a large effect size of $\eta^2 = .322$. There was also a statistically significant effect for time, $F(2, 44) = 16.423$, $p = < .001$, $\eta^2 = .287$. The main effect for group was not statistically significant, $F(1, 44) = .055$, $p = .816$, $\eta^2 = .006$. Table C.5 presents a summary of the mixed between-within ANOVA results for Aggressive Behavior on the CBCL.

Table C.5

Summary for Mixed Between-Within ANOVA for CBCL Aggressive Behavior

Source	df	SS	MS	F	p	η^2
Group	1	12.500	12.500	.055	.816	.006
Time	2	541.083	270.542	16.423	<.001*	.287
Group*Time	2	606.083	303.042	18.396	<.001*	.322
Within Cells	44	724.833	16.473			
Total	49	1884.499				

*Statistically significant at $p < .05$.

Figure C.2 graphically displays the interaction effect of mean group differences for Aggressive Behavior overtime. Group 1 represents the treatment group and Group 2 represents the waitlist control group.

Figure C.2. Estimated marginal means of Aggressive Behavior on CBCL for total group.

Rule-Breaking. Overtime, children in the treatment group demonstrated a statistically significant decrease in scores on the Rule-Breaking subscale compared to

children in the waitlist control group, as reported by the parents/guardians on the CBCL. Table C.6 presents the pretest, posttest, and follow up means and standard deviations for the Intensive CCPT group ($n = 12$) and waitlist control group ($n = 12$) on the Rule-Breaking subscales.

Table C.6

<i>Mean Scores on Rule-Breaking on the CBCL.</i>				
<u>Rule Breaking</u>	<u>Intensive CCPT Group ($n = 12$)</u>		<u>Control Group ($n = 12$)</u>	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Pretest	68.50	6.74	66.25	6.54
Posttest	61.25	9.08	64.25	8.77
Follow up	60.50	9.04	65.42	8.40

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

Results of the analysis of the dependent variable Rule-Breaking on the CBCL revealed a statistically significant interaction effect between treatment group and time, $F(2, 44) = 7.250$, $p = .002$, with a large effect size of $\eta^2 = .157$. There was also a statistically significant effect for time, $F(2, 44) = 14.374$, $p = < .001$, $\eta^2 = .310$. The main effect for group was not statistically significant, $F(1, 44) = .363$, $p = .553$, $\eta^2 = .061$.

Table C.7 presents a summary of the mixed between-within ANOVA results for Rule-Breaking on the CBCL.

Table C.7

Summary for Mixed Between-Within ANOVA for CBCL Rule-Breaking Behavior

Source	df	SS	MS	F	p	η^2
Group	1	64.222	64.222	.363	.553	.061
Time	2	327.528	163.764	14.374	<.001*	.310
Group*Time	2	165.194	82.597	7.250	.002*	.157
Within Cells	44	501.278	11.393			
Total	49	1058.222				

*Statistically significant at $p < .05$.

Figure C.3 graphically displays the interaction effect of mean group differences for Rule-Breaking overtime. Group 1 represents the treatment group and Group 2 represents the waitlist control group.

Figure C.3. Estimated marginal means of Rule-Breaking on CBCL for total group.

TRF Results

Externalizing Problems

Children in the treatment group demonstrated a statistically significant decrease in scores on Externalizing Problems as compared to children in the waitlist control group over time, as reported by the teachers on the TRF. Table C.8 presents the pretest, posttest, and follow up means and standard deviations for the treatment group ($n = 12$) and waitlist control group ($n = 12$) on the Externalizing Problems scales on the TRF.

Table C.8

Mean Scores on Externalizing Problems Scale on the TRF.

<u>Externalizing</u>	<u>Intensive CCPT Group ($n = 12$)</u>		<u>Control Group ($n = 12$)</u>	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Pretest	66.42	10.62	61.50	9.38
Posttest	59.08	10.35	58.17	9.37
Follow up	60.01	11.19	67.30	6.90

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

Results of the analysis of the dependent variable Externalizing Problems on the TRF revealed a statistically significant interaction effect between treatment group and time, $F(2, 44) = 4.042$, $p = .024$, with a large effect size of $\eta^2 = .135$. There was also a statistically significant effect for time, $F(2, 44) = 3.754$, $p = .031$, $\eta^2 = .126$. The main effect for group was not statistically significant, $F(1, 44) = .030$, $p = .864$, $\eta^2 = .001$. Table C.9 presents a summary of the mixed between-within ANOVA results for Externalizing Problems on the TRF.

Table C.9

Summary for Mixed Between-Within ANOVA for TRF Externalizing Problems.

Source	<i>df</i>	SS	MS	<i>F</i>	<i>p</i>	η^2
Group	1	5.014	5.014	.030	.864	.001
Time	2	441.333	220.667	3.754	.031*	.126
Group*Time	2	475.111	237.556	4.042	.024*	.135
Within Cells	44	2586.222	58.778			
Total	49	3507.680				

*Statistically significant at $p < .05$.

Figure C.4 graphically displays the interaction effect of mean group differences for externalizing behavior overtime. Group 1 represents the treatment group and Group 2 represents the waitlist control group. The results indicate that according to the teachers' reports, children who received intensive CCPT ($n = 12$) showed a reduction in externalizing behaviors over time, when compared to the children who received no treatment ($n = 12$). Specifically, the mean scores of the children in the intervention group decreased from pretest to posttest, and then increased slightly from posttest to follow up. The mean scores of children in the waitlist control group decreased from pretest to posttest, then increased from posttest to follow up. Because a statistical and practical effect was found for externalizing problems as reported by teachers, I further explored the externalizing problems subscales of the TRF.

Figure C.4. Estimated marginal means of Externalizing Problems on TRF for total group.

Aggressive Behavior. Children in the treatment group demonstrated a statistically significant decrease in scores on the subscale Aggressive Behavior as compared to children in the waitlist control group over time, as reported by the teachers on the TRF. Table C.10 presents the pretest, posttest, and follow up means and standard deviations for the treatment group ($n = 12$) and waitlist control group ($n = 12$) on the Aggressive Behavior subscale of the TRF.

Table C.10

Mean Scores on Aggressive Behavior Subscale on the TRF.

<u>Aggressive</u>	<u>Intensive CCPT Group (n=12)</u>		<u>Control Group (n = 12)</u>	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Pretest	67.08	12.61	60.25	7.25
Posttest	60.25	7.25	59.08	7.30
Follow up	59.00	8.22	61.42	5.94

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

Results of the analysis of the dependent variable Aggressive Behavior on the TRF revealed a statistically significant interaction effect between treatment group and time, $F(2, 44) = 4.907$, $p = .012$, with a large effect size of $\eta^2 = .130$. There was also a statistically significant effect for time, $F(2, 44) = 9.958$, $p < .001$, $\eta^2 = .264$. The main effect for group was not statistically significant, $F(1, 44) = .170$, $p = .685$, $\eta^2 = .022$.

Table C.11 presents a summary of the mixed between-within ANOVA results for Aggressive Behavior on the TRF.

Table C.11

Summary for Mixed Between-Within ANOVA for TRF Aggressive Behavior

<u>Source</u>	<u>df</u>	<u>SS</u>	<u>MS</u>	<u>F</u>	<u>p</u>	<u>η^2</u>
Group	1	29.389	29.389	.170	.685	.022
Time	2	342.694	171.347	9.958	<.001*	.264
Group*Time	2	168.861	84.431	4.907	.012*	.130
Within Cells	44	757.111	17.207			
Total	49	1298.055				

*Statistically significant at $p < .05$.

Figure C.5 graphically displays the interaction effect of mean group differences for Aggressive Behavior overtime. Group 1 represents the treatment group and Group 2 represents the waitlist control group.

Figure C.5. Estimated marginal means of Aggressive Behavior on TRF for total group.

Rule-Breaking. Children in the treatment group did not demonstrate a statistically significant decrease in scores on the Rule-Breaking subscale over time compared to children in the waitlist control group, as reported by the teachers on the TRF. Table C.12 presents the pretest, posttest, and follow up means and standard deviations for the Intensive TRF group ($n = 12$) and waitlist control group ($n = 12$) on the Rule Breaking subscales.

Table C.12

Mean Scores on Rule-Breaking on the TRF.

Rule Breaking	Intensive CCPT Group ($n=12$)		Control Group ($n=12$)	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Pretest	64.92	8.99	62.33	7.58
Posttest	58.50	8.71	60.17	8.33
Follow up	58.92	8.99	59.83	8.57

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

Results of the analysis of the dependent variable Rule-Breaking on the TRF did not show a statistically significant interaction effect between treatment group and time, $F(2, 44) = 2.445$, $p = .098$; however, there was a moderate effect size of $\eta^2 = .068$. There was a statistically significant effect for time, $F(2, 44) = 11.554$, $p < .001$, $\eta^2 = .320$. The main effect for group was not statistically significant, $F(1, 44) < .001$, $p = 1.000$, $\eta^2 = .004$. Table C.13 presents a summary of the mixed between-within ANOVA results for Rule-Breaking on the TRF.

Table C.13

Summary for Mixed Between-Within ANOVA for TRF Rule-Breaking Behavior.

Source	<i>df</i>	<i>SS</i>	<i>MS</i>	<i>F</i>	<i>p</i>	η^2
Group	1	3.553	3.553	.000	1.0	.004
Time	2	291.861	145.931	11.554	<.001*	.320
Group*Time	2	61.750	30.875	2.445	.098	.068
Within Cells	44	555.722	12.630			
Total	49	912.886				

*Statistically significant at $p < .05$.

Figure C.6 graphically displays the interaction effect of mean group differences for total Rule-Breaking behavior overtime on the TRF. Group 1 represents the group

that received treatment and Group 2 represents the group that did not receive treatment.

Figure C.6. Estimated marginal means of Rule-Breaking on TRF for total group.

Clinical Significance

Clinical significance refers to practical usefulness of treatment on client's functioning in real life (Kazdin, 2003). To determine if an intensive CCPT model positively impacted the children in the study at a clinically meaningful level, the number and percentage of children who moved from clinical or borderline level of behavioral problems to normal functioning were used as a marker of clinical significance of intensive CCPT on the children in the study (Kazdin, 2003). Using clinical/borderline cut off scores identified by the CBCL and TRF, individual participants who scored at clinical levels at pretest on the Externalizing Problems score were tracked for progress to determine movement toward nonclinical scores at posttest and follow up. According to

Achenbach and Rescola (2001), T scores below 60 are considered to be normal range, T scores of 60-63 are considered to be in the borderline range, and T scores at or above 64 are considered in the clinical range on the CBCL and TRF.

According to parent ratings for Externalizing Problems on the CBCL at pretest, 24 children (CCPT = 12 and waitlist control = 12) were identified in the borderline or clinical range. Of the 12 children in the intervention group, 11 scored in the clinical range and 1 scored in the borderline range. According to parent ratings for Externalizing Problems on the CBCL for the 12 children in the intervention at posttest, 5 scored in the clinical range, 3 scored in the borderline range, and 4 scored in the normal range. According to parent ratings for Externalizing Problems on the CBCL for the 12 children in the intervention at follow up, 5 scored in the clinical range, 2 scored in the borderline range, and 5 scored in the normal range. Therefore, of the 12 children in the intervention, 25% moved from clinical to borderline and 33% moved from clinical to normal functioning from pretest to posttest, with an average of an 8.25 decrease in score while 17% moved from clinical to borderline, and 42% moved from clinical to normative functioning at follow up, with an average of 11.66 decrease in score. Table C.14 presents a summary of the clinical significance on the CBCL.

Table C.14

Levels at Pre, Post, & Follow Up on the CBCL						
Intensive CCPT n=12			Waitlist Control (n = 12)			
	<u>Pretest</u>	<u>Posttest</u>	<u>Follow Up</u>	<u>Pretest</u>	<u>Posttest</u>	<u>Follow Up</u>
Externalizing						
Clinical	71.75			67.00	65.08	67.50
Borderline		63.50	60.08			
Normal						

Note: All scores are based upon mean T scores on CBCL.

According to teacher ratings for Externalizing Problems on the TRF, out of the 24 total study children, 16 were identified in the borderline or clinical range at pretest. Of those 16 children, eight were in the intervention group (seven scored in the clinical range and one scored in the borderline range). From pretest to posttest, two moved from clinical to normal functioning (25%) and one moved from clinical borderline (13%). From posttest to follow up, one moved from clinical to borderline (13%). From pretest to posttest, the average decrease was 8.13 points, and from posttest to follow up, the average decrease was 8.89 points. Table C.15 presents a summary of the clinical significance on the CBCL.

Table C.15

Levels at Pre, Post, & Follow Up on the TRF						
Externalizing	Intensive CCPT n=12			Waitlist Control (n = 12)		
	<u>Pretest</u>	<u>Posttest</u>	<u>Follow Up</u>	<u>Pretest</u>	<u>Posttest</u>	<u>Follow Up</u>
Clinical	66.42					67.50
Borderline			60.08	61.50		
Normal		59.08			58.17	

Note: All scores are based upon mean T scores on TRF.

APPENDIX D
EXTENDED DISCUSSION

Extended Discussion

This current study sought to determine the effectiveness of intensive CCPT with children who have been identified as having externalizing problem behaviors. Although there have been studies that explored and demonstrated the effectiveness of intensive play therapy, this current study was the first to explore the effectiveness of twice-daily CCPT sessions over the course of ten days, totaling 20 thirty-minute sessions. This study was the first collaborative study between the United States and Australia on CCPT. According to the Australian Play Therapists Association (APTA; 2012), play therapy is a relatively new field in Australia, and this collaborative study served to raise awareness of the benefits of play therapy among Australians. Results of this current study indicated intensive CCPT was an effective intervention in reducing problematic externalizing behaviors. Therefore, the results provide evidentiary support for the use of intensive CCPT with clinically externalizing children. Intensive CCPT appears to be an appropriate intervention to decrease externalizing behaviors in young children aged 6 to 9 years old and demonstrated that intensive CCPT was an effective modality cross-culturally.

Effectiveness of Intensive CCPT with Children with Externalizing Behaviors

The purpose of this study was to explore the effectiveness of CCPT in a brief and intensive structure in order to facilitate healthier functioning in a more intensive format compared to traditional weekly sessions. Building on previous research that indicated CCPT was effective in reducing problematic externalizing behaviors, such as verbal and physical aggression (Bratton et al., 2005), I examined the effect of CCPT delivered in an intensive format on reducing problematic externalizing behaviors. This section will

include a discussion of the results and the impact of intensive CCPT on reduction of externalizing problem behaviors of children identified as disruptive.

Over the course of this present study, the children who participated in the intensive CCPT group demonstrated statistically significant improvement compared to children who participated in the waitlist control group. Both parents/guardians and teachers reported a statistically significant decrease in externalizing behaviors compared to the waitlist control group. The statistical, practical, and clinical significance revealed for problematic externalizing behaviors demonstrates the level of effectiveness of intensive CCPT for young children who were identified as having externalizing problem behaviors. Mean differences on all subscales, except for Rule-Breaking on the TRF, indicated that children who participated in intensive CCPT demonstrated a trend of improvement while children in the waitlist control group demonstrated deterioration of symptoms. The small number of participants could be a reason for the lack of statistical significance on the Rule-Breaking subscale; however, there was a moderate interaction effect showing that it was practically effective.

The results of this study are consistent with other intensive play therapy studies that demonstrated improved effectiveness when increasing the number of counseling sessions in the same or less amount of time. Blanco and Ray (2011), Ray et al. (2008) and Shen (2002) demonstrated the effectiveness of brief and short-term CCPT, such as twice weekly within two to three months. Jones and Landreth (2002) demonstrated the effectiveness of 12 sessions within three weeks. Kot, Landreth, Giordano (1998), and Tyndall-Lind and Landreth (2001) demonstrated effectiveness with daily sessions within about two weeks.

According to Peterson & Flanders (2005), children exhibiting aggressive problem behaviors typically reach a peak of aggressive acts at an early age, providing evidence that early intervention for aggression is needed, such as intensive CCPT. Research indicates that direct, especially physical, aggression is more common in males compared to females, and that this is consistent across cultures, and occurs from early childhood on (Archer, 2004). This appears to explain the larger number of males (75%) referred to this current study compared to girls (25%). Parents of many of the boys referred for this current study reported behavioral issues such as fighting, destroying property, and breaking rules. Of the 25% of girls who qualified for this current study, the parents tended to report less physical aggression such as lying, sulking, and moodiness.

The results of this current study are consistent with other play therapy studies that demonstrated the effectiveness of CCPT as an effective treatment for children with externalizing problems (Bratton & Ray, 2000; Bratton et al., 2013; Bratton et al., 2005). Ray et al. (2009) demonstrated that CCPT was effective in treating externalizing behaviors in a twice-weekly format. Garza and Bratton's study demonstrated statistical significance in their twice-weekly CCPT study with elementary aged Hispanic children exhibiting externalized behavioral problems (2005). Schumann's (2010) study on once-weekly CCPT with children who exhibited aggressive behaviors demonstrated effectiveness. Bratton et al. (2013) examined the effectiveness of CCPT on preschool children with disruptive behaviors and the results demonstrated CCPT was an effective treatment. Consistent with the aforementioned studies, both play therapists and parents in this study conveyed they perceived notable decreases in observed externalizing

problem behavior. For example, the mother of a seven-year-old boy initially reported that her son demonstrated aggressive behavior at home and at school, hitting his siblings and peers when frustrated, and using defiant behavior leading to being sent home from school on several occasions. However, after the seventh session, which was first session on the fourth day of the study, the mother reported a notable decrease in aggressive behavior and stated that her son appeared happier and less defiant.

Therapeutic Relationship of CCPT and Externalizing Problem Behaviors

The favorable outcome of this current study demonstrated that the fundamental tenets of CCPT, rooted in the healing factor of the relationship between therapist and child, is effective in helping children with aggressive behavior. Therapists who utilize the core CCPT tenets (empathy, unconditional positive regard, and genuineness), offer children materials that allow for expression of aggressive feelings and behaviors (Landreth, 2012). In this current study, aggressive materials were offered in the playrooms to provide distance from difficult emotional problems in order for children to freely express their aggression (Ray, 2011). The intensive CCPT provided in this research offered materials traditionally labeled as aggressive, such as knives, guns, bop bags, handcuffs, and aggressive animals, along with other materials such as nurturing and realistic toys. In addition to the materials, the play therapists facilitated the child's freedom of expression of aggression and other emotions. Limits were also set to protect the child, play therapist, and the room and to structure the session.

Landreth (2012) stated the task of a child centered play therapist is to provide a safe therapeutic environment where children can explore feelings, behaviors, and consider other ways of being. The relationship between therapist and child in CCPT is

most important for children to heal and grow (Axline, 1969; Landreth, 2012; Moustakas, 1959). The therapeutic relationship is essential in that it assures emotional and physical safety as children explore their behaviors, such as aggressiveness and breaking rules. In CCPT, a safe and unconditionally accepting environment and relationship is provided for children to be free to accept themselves (Landreth, 2012). For example, one play therapist noted that her 6-year-old male client yelled, broke toys, and threw objects throughout the first 10 sessions. Using play therapy skills, such as reflecting feelings and limits, while offering unconditional acceptance and trusting the child's ability to resolve his problems and use effective coping skills, the therapist created an environment for the child to explore his frustrations. The play therapist reported that beginning on the 8th session, she began seeing a significant decrease in aggressive behaviors toward her (the play therapist) and more aggression toward the bop bag, such as punching and kicking. By the 12th session, the play therapist reported less aggressive behavior and more relationship play, such as creating artwork for the therapist. This example supports the effectiveness of when children are provided with intense levels of relational support, they will respond with intense levels of change.

Opponents of providing aggressive materials or allowing aggressive behaviors in the playroom report that creating an environment that permits aggressive play will lead to increased problematic aggressive behaviors (Drewes, 2008; Schaefer & Mattei, 2005). Social learning theory, according to some, demonstrates that children who are permitted to express aggressive behavior without negative consequences will show an increase of aggression because the aggressive behavior was reinforced. However, experts in development have decisively disagreed that social learning theory has been

supported in the literature regarding aggressive behavior (Archer & Cote, 2005).

Proponents of CCPT emphasize the presence of a play therapist who provides empathy as the fundamental component of the decrease in aggressive behaviors. This current study's results demonstrate that this philosophy allowed for improvement in aggressive behaviors outside of the playroom, both at home and at school.

Control Group Trends

Although the results of this study demonstrate that intensive CCPT was effective in the areas measured, except for the Rule-Breaking on the TRF, there was a noteworthy trend in the data for the waitlist control group. The data for the control group showed a trend of decreasing in externalizing behaviors from pretest to posttest, and then increasing in externalizing behaviors from the posttest to the follow up. The reason for this trend could be due to inconsistencies in the study participants' schedules. At pretest, students and teachers completed their third (of four) academic terms and then began a one-week holiday break. At posttest, the children and teachers had one week off, then returned to begin their fourth and final term of the school year. Due to difficulty adjusting to change, inconsistent schedules and routines can lead to behavior problems for many children, especially those who already have ineffective coping skills. The children in the intervention may have gained more effective coping skills and therefore continued to demonstrate progress. However, the children in the waitlist control group may have had difficulty adjusting to the change and therefore demonstrated increased levels of problematic behavior.

International Collaboration

This international collaborative study aimed to increase awareness of the benefits of mental health counseling in Australia, especially for young children. Burgess et al. (2009) reported that after reviewing the findings for the National Survey of Mental Health and Wellbeing in relation to the number of mental health problems reported, Australians do not appear to typically utilize mental health support. According to the AIHW (2012), there were approximately 45,000 reported cases of behavioral and emotional problems among children ages birth to 14 years old. The AIHW also reported that about 2.5% of the total child population reported long-term conditions of psychological disabilities between 2007-2008. According to ABS (2006), in 2004-05, 7% of people aged birth to 17 years reported mental or behavioral problems. In 2004-05, problems of psychological development (2.8%) and emotional and behavioral problems with usual onset in childhood/adolescence (3.0%) were most prevalent among those aged birth to 17 years.

Several researchers have investigated and reported the growing development of counseling and other mental health professions (Brown, 2013; Schofield, 2013). The AIHW and ABS statistics demonstrate the need to provide effective interventions earlier to Australian children, such as in primary schools, to help them gain effective coping skills and emotional regulation. Although there have been studies to explore the mental health needs in young children in Australia (Anticich, Barrett, Gillies, & Silverman, 2012; Eickelkamp, 2008; Hays, 2007), more studies, such as this current research, are needed to inform caregivers and educators of the unique developmental needs of children and how to meet them. This current study, along with the Australian play

therapy association's advocacy and training of play therapy, are important to increase developmentally appropriate services to children.

Cultural Definitions of Behavioral Problems

Cultural differences regarding how to define behavioral problems, such as externalizing behaviors, are similar in both Australia and the United States (Garcia, Akerman, & Cicchetti, 2000). Garcia et al. described differences between Western and Eastern cultures to be notable; however, Western cultures, such as Australia and the United States, to be minimal. For example, according to the Australian Institute of Family Studies' (2011) longitudinal study of Australian children, behavior problems are generally classified into two types, externalizing behaviors that are expressed outwardly and often impact upon others (i.e. over activity, temper tantrums, fighting, and disobedience), and internalizing behaviors that are inwardly expressed (i.e. worrying, fearfulness, and withdrawal). Connor, Steeber, and McBurnett (2010) described externalizing behaviors in Australia as aggressive, acting-out behaviors and hyperactive, and distractible behaviors. Consistent with the studies noted, both American and Australian play therapists in this study described problem externalizing behaviors similarly.

Although both American and Australian play therapists perceived and described externalizing behaviors in similar fashions, there were several notable cultural differences that may have affected the delivery of CCPT. For example, Australian English and American English have varying definitions for the same word, such as, children call their mother, "mum," and candy is called "lollies." When initially meeting their American play therapists, a few of the children in this present study stated, "You

talk funny!” However, the American English accent did not appear to interrupt the therapeutic process as the majority of words are the same and the children connected to their therapists, evidenced by the children’s and therapists’ reports. Some children expressed feeling sad that their American play therapists were leaving, similar to how the children expressed sadness to their sessions ending with their Australian play therapists.

To decrease cultural differences, before the intervention began, there was a one-day training with all the play therapists and supervisors to help increase awareness regarding cultural variations, as well as to decrease differences in the delivery of CCPT by reviewing the core concepts and skills of CCPT. During this training, the American play therapists practiced using CCPT skills in mock sessions with volunteer Australian children, and all the play therapists were observed to ensure the use of CCPT. In sum, the child-therapist relationship appeared similar in closeness and connection regardless of therapist’s country of origin.

Limitations

A major limitation of the current study was the small sample size recruited from a single geographical area; therefore, the results may not be generalizable to children living in other settings. A larger sample size selected from multiple regions would broaden the generalization of the results. Also, a small sample size leads to tentative conclusions regarding the overall data analysis. Another limitation is the lack of standardization of delivery regarding time between sessions. The initial design of the delivery of CCPT was to allow for 3 hours between each session to allow ample time for twice daily sessions to be two separate sessions. However, due to unexpected

scheduling issues within the school setting, time between sessions varied from week one to week two, as well as some children received services at different intervals compared to others. For example, some children had two hours between their sessions, and others had 30 minutes between sessions. Although expectations were that differences in delivery would negatively affect outcome, the results were clinically and practically effective. The outcome demonstrated that as long the children were able to receive the conditions of CCPT, the time periods between sessions did not affect the outcome.

Another limitation is that the repeated completion of the CBCL over short intervals can lead to test-retest attenuation effect (Achenbach & Rescorla, 2001). Test-retest attenuation effect could happen when the same individual takes the same assessment and there is a gradual loss in intensity when answering the same questions in a short amount of time, such as in the case of this present study. However, according to the Achenbach and Rescorla, the instrument used in this study remains sensitive to short intervals when using control groups that will receive the same or different assessment schedules but no intervention to control for such effects. Ideally, random assignment to experimental groups also controlled for test-retest attenuation effect by having the waitlist control group on the same assessment schedule as the intervention group.

Implications for Practice

The results of this study demonstrated that intensive CCPT is effective and therefore presents important implications for practice of CCPT. Practitioners should consider using intensive CCPT when working with children with externalizing behaviors

and when time and financial resources permit. However, there may be times when intensive CCPT is not practical. Some settings may not lend to such an intensive format. Some clinics or practices may not have the available space or therapists for twice-daily sessions. It also may not be practical for parents regarding the time commitment and finances. In this current study, some parents initially committed to the intensive format; however, after several days the schedule became problematic due to other obligations.

The children receiving the intervention in the school setting had an easier time attending the twice-daily sessions because they were readily available for the play therapists to pick up and then bring back to their class. However, the time between sessions became problematic during the second week due to an unforeseen scheduling conflict. The educational setting and administration in the Darwin, Northern Territory area of Australia tended to be open and flexible, which aided in the ability to rearrange schedules when needed. Schools with stricter scheduling policies, such as public schools in the US, may have a more difficult time scheduling twice-daily sessions. Schools with more flexible schedules, possibly private schools, summer camps, shelters, and crisis environments are settings where children can access services throughout the day and may allow for intensive CCPT.

There also appeared to be some practice implications for the training of play therapists due to their country of origin. Some of the US therapists had more standardized and formal training, but the Australian therapists had more clinical experience as they were already practicing clinicians who later decided to become play

therapists. However, the results of the study demonstrated that there was no statistical significant difference between US and Australian play therapists.

Implications for Research

Although this study demonstrated evidentiary support for effects of intensive CCPT on clinical levels of externalizing behaviors, further research in this area is needed in order to offer this intervention as an evidence-based modality for similar populations. It is important to conduct further studies with children identified as having externalizing behaviors to demonstrate that results can be replicated. Intensive CCPT research with other populations, such as children identified as anxious or depressed, should also be conducted to determine whether or not intensive CCPT is effective with different presenting concerns, and to provide more support for intensive CCPT. Research in other settings, such as private practice, crisis centers, hospitals, and camps, should also be explored to determine the practicality of intensive CCPT in the private sector. Once-daily sessions should also be explored to address practicality of intensive therapy. Lastly, more collaborative research should also be conducted between the US and Australia to continue to promote developmentally appropriate interventions to children, especially because play therapy is relatively new in Australia.

Conclusion

The outcome of this research showed intensive CCPT demonstrated a beneficial therapeutic effect on young children aged six to nine years old identified as having clinical levels of externalizing behaviors. Reports from both parents/guardians and teachers indicated they observed marked improvement in the externalizing problems of children who received intensive CCPT when compared to the waitlist control group.

The majority of the children receiving intensive CCPT moved from clinical levels of behavioral concerns to normal functioning, demonstrating the clinical use of intensive CCPT on daily functioning for young children.

A major strength of this study was that it was conducted in a school setting, adding to the relevance for this population and its potential for replication. Another strength is the researcher's use of three measures of assessment, pretest, posttest, and follow up. Few CCPT studies have used a follow up assessment to measure progress retention. Results of this study are promising, specifically in light of opportunities such as summer camps, schools, crisis centers, and other environments where children are readily accessible to provide intensive levels of CCPT to allow for intense levels of change.

APPENDIX E
ADDITIONAL MATERIALS

University of North Texas Institutional Review Board

Parent Informed Consent

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

Title of Study: Effectiveness of Child Centered Play Therapy in an Intensive Structure

Investigator: Rochelle Ritzi, MS, LPC, RPT, University of North Texas (UNT)
Department of Counseling and Higher Education. **Supervising Investigator:** Dee Ray, PhD., LPC-S, NCC.

Purpose of the Study:

You are being asked to allow your child to participate in a research study that involves determining the effectiveness of play therapy in a brief and intensive structure on children's disruptive behaviors, allowing children to gain healthy behaviors in a much shorter amount of time compared to what is traditionally offered.

Study Procedures:

Your child will be asked to participate in play therapy. Play therapy is a counseling intervention designed for children to express themselves in the developmentally appropriate way of playing with toys. Elementary-age children have difficulty working through problems with words, so play therapy facilitates the process by providing a play environment from which they can work through those issues that impede their academic progress. Your child decides what materials to play with and what to discuss in play therapy. Your child will not be asked invasive questions or forced to play. The play sessions will be video-recorded. The research team will observe the recordings to ensure the quality of play therapy services and the integrity of the study.

For this study, your child will be placed in one of two groups:

Group 1: Children will begin play therapy immediately and will receive two 30-min sessions (one in the morning and one in the afternoon) daily over the course of ten days within a two-week period.

OR

Group 2: Children will be placed on a wait list and will receive play therapy services at the completion on the intervention. These play therapy services will be in the form of an intervention in which a therapist trains parents to hold child-centered play sessions with their own children, with at least one individual observation of parent and child.

You will also be administered an assessment which requires approximately 20 minutes to complete. The assessment will be administered at three points in the study, beginning, end of the 10-day period, and 1 week after the 10-day period.

Foreseeable Risks:

There are no significant personal risks foreseen as likely from involvement in this study. Your child's participation is completely voluntary. You may withdraw your child at any time during the course of the study. However, possible risks may include one or more of the following:

1. Anything that is said or done during play therapy is considered confidential, meaning that the therapist will not reveal anything that happens in the session to another school official or adult. However, if your child discloses child abuse, neglect, exploitation or intent to harm another person, the therapist is required by law to report it to the appropriate authority.
2. When your child participates in play therapy, he or she will be pulled from another school activity upon the approval of the teachers. It is possible that your child might miss an academic or extracurricular experience. However, because your child's principal has agreed to their participation in this study, your child will not be placed at academic risk.
3. Because play therapy is a counseling method, your child will be expressing emotions that could be strong for him or her. The therapist will help your child talk through these emotions and will stop therapy if any harmful effects upon your child are noted. Harmful effects would include inability to maintain self-control or being in a distraught state of mind.

Benefits to the Subjects or Others:

We expect the project to benefit children by possibly decreasing disruptive behaviors. The results of this study may provide play therapists and counselors with knowledge that helps them improve child behavior so that children are happier and more successful at home and in school.

Compensation for Participants: Your child will not receive compensation for their participation in this study.

Procedures for Maintaining Confidentiality of Research Records:

All information will be kept confidential in a locked cabinet in the clinic of the Counseling Program at the University of North Texas. Names of parents and children will not be disclosed in any publication or discussion of this material. Information obtained from the instruments will be recorded with a code number. Only the research team will have a list of the participants' names. The play sessions will be video-recorded. The research team will observe the recordings to ensure the quality of the study. At the end of this study, the videos may possibly be shown in professional presentations for educational purposes. Identity information such as name, place of living, and other specific

information will not be revealed when videotapes are shown in educational settings. However, you may choose to withdraw your consent at any time and the video recordings of your child will not be used.

Questions about the Study

If you have any questions about the study, you may contact Dr. Dee Ray at (940) 565-2066 or Dee.ray@unt.edu. Dr. Ray is a professor at the University of North Texas in the Department of Counseling and Higher Education located in Denton, TX, United States.

Review for the Protection of Participants:

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

Research Participants' Rights:

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

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

Printed Name of Child

Printed Name of Parent or Guardian

Signature of Parent or Guardian

Date

Child Assent Form

You are invited to be part of a research project being done by the University of North Texas Department of Counseling and Higher Education.

This study involves looking at whether play therapy is helpful to you. Play therapy is a time when you will come to a playroom with a counselor who will invite you to play with the toys in lots of the ways you like. Sometimes for children it is hard to share feelings with words and it helps to play with toys to express how you feel.

You will be asked to come to play therapy two times a day, morning and afternoon, for ten days, or your parent might learn how to do play therapy with you at home.

If you decide to be a part of this study, please remember you can stop coming any time you want to and nothing bad will happen.

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

Printed Name of Child

Signature of Child

Date

Signature of Principal Investigator

Date

Waiver of Assent

The assent of _____(name of child) was waived due to:

_____ Age

_____ Maturity

_____ Psychological State

Signature of Parent/Guardian

Date

Assessment Instructions to Parents

The following instructions were given to parents immediately before they began each assessment (pre, post, and follow up).

Welcome (parent/guardian/teacher name):

Rochelle Ritzi has asked you to complete the on-line Child Behavior Checklist for (child name). If you are resuming your On-Line Entry session, the answers you gave previously will be displayed up to the point you exited. You can change these answers, or simply click the NEXT button to get to the screen where you left off.

A series of screens will display one or more questions about (child's name). Rochelle has asked that you answer all the questions in one setting; however, if you need to exit On-Line Entry before you have answered all the questions, click the SAVE button to store your responses.

All information you enter in On-Line Entry is completely secure. Only authorized staff for Rochelle will have access to the information you enter.

Child Behavior Checklist

Please complete this on-line form to reflect *your* view of (child's name)'s behavior in the past 7 days, even if other people might not agree. Feel free to add comments in the areas provided.

Assessment Instructions to Teachers

The following instructions were given to teachers immediately before they began each assessment (pre, post, and follow up).

Welcome (teacher's name):

Rochelle Ritzi has asked you to complete the on-line Teacher Report Form for (child name). If you are resuming you On-Line Entry session, the answers you gave previously will be displayed up to the point you exited. You can change these answers, or simply click the NEXT button to get to the screen where you left off.

A series of screens will display one or more questions about (child's name). Rochelle has asked that you answer all the questions in one setting; however, if you need to exit On-Line Entry before you have answered all the questions, click the SAVE button to store your responses.

All information you enter in On-Line Entry is completely secure. Only authorized staff for Rochelle will have access to the information you enter.

Teacher Report Form

Please complete this on-line form to reflect *your* view of (child's name)'s behavior in the past 7 days, even if other people might not agree. Feel free to add comments in the areas provided.

COMPREHENSIVE REFERENCE LIST

- Achenbach, T. M., & Rescorla, L. A. (2001). *Manual for the ASEBA school-age forms & profiles*. Burlington, VT: University of Vermont, Research Center for Children, Youth, & Families.
- Achenbach, T. M., & Rescorla, L. A. (2000). *Manual for the ASEBA preschool forms and profiles*. Burlington, VT: University of Vermont Department of Psychiatry.
- Allison, K. & Rossouw, P.J. (2013). The therapeutic alliance: Exploring the concept of “safety” from a neuropsychotherapeutic perspective. *International Journal of Neuropsychotherapy*. 1, 21-29 doi: 10.12744/ijnpt.2013.0021-0029
- Anderson, E. M., & Lambert, M. J. (2001). A survival analysis of clinically significant change in outpatient psychotherapy. *Journal of Clinical Psychology*, 57, 875-888.
- Anderson, H., & Kowal, E. (2012). Culture, history, and health in an Australian Aboriginal community: The case of utopia. *Medical Anthropology*, 31(5), 438-457. doi:10.1080/01459740.2011.636411
- Anticich, S., Barrett, P., Gillies, R., & Silverman, W. (2012). Recent advances in intervention for early childhood anxiety. *Australian Journal of Guidance & Counselling*, 22(2), 157-172. doi:10.1017/jgc.2012.24
- Archer J. (2004). Sex differences in aggression in real-world settings: A meta analytic review. *Review of General Psychology*, 8, 291–322.
- Archer, J., & Cote, S. (2005). Sex differences in aggressive behavior. In R. Tremblay, W. Hartup, & J. Archer (Eds.), *Developmental origins of aggression* (pp. 425–443). New York: Guilford Press.
- Arden, J. & Linford, L. (2009). *Brain-based therapy for adults*. New York, NY: Wiley.

- Australian Bureau of Statistics 2004. (2006). *Mental health in Australia: A snapshot, 2004-5*. Cat. no. 4430.0, ABS, Canberra.
- Australian Bureau of Statistics, Census of Population and Housing (2011). Retrieved from: <http://profile.id.com.au/darwin/population>
- Australian Institute of Family Studies. (2011). *The longitudinal study of Australian children: Annual statistical report 2010*. Retrieved from <http://www.aifs.gov.au/growingup/pubs/asr/2010>
- Australian Institute of Health and Welfare 2012. *A picture of Australia's children 2012*. Cat. no. PHE 167. Canberra: AIHW.
- Australian Play Therapists Association (APTA). (n.d.). *About APTA*. Retrieved from <http://www.apta.asn.au>
- Axline, V. (1969). *Play therapy*. New York, NY: Ballantine Books.
- Badenoch, B. (2008). *Being a brain-wise therapist: A practical guide to interpersonal neurobiology*. New York, NY: W. W. Norton & Co.
- Badenoch, B. (2011). *The brain-savvy therapist's workbook*. New York, NY: W. W. Norton & Co.
- Badenoch, B. & Kestly, T. (2014). Exploring the neuroscience of healing play at every age. In *Play therapy: A comprehensive guide to theory and practice*, D. Crenshaw & A. Stewart. (Eds.). New York, NY. Guilford Press.
- Baggerly, J., & Jenkins, W. W. (2009). The effectiveness of child-centered play therapy on developmental and diagnostic factors in children who are homeless. *International Journal of Play Therapy*, 18(1), 45-55. doi:10.1037/a0013878
- Boer, S., Oort, F., Donker, M., Verheij, F., & Boon, A. (2012). Childhood characteristics

- of adolescent inpatients with early-onset and adolescent-onset disruptive behavior. *Journal of Psychopathology & Behavioral Assessment*, 34(3), 415-422. doi:10.1007/s10862-012-9283-8
- Blanco, P. J., & Ray, D. C. (2011). Play therapy in elementary schools: A best practice for improving academic achievement. *Journal of Counseling & Development*, 89(2), 235-243.
- Bor, W., Najman, J. M., Andersen, M. J., O'Callaghan, M., Williams, G. M., & Behrens, B. (1997). The relationship between low family income and psychological disturbance in young children: An Australian longitudinal study. *Australian And New Zealand Journal of Psychiatry*, 31(5), 664-675. doi:10.3109/00048679709062679
- Bratton, S. C., Ceballos, P. L., Sheely-Moore, A. I., Meany-Walen, K., Pronchenko, Y., & Jones, L. D. (2013). Head start early mental health intervention: Effects of child-centered play therapy on disruptive behaviors. *International Journal of Play Therapy*, 22(1), 28-42. doi:10.1037/a0030318
- Bratton, S., & Ray, D. (2000). What the research shows about play therapy. *International Journal of Play Therapy*, 9(1), 47-88. doi:10.1037/h0089440
- Bratton, S. D., Ray, D., Rhine, T., & Jones, L. (2005). The efficacy of play therapy with children: A meta-analytic review of treatment outcomes. *Professional Psychology: Research and Practice*, 36(4), 376-390. doi: 10.1037/0735-7028.36.4.376.
- Brown, J. (2013). Counseling and psychotherapy in Australia: Championing the

- egalitarian society? In R. Moodley, U. P. Gielen, R. Wu (Eds.), *Handbook of counseling and psychotherapy in an international context* (pp. 171-181). New York, NY: Routledge/Taylor & Francis Group.
- Burgess, P. M., Pirkis, J. E., Slade, T. N., Johnston, A. K., Meadows, G. N., & Gunn, J. M. (2009). Service use for mental health problems: Findings from the 2007 National Survey of Mental Health and Wellbeing. *Australian & New Zealand Journal of Psychiatry*, 43(7), 615-623. doi:10.1080/00048670902970858
- Cacioppo, J. T., Visser, P. S., & Pickett, C. L. (2006). *Social neuroscience: People thinking about thinking people*. Cambridge, MA: MIT Press.
- Carlstedt, R. A. (2011). Conceptual, methodological and practical foundations of integrative evidence-based clinical research, diagnostics, and interventions. In R. A. Carlstedt (Ed.). *Handbook of integrative clinical psychology, psychiatry, and behavioral medicine: Perspectives, practice, and research* (pp. 1-16). New York, NY: Springer.
- Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2nd ed.). Hillsdale, NJ: Lawrence Erlbaum Associates.
- Cohen, J. (1994). The earth is round ($p < .05$). *American Psychologist*, 49, 997-1003.
- Connor, D. F., Steeber, J., & McBurnett, K. (2010). A review of attention deficit/hyperactivity disorder complicated by symptoms of oppositional defiant disorder or conduct disorder. *Journal of Developmental and Behavioral Pediatrics*, 31, 427-440.
- Creswell, J. W. (2014). *Research design: Qualitative, quantitative, and mixed methods approaches* (4th ed.). Thousand Oaks, CA: Sage.

- Dahlitz, M. J. (2013). Klaus Grawe. *The Neuropsychotherapist*, 2, 128-129.
- Dahlitz, M. J., & Rossouw, P. J. (2014). The consistency-theoretical model of mental functioning: Towards a refined perspective. In Rossouw, P. J. (Ed.), *Neuropsychotherapy: Theoretical underpinnings and clinical applications*. Brisbane, Queensland, AU: Mediros Pty Ltd.
- Drewes, A. (2008). Bobo revisited: What the research says. *International Journal of Play Therapy*, 17, 52–65.
- Eickelkamp, U. (2008). (Re)presenting experience: A comparison of Australian Aboriginal children's sand play in two settings. *International Journal of Applied Psychoanalytic Studies*, 5(1), 23-50. doi:10.1002/aps.136
- Fall, M, Navelski, L. F., Welch, K. K. (2002). Outcomes of a play intervention for children identified for special education services. *International Journal of Play Therapy*, 11(2), 91-106.
- Fiorentine, R. (2001). Counseling frequency and the effectiveness of outpatient drug treatment: Revisiting the conclusion that “more is better”. *American Journal of Drug and Alcohol Abuse*, 27(4), 617–631.
- Fiorentine, R. & Anglin, M. D. (1996). More is better: Counseling participation and the effectiveness of outpatient drug treatment. *Journal of Substance Abuse Treatment*, 13, 341–348.
- Freire, E., & Grafanaki, S. (2013). Measuring the relationship conditions in person-centered and experiential psychotherapies: Past, present and future. In M. Cooper, J.C. Watson, & D. Holldampf (Eds.). *Person-centered and experiential*

- therapies work: A review of the research on counseling, psychotherapy and related practices.* (pp. 188-214). Herefordshire, United Kingdom: PCCS Book.
- Fujii, C., Renno, P., McLeod, B. D., Lin, C., Decker, K., Zielinski, K., & Wood, J. J. (2013). Intensive cognitive behavioral therapy for anxiety disorders in school-aged children with autism: A preliminary comparison with treatment-as-usual. *School Mental Health*, 5(1), 25-37. doi:10.1007/s12310-012-9090-0
- Garcia, C., Akerman, A., & Cicchetti. D. (2000). Cultural influences on developmental processes and outcomes: Implications for the study of development and psychopathology. *Developmental Psychopathology*, 12, 333–356.
- Garza, Y., & Bratton, S. (2005). School-based child centered play therapy with Hispanic children: Outcomes and cultural considerations. *International Journal of Play Therapy*, 14, 51–80.
- Ginott, H. (1961). *Group psychotherapy with children: The theory and practice of play therapy*. New York: McGraw-Hill.
- Ginsberg, B. G. (1976) Parents as therapeutic agents: The usefulness of filial therapy in a community psychiatric clinic. *American Journal of Community Psychology*, 4(1), 47-54.
- Ginsberg, B. G. (1984). Filial therapy with retarded children and their families. *American Psychology Bulletin*, 6, 332-334.
- Goetze, H. (1994). Processes in person centered play therapy. In J. Hellendoorn, B.R. van der Kooij, & B. Sutton-Smith (Eds.), *Play and intervention* (pp. 63-76). New York: NY, New York University Press.
- Grawe, K. (2007). *Neuropsychotherapy: How neurosciences inform effective*

- psychotherapy*. New York, NY: Taylor & Francis.
- Grskovic, J. A., & Goetze, H. (2008). Short-term filial therapy with German mothers: Findings from a controlled study. *International Journal of Play Therapy*, 17(1), 39-51. doi:10.1037/1555-6824.17.1.39
- Guerney, B. (1964). Filial therapy: Description and rationale. *Journal of Counseling Psychology*, 28(4), 304-310.
- Guerney, L. F. (1983). Client-centered (nondirective) play therapy. In C. Schaefer & K. O'Connor (Eds.), *Handbook of play therapy* (pp. 21-64). New York, NY: Wiley.
- Guerney, L. F. (2001). Child-centered play therapy. *International Journal of Play Therapy*, 10, (13-31).
- Hamre, B. K., Pianta, R. C., Downer, J. T., & Mashburn, A. J. (2008). Teachers' perceptions of conflict with young students: Looking beyond problem behaviors. *Social Development*, 17(1), 115-136.
- Hansen, N. B., & Lambert, M. J. (2003). An evaluation of the dose-response relationship in naturalistic treatment settings using survival analysis. *Mental Health Services research*, 5, 1-12.
- Hayes, L. (2007). Problem behaviours in early primary school children: Australian normative data using the Strengths and Difficulties Questionnaire. *Australian & New Zealand Journal of Psychiatry*, 41(3), 231-238.
- Heppner, P., Rogers, M., & Lee, L. (1984). Carl Rogers: Reflections on his life. *Journal of Counseling & Development*, 63(1), 14-20.
- Hunt, K. H. (2010). The impact of brief play therapy training on the emotional awareness of care workers in a young children's residential care setting in Australia. *British*

Journal of Guidance & Counselling, 38(7), 287-299.

Iacoboni, M. (2008). *Mirroring people*. New York, NY: Farrar, Straus and Giroux.

Jones, E., & Carnes-Holt, K. (2010). The efficacy of intensive individual child-centered play therapy for chronically ill children. In J. N. Baggerly, D. C. Ray, S. C. Bratton (Eds.), *Child-centered play therapy research: The evidence base for effective practice* (pp. 51-67). Hoboken, NJ: John Wiley & Sons Inc.

Jones, E., & Landreth, G. (2002). The efficacy of intensive individual play therapy for chronically ill children. *International Journal of Play Therapy*, 11(1), 117–140.

Kaduson, H., & Schaefer, C. E. (2006). *Short-term play therapy for children*. (2nd ed.). Guilford Publications.

Kazdin, A. (2003). Clinical significance: Measuring whether interventions make a difference. In A. Kazdin (Ed.), *Methodological issues & strategies in clinical research* (3rd ed., pp. 691-710). Washington, DC: American Psychological Association.

Kot, S., Landreth, G. L., & Giordano, M. (1998). Intensive child-centered play therapy with child witnesses of domestic violence. *International Journal Of Play Therapy*, 7(2), 17-36. doi:10.1037/h0089421

Lambert, M. J. (2013). The efficacy and effectiveness of psychotherapy. In M. J. Lambert (Ed.). *Bergin and Garfield's handbook of psychotherapy and behavior change* (6th ed., pp. 169-218). New York, NY: Wiley.

Landreth, G. L. (2002). *Play therapy: The art of relationship* (2nd ed.). New York, NY: Routledge/Taylor & Francis Group.

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

- Routledge/Taylor & Francis Group.
- Landreth, G. L. & Bratton, S. C., (2006). *Child parent relationship therapy (CPRT) treatment manual: A 10-session filial therapy model for training parents*. New York, NY: Routledge/Taylor & Francis Group.
- Leblanc, M., & Ritchie, M. (2001). A meta-analysis of play therapy outcomes. *Counselling Psychology Quarterly*, 14(2), 149-163.
doi:10.1080/09515070110059142
- LeDoux, J. (2005). *Synaptic Self. How our Brains become who we are*. New York, NY: Penguin.
- Lin, Y., and Bratton, S. C. (2015), A meta-analytic review of child-centered play therapy approaches. *Journal of Counseling & Development*, 93: 45–58.
doi: 10.1002/j.1556-6676.2015.00180.x
- Littrell, J. M., Malia, J. A. & Vanderwood, J. (1995). Single session brief counseling in a high school. *Journal of Counseling and Development*, 73, 451-458.
- Mence, M., Hawes, D. J., Wedgwood, L., Morgan, S., Barnett, B., Kohlhoff, J., & Hunt, C. (2014). Emotional flooding and hostile discipline in the families of toddlers with disruptive behavior problems. *Journal of Family Psychology*, 28(1), doi: 10.1037/a0035352
- Moustakas, C. (1959). *Psychotherapy with children*. New York: Harper and Brothers.
- Muro, J., Ray, D., Schottelkorb, A., Smith, M., & Blanco, P. (2006). Quantitative analysis of long-term play therapy. *International Journal of Play Therapy*, 15, 35-58.
- Myers, S. S., & Pianta, R. C. (2008). Development commentary: Individual and contextual influences on student-teacher relations and children's early problem

- behaviors. *Journal of Clinical Child & Adolescent Psychology*, 17(3), 600-608.
doi: 10.1080/15374410802148160
- Nordling, W., & Guerney, L. (1999). Typical stages in child-centered play therapy. *Journal for the Professional Counselor*, 14, 17-23.
- Pallant, J. (2013). *SPSS survival manual: A step by step guide to data analysis using IBM SPSS* (5th ed.). Berkshire, England, McGraw-Hill.
- Peterson, J., & Flanders, J. (2005). Play and the regulation of aggression. In R. Tremblay, W. Hartup, & J. Archer (Eds.), *Developmental origins of aggression* (pp. 133-157). New York: Guilford Press.
- Piaget, J. (1951). Egocentric thought and sociocentric thought. In *J. Piaget, Sociological studies*, 270-286. London, England: Routledge.
- Piaget, J., & Inhelder, B. (1996/1969). *The psychology of the child*. New York, NY: Basic Books.
- Play Therapy Australia (PTA). (n.d.). *Welcome to the play therapy Australia website: Proudly promoting the world of play therapy*. Retrieved from <http://www.playtherapyaustralia.com>
- Ray, D. C. (2011). *Advanced play therapy: Essential conditions, knowledge, and skills for child practice*. New York, NY: Routledge/Taylor & Francis Group.
- Ray, D. C., Armstrong, S. A., Balkin, R. S. and Jayne, K. M. (2015), Child-centered play therapy in the schools: Review and meta-analysis. *Psychology in the Schools*, 52: 107–123. doi: 10.1002/pits.21798
- Ray, D. C., Blanco, P. J. Sullivan, J. M., Holliman, R. (2009). An exploratory study of child centered play therapy with aggressive children. *International Journal of Play*

- Therapy*, 18(3), 162-175. doi:10.1037/a0014742
- Ray, D., Bratton, S., Rhine, T. & Jones, L. (2001). The effectiveness of play therapy: Responding to the critics. *International Journal of Play Therapy*, 10(1), 85-108. doi:10.1037/h0089444
- Ray, D. C., Henson, R. K., Schottelkorb, A. A., Brown, A., & Muro, J. (2008). Effect of short- and long-term play therapy services on teacher-child relationship stress. *Psychology in the Schools*, 45(10), 994-1009.
- Ray, D. C., Lee, K. R., Meany-Walen, K. K., Carlson, S. E., Carnes-Holt, K. L., & Ware, J. N. (2013). Use of toys in child-centered play therapy. *International Journal of Play Therapy*, 22(1), 43-57. doi:10.1037/a0031430
- Ray, D., Schottelkorb, A., & Tsai, M. (2007). Play therapy with children exhibiting symptoms of attention deficit hyperactivity disorder. *International Journal of Play Therapy*, 16, 95–111.
- Ray, D. C., Stulmaker, H. L., Lee, K. R., & Silverman, W. K. (2013). Child-centered play therapy and impairment: Exploring relationships and constructs. *International Journal of Play Therapy*, 22(1), 13-27. doi:10.1037/a0030403
- Rogers, C. R. (1951). *Client-centered therapy*. Boston, MA. Houghton Mifflin.
- Rogers, C. R. (1961). *On becoming a person: A therapist's view of psychotherapy*. Boston, MA. Houghton Mifflin.
- Rogers, C. R. (1980). *A way of being*. Boston, MA. Houghton Mifflin.
- Rogers, C. (1989). *The Carl Rogers Reader edited by Kirschenbaum and Henderson*. New York, NY. Houghton Mifflin.
- Rossouw, P. J. (2011). The triune brain: Implications for neuropsychotherapy.

Neuropsychotherapy, 5, 2-3.

Rossouw, P. J. (2012). Effective client focused interventions: The top-down and bottom-up discourse. *Neuropsychotherapy News*, 11, 2–4. Retrieved from

<http://mediros.com.au/wp-content/uploads/2012/11/NPTIG-Newsletter-11.pdf>

Schaefer, C., Landreth G., and Pehrsson, D. E. (n.d.). Play therapy makes a difference. *Association for Play Therapy*. Retrieved from

<http://www.a4pt.org/?page=PTMakesADifference>

Schaefer, C., & Mattei, D. (2005). Catharsis: Effectiveness in children's aggression. *International Journal of Play Therapy*, 14(2), 103–109.

Schnyder, U. (2009). Future perspectives in psychotherapy. *European Archives and Psychiatry and Clinical and Clinical Neuroscience*, 259 (Suppl.2), 123-128.

Schofield, M. J. (2013). Counseling in Australia: Past, present, and future.

Journal of Counseling & Development, 91(2), 234-239. doi:10.1002/j.1556-6676.2013.00090.x

Schottelkorb, A., Swan, K. L., Garcia, R, Gale, B., and Bradley, B. (2014). Therapist perceptions of relationship conditions in child-centered play therapy. *International Journal of Play Therapy*, 23(1), 1-17.

Schumann, B. (2010). Effectiveness of child-centered play therapy for children referred for aggression. In J. N. Baggerly, D. C. Ray, S. C. Bratton (Eds.). *Child-centered play therapy research: The evidence base for effective practice* (pp. 193-208). Hoboken, NJ: John Wiley & Sons Inc.

Seligman, L., & Reichenberg, L. W. (2013). *Theories of counseling and psychotherapy: Systems, strategies, and skills*. Upper Saddle River, NJ. Pearson.

- Shen, Y. (2002). Short-term group play therapy with Chinese earthquake victims: Effects on anxiety, depression and adjustment. *International Journal of Play Therapy*, 11(1), 43-63. doi:10.1037/h0088856
- Siegel, D. J. (2012a). *The developing mind, second edition: How relationships and the brain interact to shape who we are*. New York: Guilford Press.
- Siegel, D. J. (2012b). *Pocket guide to interpersonal neurobiology: An integrative handbook of the mind*. New York: W.W. Norton & Company.
- Siegel, D. J., & Bryson, T. P. (2011). *The whole-brain child: 12 Revolutionary strategies to nurture your child's developing mind, survive everyday parenting struggles, and help your family thrive*. New York: Delacorte Press.
- Siegel, D. J. (2010). *The mindful therapist: A clinician's guide to mindsight and neural integration*. New York: W.W. Norton & Company.
- Sink, C. A., & Stroh, H. (2006). Practical significance: The use of effect sizes in school counseling research. *Professional School Counseling*, 9(5), 401-411.
- Smith, N., & Landreth, G. (2003). Intensive filial therapy with child witnesses of domestic violence: A comparison with individual and sibling group play therapy. *International Journal of Play Therapy*, 12(1), 67-88. doi:10.1037/h0088872
- Teisl, M., & Cicchetti, D. (2008). Physical abuse, cognitive and emotional processes, and aggressive/disruptive behavior problems. *Social Development*, 17(1), 1-23.
- Tyndall-Lind, A., & Landreth, G. L. (2001). Intensive short-term group play therapy. In G. L. Landreth (Ed.), *Innovations in play therapy: Issues, process, and special populations* (pp. 203-215). New York, NY: Brunner-Routledge.
- Tyndall-Lind, A., Landreth, G. L., & Giordano, M. A. (2001). Intensive group play therapy

with child witnesses of domestic violence. *International Journal of Play Therapy*,
10(1), 53-83. doi:10.1037/h0089443