SOCIAL-EMOTIONAL COMPETENCIES OF AFRICAN AMERICAN CHILDREN:

IMPACT OF CHILD-CENTERED PLAY THERAPY

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African American children experience risks due to heightened socio-environmental problems and responding to negative racial messages in their environments. Child Centered Play Therapy (CCPT) is one viable intervention for the development of social emotional competence among African American children to help mediate adverse conditions. I sought to explore the effects of CCPT on the social emotional competencies of African American children utilizing Social Emotional Assets and Resilience Scale-Parent & Teacher (SEARS-P; SEARS-T) reports. Thirty-seven African American participants with a mean age of 6.68 years were recruited from four suburban elementary schools in the southwest U.S. Twenty participants were randomly assigned to the intervention group receiving a mean of 13.3 CCPT sessions over 8 weeks, and 17 participants were assigned to the waitlist control group. Factorial ANOVA results indicated that parents reported statistically and practically significant improvement for children who participated in CCPT in overall social-emotional competencies. Follow-up analysis revealed statistical and practical improvement in children’s empathy, as well as practical improvement in self-regulation/responsibility and social competence. Teacher-reported results indicated practical but non-statistically significant improvement in overall social-emotional competencies for children who participated in CCPT, including statistical and practical improvement in children’s responsibility, as well as practical improvement in self-regulation, social competence, and empathy. Thus, CCPT showed promise as a culturally responsive treatment intervention to improve African American children’s social-emotional competencies.
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It is with great gratitude and love that I dedicate this journey to the people that have left a lasting impact on my life. I would first like to give thanks and praises to God for giving me the strength and courage for this journey. I want to thank my loving and supportive parents and big brother. Thank you for believing in me and encouraging me to pursue my dreams. I am the hardworking woman I am today because of you. To Kylea, Kamri, and Gavin, thank you for reminding me of the importance of unconditional love and acceptance. To my grandmother who rests in eternal peace, your love and spiritual wisdom has left a lasting impact on my career trajectory. I love and miss you! To my extended family and FMBC members, I am forever grateful for your prayers and words of encouragement. To my friends Tamra, Angela, Shar, Cori, and Sam, thank you for giving me that much needed push and always being there in my many times of need. Dee, thank you for allowing me to experience the healing power of relationships. You had the unique ability to help me feel seen, heard, and valued which ultimately gave me the courage to fully experience the vulnerabilities of my personal and professional growth. Leslie, thank you for filling my life with your continuous warmth and support. Natalya, your genuine spirit, talks, and encouragement help me through the valleys of this process. Angie, your sisterly guidance, smile and support motivated me through the toughest part of this journey. Thank you for being the final piece to connect my overall experience. To Brittany and Liz, my friendship and authentic bond with the two of you over the last four years is indescribable. When we first met, little did I know that both of you would be the source of my strength in this process. We have laughed, cried, and experienced many highs and lows together. To my cohort, I could not imagine sharing this journey without all of you. To the children, clients, and students I have worked with, each of you have left a special footprint on my heart. Thank you!
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SOCIAL-EMOTIONAL COMPETENCIES OF AFRICAN AMERICAN CHILDREN:
IMPACT OF CHILD-CENTERED PLAY THERAPY

Introduction

African American children comprise the second largest ethnic minority group in the United States. According to the U.S. Census Bureau (2010), 9.2 million African American children reside in the United States. This population accounts for 14% of the U.S. general population (U.S Census, 2010) and is heavily concentrated in the southern region of the U.S., totaling around 34% of the region (Harris & Graham, 2014). African American children may experience many challenges and barriers related to education, access to support services, and societal perceptions (Boyd-Franklin, 2003). As one of the most at-risk ethnic groups, African American children are predisposed to many mental health problems (Belgrave & Allison, 2013). Social emotional competencies are protective factors thought to mediate the adverse risks factors experienced by African American children (Belgrave & Allison, 2013). These competencies are especially critical for African American children because they must navigate educational systems, and institutional racism, and negative societal perceptions, while maintaining meaningful relationships with others despite societal perceptions (APA, 2008).

Risk Factors for African American Children

Family structure. African American children are more likely to live in single parent families than their peers. (Harris & Graham, 2014). Currently, 50.9% live in single-mother households (Belgrave & Allison, 2013). Researchers have described single parenthood as a strong mediator of psychosocial development (Greenberg, Domitrovich, & Bumbarger, 2001). Furthermore, children in single-parent families are three times more likely to experience greater academic challenges than children in two-parent homes, such as lower performance on standardized testing and early dropout (APA, 2012; McNeil et al., 2008). The most adverse
consequence for single-parent families is the increased risk for poverty (Harris & Graham, 2014). African American single parents tend to report incidences of temper tantrums, impulsivity, and physical aggression (Murray, Bynum, Brody, Willert, Stephens, 2001).

Poverty. According to the U.S. Census Bureau (2010), an estimated 4 million African American children live in poverty. African American children in poverty are exposed to greater levels of violence, family disruptions, smaller social and organizational networks, and limited resources (Belgrave & Allison, 2013). These challenges put African American children at a greater risk for academic, psychological and physical problems. (APA, 2008). The biggest consequences of childhood poverty for African American children are internalizing and externalizing behavior problems (McBride, Berkel, & Copeland-Linder, 2011). An estimated 21% of African American children of poverty have mental health related problems (Stagman & Cooper, 2010). Children of poverty tend to have greater risks for antisocial, withdrawn behaviors, and aggressive behaviors (Yoshikawa, Aber, & Beardslee, 2012). Because children of poverty are exposed to frequent maladaptive environmental experiences, their coping skills may be impaired. (McBride et al., 2011). These problems are often observed and the most problematic in educational settings (Mann & Randolph, 2014).

Emotional well-being. The manifestations of emotional problems in African American children are additionally influenced by gender and sociocultural factors (Belgrave & Allison, 2013). African American children may face emotional challenges because of a high degree and range of emotional expression (APA, 2008). Ward (2000) theorized that Caucasian American children tend to have more emotional restraint, whereas, African American children exhibit more comfort with expressing a variety of emotions. African American children are likely perceived by adults outside of their cultural group as overly emotional and reactive (Ward, 2000). Thus,
African American children might frequently face the challenge of emotional self-regulation in accordance with larger societal norms rather than cultural expectations for optimal functioning (APA, 2008). Emotional regulation is a critical task for African Americans as frequent or intense emotional experiences inhibit the ability to manage emotions in socially desired ways (Lemerise & Arsenio, 2000).

The prevalence of emotional challenges is high for African American children due to neighborhood characteristics, single-parent family structure, and poverty (Barbarin & Soler, 1993). These challenges can result in maladaptive emotional behaviors and responses. African American children experience more depressive symptomology related to interpersonal problems and ineffectiveness than their Caucasian American peers (Barbarin, 1999). African American males in particular may typically be socialized to restrict and suppress their emotions with the exemption of anger (Zeman et al. 2013). For example, Belgrave and Brevard (2015) hypothesized that depression and anxiety might manifest as anger and aggression in African American males. Thus, emotional disturbances are present but may be less noticeable in African American males. Children with low levels of emotional expressivity may be at risk for maladaptive behaviors such as aggression (Sullivan, 2010). Belgrave and Brevard (2015) explained African American boys might carry themselves as tough and aggressive in order to gain respect and protection against threats. However, these characteristics are not conducive in some social settings, particularly the school environment (Belgrave & Brevard, 2015).

Contrarily, African American girls appear more likely identified and observed as anxious, irritable and depressed (Barbarin, 1999). Palapattu et al. (2006) studied a sample of 114 adolescents to examine the gender differences in anxiety symptoms. Results revealed that the African American females reported higher levels of anxiety than the African American males.
The researchers hypothesized the differences may be attributed to psychosocial and biological factors such as parental attitudes about emotional expression, coping skills, and manifestation of anxiety.

**Academic setting.** African American children are increasingly predisposed to academic barriers due to the interaction of social, economic, and familial factors (Harris & Graham, 2014). In particular, African American children are confronted with racial stereotypes, lower expectations, negative peer influences, and lower parental involvement in the school realm (Mann & Randolph, 2011). African American children have the greatest percentage of behavioral problems in the school setting (Rudd, 2014). According to Rudd (2014), the high rates of discipline infractions for African American children begin as early as preschool. African American children are frequently described in the school setting as overly aggressive, hyperactive, and disruptive (Harris & Graham, 2014). African American children are more likely to face expulsion, suspension, and behavioral reprimands than any other cultural group. African American children of all ages are three times more likely to be suspended and expelled from school than Caucasian students (U.S. Department of Education, 2014). According to the U.S. Department of Education (2014), the average suspension rate for African American children is 16% as opposed to 5% for Caucasian students. African American boys are the primary source of concern in the academic settings. Skiba et al. (2011) found that African American boys are two times more likely to receive behavioral referrals than their Caucasian peers.

Suspensions and expulsions have short- and long-term effects on African American children, such as losing class time, persistence in behavioral problems, and increased probability of future academic discipline (Splett & Hawks, 2011). These factors are problematic for emotional and social development with peers and teachers (Mann & Randolph, 2014).
Furthermore, African American students often react to discipline infractions with perceptions of negative attention and feelings of alienation (Harris & Graham, 2014). The long-term consequences include increased risks for later delinquency and school dropout (Splett & Hawks, 2011). According to Splett and Hawks (2011), delinquency and school dropout are associated with adulthood drug abuse, incarceration, and problems related to mood.

**Social Emotional Competencies**

The social, environmental, and economical factors related to African American children contribute to risks for impaired socioemotional functioning (Mann & Randolph, 2014). Many of the academic, behavior, and emotional struggles faced by African Americans are linked to undeveloped social emotional competence (Barbarin, 2013b). Social emotional competence is a multidimensional construct and entails characteristics such as empathy, responsibility, self-regulation, and social competences (Merrell, 2011). These competencies allow children to communicate effectively with one another, interact positively with others, and regulate their behaviors (Barbarin et al., 2008).

**Empathy.** Empathy is a critical aspect of overall social-emotional competence (Merrell, 2011). Empathy is an interpersonal skill that involves awareness and ability to take the perspective and respond to the emotions of others (Harris & Graham, 2014). This attribute promotes the capacity to respond sensitively to others, engage in cooperation, and develop close relationships (Kersey & Masterson, 2013). Empathy has been postulated as a protective factor against conduct and disruptive behavior characteristics (Harris & Graham, 2014). According to Supplee et al. (2009), early struggles with empathy are associated with later maladaptive externalizing behaviors and underachievement. Prolonged empathy dysfunction increases risks for mental health disorders such as oppositional defiant and conduct disorder (de Weid, Gipsen-
Empirical research has supported that social-emotional competence is related to academic performance and positive scholastic attitudes in African American children. For example, McMahon et al. (2006) found empathy and gender predicted prosocial behavior. Results revealed that African American males with higher self-reports of empathy were rated with higher prosocial behaviors than females. The results also indicated higher levels of empathy for both African American males and females were negatively correlated with aggressive behaviors (McMahon et al., 2006).

**Social competence.** Social competence is another ability integral to overall social-emotional competence (Vahedi, Farrokhi, Farajian, 2012). Social competence is the ability to maintain friendships with peers, engage others verbally, and experience a sense of comfort with peers (Merrell, 2011). Research supports social competence is positively correlated to happiness, quality of life, respect for self and others, and positive self-concept (Frydenberg, Deans, & O'Brien, 2012). For example, Barbarin (2013b) investigated the relationship between social-emotional competence and academic skills for African American and Latino children beginning in kindergarten through second grade. The results of regression analyses showed higher social competence (e.g. self-regulation, social competence, and peer relationships) was a significant predictor of higher reading and math scores. Iruka, Burchinal, and Cai (2010) found similar results with social competency and achievement, confirming that parental report of close relationships and high social skills in kindergarten predicted higher math and reading scores in the third grade for African American children.

**Self-regulation.** Self-regulation is vital for success in many aspects of development. Self-regulation is a socio-cognitive process, which entails monitoring and evaluating behavior and effectively expressing emotions (Winne & Hadwin, 2011). This social emotional competence
skill requires children to translate their previous knowledge to regulate their thoughts, behaviors, and emotions (Eisenberg & Sulik, 2012). Children with self-regulation skills tend to have better behavior adjustment and academic performance (Caughey, Mills, Owens, & Hurst, 2013). In exploration of self-regulation among African American children, Sullivan, Helms, Kliwer, & Goodman (2010) examined the associations of self-reports of emotional and self-regulation of 358 African American children. Sullivan et al. (2010) found that children who demonstrated ability to regulate their anger had fewer incidences of physical aggression.

African American children have to rely even more on their social emotional skills when facing daily challenges, particularly those related to negative racial messages about physical appearance, intelligence, and self-worth (Mann & Randolph, 2014). Thus, social emotional attributes may help counteract adverse risks (Harris & Graham, 2014). They may enable children to develop critical socio-emotional skills for coping and adapting to challenges. Therefore, social emotional competence may serve as a protective factor against maladaptive development for African American children (Carter, Briggs-Gowan, & Davis, 2004).

**Child-Centered Play Therapy**

Child-centered play therapy (CCPT) is a treatment modality for working with children based on person-centered philosophy (Ray, 2011). The therapeutic nature of CCPT helps foster development of social emotional competence through empathy, unconditional acceptance, limit setting, and esteem building. These therapeutic aspects help children regulate their behavior and emotions, develop healthy relationships, and improve self-concept. However, despite the many benefits of CCPT, this treatment modality has yet to be explored as a culturally responsive and effective intervention for African American children.

*CCPT with African American Children*
The body of play literature strongly supports the importance of addressing multicultural issues and identifying culturally relevant treatments for diverse child populations (Baggerly & Parker, 2005; Ritter & Chang, 2002; Sheely-Moore & Bratton, 2010). Although no experimental play therapy studies have explored the use of CCPT exclusively with African American children, studies with the inclusion of African children have shown promise. Post (1999) conducted a quasi-experimental study with a large percentage (82%) of African American children but lacked an exclusive focus on African American children. Post (1999) examined the impact of CCPT on the self-esteem and locus of control of 168 at-risk children in fourth through sixth grade and found that children participating in CCPT group demonstrated better outcomes on self-esteem and internal locus of control. Baggerly & Parker (2005) conducted child-centered group play therapy (CCGPT) with 22 African American elementary males to address low self-esteem, depression, aggression, and defiance. Utilizing verbal and behavioral observations, the authors concluded the group dynamics of CCPT honors the African worldview of emotional vitality, collective survival, interdependence, and harmonious blending (Baggerly & Parker, 2005). The therapists acknowledged an African American worldview through toys representative of the African American culture, facilitation of a therapeutic environment for cultural expressions, reflections targeting group interactions, feelings, and responsibility. The therapist noted improvements in the African American males’ self-confidence, belongingness, and self-control.

Despite the lack of experimental research with African American children, CCPT has shown cross-cultural effectiveness. Garza and Bratton (2005) examined the effectiveness of CCPT as a culturally responsive intervention with Hispanic children. The Hispanic children participating in CCPT demonstrated significant reduction in internalizing and externalizing behavior problems with moderate to large effects. In addition, CCPT has been proven to be
Research supports the efficacy of CCPT as an intervention for children presenting with a range of emotional, social, and behavioral problems (Bratton, Ray, Rhine, & Jones, 2005). Additionally, CCPT has cross-cultural applications among Hispanic, Japanese, Chinese, and Iranian groups (Ray, 2014). Despite success of CCPT with these cultural groups, little is known about the effectiveness and cultural sensitivity of CCPT with the needs of African American children. African American children face many socio-environmental risks, which affect their socio-emotional development (Persson, 2005). Despite notable effectiveness of CCPT on various externalizing and internalizing problems, to date, no randomized controlled studies directly focus on African American children. The purpose of the current study was to examine the effects of CCPT on the social-emotional competencies and self-esteem of African American children presenting with problem behaviors. Specifically, the research questions were the following: 1) How does participation in CCPT impact the social emotional competencies of African American children who are identified with problem behaviors as reported by parents? and 2) How does participation in CCPT impact the social emotional competencies of African American children who are identified with problem behaviors as reported by teachers?
Methodology

Participants

Participants were children enrolled in Kindergarten through 4th grade at four Title I local elementary schools in the southwest United States. The participant inclusion criteria for this study included: a) Parent/guardians identified the children as African American; b) Children were 5-10 years old; c) Children were enrolled in grades Kindergarten through 4th grade; d) Children were referred by the teacher or school counselor due to problematic classroom behaviors; e) Children received consent from parent or guardian; f) Children agreed to participate in the study; g) Teachers and parents of children agreed to complete assessments and participate in the study; and i) Children did not receive concurrent play therapy or counseling services for the duration of the study.

A priori power analysis using G*Power 3.1 indicated a sample size of 34 participants was required in order to achieve a medium effect size of \( f = .25 \), power of .80, at an alpha level of .05. Initially 44 parents and teachers of potential participants gave their consent for the study. During the duration of the study, seven participants (Intervention group = 4, Control group = 3) were dropped from the study due to relocation to another school resulting in a sample size of 37. Of the 37 African American participants, 29 were male and 9 were females. The ages of the participants included eleven 5-year-olds, eight 6-year-olds, five 7-year-olds, six 8-year-olds, six 9-year-olds, and one 10-year-old \( (M=6.68) \). Twenty participants were randomly assigned to the intervention group and 17 participants were in the waitlist control.

Instruments

The SEARS is a strengths-based social emotional assessment measure for children and adolescents ages 5 to 18 years old (Merrell, 2011). The SEARS has a unique cross-informant
feature to allow for multiple perspectives of the social emotional competencies of children. The SEARS assessment tool focuses on the positive social, emotional, and behavioral attributes and characteristics of children rather than deficits.

SEARS-P. The SEARS-P is a 39 item self-administered parent, guardian, and caregiver report of social emotional competencies among children aged 5 to 18 years old (Merrell, 2011). Respondents are asked to rate children on a 4-point rating scale based on the degree to which the statement presented is true. The ratings include “never,” “sometimes,” “often,” or “always” true for the child during recent months. The SEARS-P includes three subscales that comprise the total score. The three subscales assess social emotional competencies that promote success in children in home and community contexts: 1) Self-Regulation/Responsibility (22 items), 2) Social Competence (10 items), and 3) Empathy (7 items). Internal consistency reliability estimates are strong for all three subscales and the total score with alpha coefficients ranging from .87 to .95. Test-retest reliability for the SEARS-P is adequate with moderate to high coefficients (.88-.93) for all of the subscales. Merrell (2011) reported strong convergent validity with other child behavioral assessments. In the current study, Cronbach's alpha demonstrated a .96 for all participants on the SEARS-P pretest.

SEARS-T. The SEARS-T is a 41-item teacher report of perceived social-emotional competencies for children aged 5 to 18 years old (Merrell, 2011) that mirrors the structure of the SEARS-P. The SEARS-T includes four subscales that comprise the total score: 1) Self-Regulation (SR), 2) Social Competence (SC), 3) Empathy (E), and 4) Responsibility (R). Reported internal consistency is strong with Cronbach’s alpha coefficients of .98 for the Total score and .91 to .95 for the four subscales (SEARS, Merrell, 2011). Test-retest reliability is adequate with moderate to high coefficients ranging .84 to .94 for all scales. Merrell (2011)
reported strong convergent validity with other teacher measures of child behavior. In the current study, Cronbach's alpha demonstrated a .86 for all participants on the SEARS-T pretest.

**Procedures**

Upon university institutional review board approval, I recruited participants from four elementary schools in the southern U.S. that had been categorized as serving a high number of children from low-income families. I first met with school personnel to discuss the background, description, and how to identify potential participants for the study. School counselors and teachers at each of the schools were asked to identify African American children who displayed problematic behaviors such as problems with teachers and peers, interpersonal difficulties, misconduct, maladaptive coping strategies, destroying property, and non-compliance based on classroom observations. The parents of referred participants were notified about the study and provided with parent consent forms. The research team collected all parent consent forms from each of the schools and determined children’s eligibility for the study. Upon receiving informed consent from parents, the researcher obtained consent from the teachers and assent from the children. After completion of all consents and assent, teachers completed the SEARS-T and parents completed the SEARS-P.

In accordance with randomized controlled trial methods, children who met criteria were randomly assigned through block randomization procedures to the CCPT experimental group or the waitlist control group. Children in the CCPT experimental group were scheduled to receive 30 minutes of CCPT twice a week for eight weeks. Due to student absences and school breaks, participants in the CCPT experimental group received between 8 to 16 sessions with a mean of 13.2 ($Mo=16$) sessions. The CCPT play therapy sessions were conducted in the student’s school in a fully equipped playroom in accordance with Ray’s (2011) CCPT treatment manual. At the
end of the 8-week intervention period, teachers and parents of participants in the CCPT and wait-list control groups completed the SEARS-T and SEARS-P as posttest measures.

**Intervention group procedures.** Participants assigned to the CCPT experimental group (n=20) were scheduled to participate in 16 sessions over 8 weeks for a total of 30 minutes at the child’s school. CCPT is a developmentally appropriate treatment modality using the therapeutic nature of play, the child’s natural communication, to facilitate the child’s expression of thoughts, feelings, behaviors, and desires. The CCPT therapists provided treatment according to the guidelines outlined in the CCPT treatment manual (Ray, 2011). Counselors responded with tracking verbal and non-verbal content and play behaviors, encouragement, empathic responses, esteem-building, returning responsibility, and therapeutic limit setting. Counselors used these skills to facilitate a warm, empathic, genuine, and permissive environment for full expression.

I followed the recommendations of Landreth (2012) and Ray (2011) to determine playroom assembly, toys, and materials chosen for each of the playrooms in the four schools. The toys and materials selected for the playroom represented different categories such as nurturing, mastery, creative and expressive, aggressive, and relational. These categories of materials were chosen specifically with the purpose to allow children a wide range of expression with or without verbal communication. Additionally, the toys were adapted to capture the African American culture such as African American dolls, figures, and religious symbols following the recommendation of Change and Ritter (2005). Toys representative of a child’s culture allow children to play out culturally related feelings and work through them within the play therapy relationship (Hinds, 2005).

Counselors conducting play therapy included doctoral level students and one faculty member in a graduate counseling program. Counselors included one African American female,
seven Caucasian females, and one Caucasian male. As recommended by the CCPT treatment manual (Ray, 2011), all counselors met the following criteria: 1) one or more years of experience conducting play therapy, 2) master’s degree in counseling, 3) successful completion of two play therapy courses, and 4) successful completion of counseling practicum with supervised experience in play therapy. Prior to providing play therapy treatment, all counselors participated in direct training on delivering the CCPT treatment protocol to participants. In order to ensure fidelity of protocol, the researcher adhered to the guidelines outlined in the CCPT treatment manual (Ray, 2011). All play therapy sessions for the research were video-recorded for the purpose of required weekly supervision conducted by two play therapy faculty members with advanced experience. The Play Therapy Skills Checklist (PTSC; Ray, 2011) was utilized to conduct fidelity and adherence to the CCPT protocol. I randomly selected one video for each child participant and completed the PTSC whereby responses from the play therapist were coded according to CCPT categories. Video review indicated that play therapists adhered to protocol in 98% of responses, exceeding Ray’s guidelines of 90% adherence.

**Wait-list control group procedures**

Children randomly assigned to the wait-list control group did not receive treatment during the 8-week intervention. After the completion of the 8-week intervention and data collection, children on the wait-list group received weekly play therapy. The counselors providing the treatment included doctoral level counselors with experience in play therapy. Furthermore, the counselors participated in weekly supervision.

**Results**

In order to address how participation in CCPT affected the social emotional competencies of African American children who were identified with behavioral problems as reported by
parents, a factorial analysis of variance (ANOVA) was conducted to examine Total scores on SEARS-P and SEARS-T of children who participated in the CCPT group on overall social emotional competence compared to children on the waitlist control group across pretest and posttest. The CCPT group was utilized as the independent variable and the SEARS-P and SEARS-T Total scores as the dependent variables. Given the statistical and practical significance on SEARS-P and practical significance on SEARS-T, I conducted follow-up analyses of factorial ANOVAs on the remaining SEARS-T and SEARS-P subscales. Table 1 presents the means and standard deviations for pre and post Total and subscales scores for SEARS-P and SEARS-T. The assumptions for level of measurement, random sampling, independence of observations, homogeneity of variance, normal distribution, and homogeneity of interrelations were all reasonably met. The alpha level for statistical significance was set at .05 to examine statistically significant differences between the means across time. Partial eta squared ($\eta_p^2$) effect sizes were reported in order to assess the practical significance of the results through variance accounted for. According to Cohen’s (1977) guidelines, eta squared ($\eta_p^2$) was interpreted as .01 is small, .06 is medium, and .14 is large effect.

Parent Report on SEARS

A factorial analysis of variance (ANOVA) was conducted to examine parents’ reports of African American children who participated in the CCPT group on overall social emotional competence compared to children on the waitlist control group across pretest and posttest. Results showed a statistically significant interaction between treatment group and time, $F(1, 35) = 4.87, p < .05$, with a medium to large effect size of $\eta_p^2 = .122$. The main effect of time was not statistically significant, $F(1, 35) = 3.105, p = .081$, yet there was a medium effect size of
\[ \eta_p^2 = .072. \] The main effect between groups was not statistically significant, \( F(1, 35) = .011, p = .91, \eta_p^2 = .942. \)

**Post Hoc Analyses for Parent Report**

**Self-Regulation/Responsibility.** Results of the factorial ANOVA showed no significant interaction effect between treatment group and time, \( F(1, 35) = 2.821, p = .102, \) yet there was a medium effect size of \( \eta_p^2 = .075. \) The main effect of time was statistically significant, \( F(1, 35) = 10.030, p = .033, \) with a large effect size of \( \eta_p^2 = .209. \) The main effect between groups was not statistically significant, \( F(1, 35) = .013, p = .911, \eta_p^2 = .731. \)

**Social Competence.** Results of the factorial ANOVA for the Social Competence subscale showed no statistically significant interaction between treatment group and time, \( F(1, 35) = 2.980, p = .093, \) yet there was a medium effect size of \( \eta_p^2 = .078. \) The main effect of time was not statistically significant, \( F(1, 35) = .202, p = .656, \) with a small effect size of \( \eta_p^2 = .006. \) The main effect between groups was not statistically significant, \( F(1, 35) = .043, p = .837, \eta_p^2 = .947. \)

**Empathy.** Results of the factorial ANOVA for Empathy showed a significant interaction effect between treatment group and time, \( F(1, 35) = 4.335, p = .045, \) and a medium to large effect size of \( \eta_p^2 = .110. \) The main effect of time was not statistically significant, \( F(1, 35) = .009, p = .926, \) with a small effect size of \( \eta^2 = .002. \) The main effect between groups was not statistically significant, \( F(1, 35) = .006, p = .938, \eta_p^2 = .884. \)

**Teacher Report on SEARS**

In order to address how participation in CCPT impacted the social emotional competencies of African American children who were identified with behavioral problems as reported by teachers, a factorial analysis of variance (ANOVA) was utilized to examine teachers’ reports of African American children who participated in the CCPT group on overall social
emotional competence compared to children on the waitlist control group across pretest and posttest. Results showed no statistically significant interaction between treatment group and time, \( F(1, 35) = 2.60, p = .116 \), yet there was a medium effect size of \( \eta^2 = .069 \). The main effect of time was not statistically significant, \( F(1, 35) = 3.621, p = .087 \), with a medium effect size of \( \eta^2 = .094 \). The main effect between groups was not statistically significant, \( F(1, 35) = 2.053, p = .161, \eta^2 = .990 \).

**Self-Regulation.** Results of the factorial ANOVA for Self-Regulation showed no significant interaction effect between treatment group and time, \( F(1, 35) = 1.249, p = .271 \), with a small effect size of \( \eta^2 = .034 \). The main effect of time was not statistically significant, \( F(1, 35) = .173, p = .680 \), with a negligible effect size of \( \eta^2 = .005 \). The main effect between groups was statistically significant, \( F(1, 35) = 4.147, p = .049, \eta^2 = .987 \).

**Social Competence.** Results of the factorial ANOVA for Social Competence showed no significant interaction effect between treatment group and time, \( F(1, 35) = 3.295, p = .055 \), yet there was a medium to large effect size of \( \eta^2 = .101 \). The main effect of time was not statistically significant, \( F(1, 35) = .072, p = .790 \), with a negligible effect size of \( \eta^2 = .002 \). The main effect between groups was not statistically significant, \( F(1, 35) = .256, p = .616, \eta^2 = .983 \).

**Empathy.** Results of the factorial ANOVA for Empathy showed no significant interaction effect between treatment group and time, \( F(1, 35) = 1.288, p = .264 \), and with a small effect size of \( \eta^2 = .034 \). The main effect of time was not statistically significant, \( F(1, 35) = .1399, p = .245 \), with a small effect size of \( \eta^2 = .037 \). The main effect between groups was not statistically significant, \( F(1, 35) = 1.583, p = .217, \eta^2 = .928 \).

**Responsibility.** Results of the factorial ANOVA for Responsibility showed a significant interaction effect between treatment group and time, \( F(1, 35) = 4.642, p = .038 \), with a medium
to large effect size of $\eta_p^2 = .117$. The main effect of time was not statistically significant, $F (1, 35) = 1.413, p = .243$, with a small effect size of $\eta_p^2 = .039$. The main effect between groups was not statistically significant, $F (1, 35) = 1.314, p = .260, \eta_p^2 = .039$.

Discussion

The current study sought to investigate the impact of CCPT on the social emotional competencies of African American children. Specifically, this study examined the effect of CCPT on African American children’s overall social emotional competence as measured through pretest and posttest parent and teacher reports. Results of this study indicated that parents observed significant and practical changes in their children who participated in play therapy when compared with children who did not receive intervention. Teachers also reported positive change for children who participated in CCPT as compared to children who did not receive intervention, yet to a lesser degree than parents. Results indicated a need to discuss the following areas: 1) social emotional competence, 2) play therapy with African American children, 3) implications of findings, 4) limitations of findings, and 5) recommendations for future practice.

Social Emotional Competencies

Overall Social Emotional Competence

The statistical and practical results suggest the positive impact of CCPT on overall social emotional competence for African American children based on parent report. Children in the CCPT experimental group demonstrated improvements in social emotional competence compared to those in the waitlist control group. Additionally, the medium to large effect size ($\eta_p^2 = .12$) indicated observable improvement for the CCPT treatment group over time. This effect size is consistent with previous play therapy studies as discussed in Ray et al. (2015) and Lin and
Bratton (2015). These findings indicate that CCPT may be a viable treatment modality to support African American children in the healthy development of social emotional competence.

Although teachers’ reports did not result in statistically significant differences between CCPT and the waitlist control groups on overall social-emotional competence, a medium effect size was detected which indicates observable change in overall competence when reported by teachers. Based on teacher pretest and posttest results, children in the CCPT intervention improved at an observable level and those in waitlist control group slightly improved on social emotional competence over time. However, teachers did not report observed changes at the same level as parents. Helker and Ray (2009) explained the challenges some teachers face in recognizing and accepting behavioral change. The results could be further complicated by racial and cultural dynamics. Researchers have claimed that teachers’ expectations may sometimes be influenced by racial biases (Boyd-Franklin, 2002). Belgrave and Allison (2013) theorized that in comparison to parents, teachers are more likely to report higher frequencies of problematic behaviors among African American children compared to other cultural groups. Ferguson (2003) highlighted that once teachers have formed negative perceptions about the behaviors of African American students, their perceptions do not change a great deal, indicating that teacher perceptions of African American children may be difficult to change. Furthermore, Fenwick (2013) proposed that teachers, specifically non-African American teachers, often believe the problems of African American children are beyond what interventions can repair. Because the majority of teachers involved in the current study were non-African American, the preceding issues may have been influential in their reporting of observed behavior.

*Social Emotional Constructs: Self-Regulation, Social Competence, Empathy, and Responsibility*
In the following paragraphs, I will further discuss the findings related to each of the following subscales for the SEARS parent and teacher report: Self-Regulation, Social Competence, Empathy, and Responsibility.

**Self-Regulation.** The scores for Self-Regulation were consistently the lowest of all subscales across teacher and parent reports. The parent and teacher reports on Self-Regulation were not statistically significant when comparing the CCPT intervention and waitlist control group. However, the results did result in practical significance and indicated African American children in the CCPT group made some progress on self-regulation. Parent report yielded medium effects, which can be interpreted as observable changes in self-regulation. However, teacher reports resulted in small effects, which can be interpreted as real change in self-regulation but difficult to detect. These findings are useful for identifying viable treatments for African American children. Self-regulation struggles are commonly reported challenges by parents particularly in systemic environments such as school and community settings (Tamis-LeMonda et al., 2008). Thus, treatment modalities such as CCPT might serve as a treatment intervention for the advancement of self-regulation for African American children. CCPT therapists provide opportunities for full expression, reality testing, limit-setting, and decision-making for facilitating self-regulation (VanFleet, Sywulak, & Sniscak, 2010).

**Social Competence.** The Social Competence subscale resulted in the most consistent findings between teacher and parent reports. Although parent and teacher scores resulted in non-statistically significant findings, the scores of African American children in the CCPT group demonstrated practical significance as evidenced by a medium effect for parent and medium to large effect for teachers. The results indicated observable changes in the level of social competence displayed by children who participated in CCPT. The practical significance of the
Social Competence scores suggest the social benefits of CCPT. In CCPT, the relationship not only serves as the therapeutic agent for client change but also a model for the child’s relationships with others (Ray, 2011). The therapeutic relationship is characterized by empathy, congruence, and unconditional positive regard (Landreth, 2012). Through a child’s interactions with a therapist, she may begin to recognize acceptance, social rules, and effective communication patterns. As the therapeutic relationship evolves, children are able to freely explore and practice social skills in a safe environment. For the African American children in this study, the observed changes by parents and teachers might be influenced by the development of the therapist-child relationship in CCPT. It can be postulated that social interactions with the therapist positively influenced the child’s social behavior.

Empathy. The Empathy subscale resulted in distinct differences between teacher and parent report. The teacher scores resulted in non-statistically significant findings on empathy with a small effect whereas parent report indicated statistical and practical significance. The lack of statistical and practical significance suggests teachers noted change to a lesser degree than parents. The results of the SEARS-P Empathy subscale for the current study provides additional support for CCPT as a treatment modality for the enhancement of empathy in African American children. The empathy scores also yielded moderate effect sizes. This suggests that CCPT may facilitate the development of empathy in African American children. Harris & Graham (2014) argued for the need for studies exploring prosocial behaviors such as empathy for African American children. In CCPT, children are allowed to experience many opportunities for empathic reactions and responses from the therapist. Landreth (2012) explained conveying empathy is one of the most powerful therapeutic assets because it results in children feeling
understood. Thus, the empathic experiences provided in CCPT might lead to the child’s expression of empathy and emotionality, as indicated by the results of this study.

**Responsibility.** One of the main objectives of CCPT is to facilitate the development of self-responsibility (Ray, 2011). The statistical and practical findings of teacher responsibility scores for children participating in CCPT support this objective. In CCPT, the therapist empowers and encourages children to experience their own capabilities by returning responsibility in the playroom. Returning responsibility conveys respect for children’s ability to solve problems, make choices, and do things for themselves. The results of the Responsibility subscale suggest support for CCPT as a viable intervention for the facilitation and enhancement of responsibility for African American children.

*Play Therapy with African American Children*

The exclusive study of African American children to understand the impact of CCPT is sparse in the play therapy literature. African American children have been included in previous experimental play therapy studies but only in small percentages with the exception of Post’s (1999) study. Post’s (1999) study included 82% of African American children and resulted in positive benefits on self-esteem and internal locus of control. Despite the limited number of African Americans in play therapy studies, findings from Lin & Bratton’s (2015) recent meta-analysis indicated moderate treatment effects for children from different ethnic groups receiving play therapy. This study further supports the impact of CCPT with African American children. The African American children in this study improved in overall social emotional competence and in the areas of self-regulation, social competence, empathy, and responsibility. These improvements are important for academic and interpersonal successes. Improvements in these areas are critical given that common referrals for therapy are based on school related behavior
concerns (Boyd-Franklin, 2006). McAdoo (2002) proposed therapy referrals are likely due to teacher and parent expectations. The results of this study suggests CCPT could be a culturally sensitive intervention for common struggles reported by significant individuals in the lives of African American children. According to Nader (2007), African American parents and teachers frequently report externalizing problems such as impulsivity, disobedience and physical aggression. CCPT can address these concerns because the therapist builds a therapeutic relationship that allows children to fully express their thoughts and feelings in ways that are unique to their lived experiences.

The CCPT relationship is vital in the therapeutic process (Landreth, 2012). In order for children to experience the healing nature of the therapeutic relationship, the actions and responses of CCPT therapists’ convey the messages “I see you, I hear you, I understand, and I care (Landreth, 2012, p. 209-210).” These messages foster full presence, prizing, and value of the children in the CCPT relationship. This type of therapist relationship is especially important for African American children because they are often harshly evaluated for their cultural way of being in their social environments. The CCPT relationship can facilitate the prizing and valuing of African American children who often experience opposition with others in their environment. Additionally, within the context of the relationship, the therapist facilitates opportunities for children to develop self-regulation and self-control. These opportunities reduce the need for engaging in problematic behaviors. Furthermore, children are able to meet their needs in more adaptive and socially desirable ways which positively affects their functioning in their home and school environments.

Regarding the need for intervention within the school environment, relationally-based interventions such as CCPT are well-suited to the meet the needs of African American children.
Because African American children have the highest percentage of behavioral reprimands in schools when compared to other cultural groups (Rudd, 2014), the philosophical focus of CCPT on relationship and the self-actualizing tendency of every child may offer an affirming experience to African American children who are struggling in schools. The therapeutic nature of CCPT allows for the development of adaptive coping, self-control, and self-direction to address behavioral struggles. African American children are frequently described as overly aggressive and disruptive by teachers and school personnel (Harris & Graham, 2014). Thus, African American children are more likely to experience suspension and expulsion related to externalizing behaviors exhibited in the school environment (Splett & Hawkins, 2011). The high incidence of behavioral problems suggest African American children are treated more harshly in the educational setting in comparison to their peers. Davis (2001) theorized that problems African American children face due to institutional practices in the school system are more chronic and extreme. These negative views are more prevalent when African American children are the minority in a school setting such as the participants of this study. When African American children are the minority, their cultural demeanors and behaviors are often misunderstood and negatively evaluated by teachers (Belgrave & Allison, 2013). This is especially true when African American children attend schools with primarily non-African American teachers and personnel (Davis, 2001). These conclusions suggest the importance of the therapist’s role in CCPT for African American children. CCPT therapists ensure their verbal and non-verbal behaviors convey true acceptance and respect. This helps build trust and safety for the child to work through their experiences.

Drewes (2005) proposed that the behaviors and actions of play therapists are critical in providing play therapy to children in diverse populations. Thus, the therapist-child interactions
become critical for the effectiveness of the play therapy process (Drewes, 2005). Therapists in this study included a majority of Caucasian American females. Most therapists in this study reported past clinical experiences and understanding of the African American culture in some capacity but some shared concerns about the current racial and political climate affecting how and what they responded to in the room. Despite therapists’ concerns, many therapists in this study expressed the importance and awareness of being culturally sensitive in their observations and reflections.

Cultural understanding is critical for African American children given the common mistrust and barriers to seeking mental health treatments (Mann & Randolph, 2014). Hinds (2005) explained play therapists of all races - but particularly non-African American therapists need to understand the historical and cultural implications of being an African American child in today’s society. CCPT facilitates a relationship for the therapist to validate and accept the experiences of African American children (Ray, 2011). This facilitation results in increased empathy and care for the child. The relationship can help African American children experience feelings of being valued despite feedback from outside sources. Hinds (2005) suggested cultural competence training for therapists who work with African American children, specifically related to the African American experience in the U.S. Additionally, a need exists for more African American therapists, particularly African American males.

Very few toys and expressive materials are representative of the African American culture (Hinds, 2005). For example, most dolls and figures have Eurocentric features. Thus, African American children are often limited to express their feelings, thoughts, and experiences with play materials that are not always truly representative of their culture (Hinds, 2005). For this study, some of the recommended toys were adapted to include toys to provide more
representation for the African American children receiving play therapy. For example, we included cultural dolls, figures, and religious figures. It is important to note, although cultural dolls and figures were included, it was difficult to find dolls that were truly representative of the African American culture. Traditional toy stores did not include doll choices for the African American culture. Therefore, this study required an extensive search to find culturally sensitive dolls and figures. Once dolls were located, there was a limited selection and they were more expensive compared to other dolls.

**Limitations**

Despite the valuable results and implications for CCPT as a viable treatment intervention for African American children, limitations are offered for consideration when interpreting data results. This study was conducted with a small sample size in schools located in the southwest United States with primarily male students from lower income and single parent families. The sample limits the generalizability of the results for African American children across genders, geographic location, and SES status. Additionally, this sample was identified within schools where African American children were a clear minority. Due the lack of African American play therapists in the geographical area, the primary researcher was the only African American therapist for the study. The racial status of researcher may have led to researcher bias. Additionally, the teacher and parent findings may have resulted in rater bias (Rubin & Bellamy, 2012). The parents and teachers were not notified about group assignment in either the CCPT or waitlist control group; however; they might have become aware of assignment over time. As a result, teacher and parent awareness might have affected their responses on assessment. Results of statistical analyses should be interpreted with caution. Due to the exploration of sub-constructs of social emotional competencies, multiple analyses were conducted increasing the risk of Type I
error. The use of a waitlist control group instead of another treatment group is another limitation. Due to this factor, it is difficult to determine if CCPT with African American children is superior to another form of therapeutic treatment.

**Recommendations for Future Research**

Based upon the findings and limitations of the current and previous studies, I present several recommendations for future research. Future research could benefit from studies that allow for more generalization for other African American groups. It might be helpful to target more diverse presentation of African American males and females from various SES backgrounds and family make-up. Due to the cultural factors of African American children, future researchers are encouraged to explore the treatment outcomes of children participating in CCPT paired with therapists that are racially similar and dissimilar. Research exploring racial background of the therapist can help practitioners determine if there is a greater or similar impact of matching African American children with racially similar therapists. The lack of significant findings from teacher report in comparison to parent report is consistent with previous research (see Cheng, 2015; Garza & Bratton, 2005; Helker & Ray, 2009). The weaker findings regarding teacher report suggest the need for further investigation regarding the influences of teacher-child relationships. Research with African American children could benefit from examining the influences of teacher report on the social emotional competence of African American children participating in CCPT. Future researchers are encouraged to conduct follow up assessments for CCPT research exploring the long-term impact on social emotional competences.

Finally, reports regarding specific categories of social emotional competencies resulted in mixed findings. Although social competence was observed as similarly improved by parent and teacher reporters, other constructs such as empathy and self-regulation were observed differently
by parents and teachers. Further research is needed to explore the constructs related to social emotional competence and how these constructs are perceived and observed by parents and teachers.

**Implications for Practice**

The results of this study present critical implications for practice with African American children. CCPT is a developmentally appropriate intervention for children and results from the current study support its effectiveness with the enhancement of social emotional competencies. Findings of this study indicate CCPT supports the development of overall social emotional competence for African American children. The therapeutic nature of CCPT helps facilitate the social-emotional growth through therapists’ use of empathy, unconditional acceptance, limit setting, and esteem building conveyed to the child. As a result, children are provided with opportunities to regulate their behavior and emotions, develop harmonious relationships, and improve self-responsibility.

My observations and experiences suggest the importance of incorporating culturally diverse toys and materials in the playroom. Adapting toys to fit the culture allow for representation and facilitation of the child’s true experiences. In the current study, we added dolls, figures, and religious symbols. Although not used in this study, practitioners should consider adding diverse puppets, food, and dress-up clothes. According to Hinds (2005), African American children have highly imaginative play behaviors. The inclusion of more culturally focused toys can assist children in fully expressing their thoughts, feelings, and behaviors.

Training for both play therapists and teachers are important implications of this study. African American children have unique experiences in society. Clinicians should also consider attending cross-cultural training and engaging in more clinical practice with African American
children by providing counseling services in the environments where African American children spend the most time (i.e. schools, community centers, and church). These opportunities will allow clinicians to apply knowledge and understanding in practical ways.

Conclusion

The development of social emotional competence is particularly important for African American children given challenges related to socio-environmental risks, limited resources, and historical events (APA, 2008). These culturally related challenges can lead to emotional, social, and behavioral problems that can persist into adulthood (Belgrave & Allison, 2015). Social emotional competence acts as a buffer against severe emotional and behavioral problems that could persist into adulthood (Harris & Graham, 2014). This study sought to add to the body of literature regarding interventions and support of CCPT with African American children. Findings indicated statistically significant improvements on overall social emotional competence as reported by both parents and teachers. Parent report indicated greater improvements when compared to teacher report and there were mixed findings regarding sub-constructs of social emotional competencies. The findings of this study support the positive benefits of CCPT found in previous research with other ethnic populations. Although, positive benefits were found, future research and practitioners should be mindful of cultural adaptations for the African American children to enhance the opportunity for full expression.
References


Processes in Development: New Directions and International Perspectives (pp. 79 - 107). Routledge: NYC
Table 1
Mean Scores and Standard Deviations on SEARS-P and SEARS-T Total Scores

<table>
<thead>
<tr>
<th>Scale</th>
<th>Intervention Group (n = 20)</th>
<th>Waitlist Control Group (n = 17)</th>
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<td>Pretest</td>
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APPENDIX A

EXTENDED LITERATURE REVIEW
The following review is a synthesis of literature and research in relation to five areas: (a) characteristics of African American children, (b) importance of social emotional competencies for African American children, (c) importance of self-esteem and African American children, (d) impact of child-centered play therapy on social emotional competence and (e) impact of child-centered play therapy on self-esteem.

Characteristics of African American Children

African American children comprise the second largest ethnic minority group in the United States. According to the U.S. Census Bureau (2010), 9.2 million African American children reside in the United States. This population total accounts for 14% of the general population. African American children and their families are heavily concentrated in the southern region of the United States, totaling around 34% (Harris & Graham, 2014). By 2040, African American and Latino children will constitute the majority of the U.S. child population (Harris & Graham, 2014). African American children are one of the most at-risk ethnic groups and they are predisposed for many mental health problems (Belgrave & Allison, 2013). African American children face risks related to psychosocial development due to high percentages of single parent families, poverty, and academic disparities (Harris & Graham, 2014). Due to the characteristics and social environmental risks of African American children in the U.S., counselors are increasingly challenged to address and meet the psychological needs of African American children.

African American Family Structure Concerns

Family structure has a critical impact on the mental health of children (Mooney, Oliver, & Smith, 2009). The family characteristics of African American children affect their overall wellbeing. The African American family is greatly impacted by single parenthood. Currently,
36.6% of African American children live in two parent households, 50.9% live in single-mother households, 4.3% live in father-only households, 8% live in intergenerational households, and 8.7% live in households with neither parent present (Belgrave & Allison, 2013). African American children are more likely to live in single parent families than their peers. (Harris & Graham, 2014). The percentage of African American children living in single-mother families are 50.9%, whereas 19.3% Caucasian and 28% of Latino children live in single-mother households (Belgrave & Allison, 2013). Researchers have described single parenthood as a strong mediator of psychosocial development (Greenberg, Domitrovich, & Bumbarger, 2001). Children in these family structures often have adverse economic, social, and academic consequences. Single parent households are more likely to face economic hardships. The highest poverty rates are among African American children in single-mother households (Belgrave & Allison, 2013). In 2009, 53.3% of African American children of single mothers lived in poverty, whereas 16.7% of African American children reside in households with two parents (U.S. Census Bureau, 2010). Due to economic status of single parent families, African American children are more likely to reside in poorer school districts and neighborhoods (Belgrave & Allison, 2013). Furthermore, children in single-parent families tend to experience greater academic challenges than children in two-parent homes (APA, 2003). For example, African American children of single parent homes are three times more likely to drop out of school, have lower GPAs, and perform lower on standardized testing than children in two parent households (McNeil et al., 2008). Externalizing problems related to conduct are the most commonly reported problems by single African American parents (Nader, 2007). African American children in single parent families tend to report incidences of temper tantrums, impulsivity, and physical
aggression (Murray, Bynum, Brody, Willert, Stephens, 2001). These symptoms are further exacerbated by problems related to the socioeconomic hardships.

**Socio-Economic Concerns**

African American children are disproportionately impacted by poverty and turbulent economic conditions (Harris & Graham, 2014). African American children in poverty are exposed to greater levels of violence, family disruptions, smaller social and organizational networks, and limited resources (Belgrave & Allison, 2013). These challenges put African American children at a greater risk for academic, psychological and physical problems. (APA, 2003). According to the U.S. Census Bureau (2013), an estimated 4 million African American children live in poverty. The poverty rate for African American children has increased by 5% since 2006 (Harris & Graham, 2014). African Americans are two to four times more likely than Caucasian Americans to live in poverty. On average, 32% of African American children live at or below poverty level (U.S. Census Bureau, 2013). This rate compares to 12% of Caucasian American and 25% of Latino American children who live at the poverty level. Childhood poverty has adverse consequences related to their education, physical health, and psychological development (Evans, 2004). These consequences have the potential to manifest into severe emotional and behavioral problems in later development adulthood (Kim et al., 2013). However, the high incidences and increased risks related to poverty can be mediated through intervention and psychological services for African American children.

The high poverty rates for African American children correlate with poorer mental health outcomes. The biggest consequences of childhood poverty for African American children are internalizing and externalizing behavior problems (McBride, Berkel, & Copeland-Linder, 2011). An estimated 21% of African American children of poverty have mental health related problems
Children of poverty tend to have greater risks for antisocial, withdrawn behaviors, and aggressive behaviors due to the increased probability of exposure to violence, harsh parenting, and family economic stressors (Yoshikawa, Aber, & Beardslee, 2012). Chronic stress and emotional dysregulation are common consequences for children who live in poverty (Evans & Kim, 2007). Because children of poverty are exposed to frequent maladaptive environmental experiences, their coping skills may be impaired. Children often experience emotional problems such as anxiety and depression (McBride et al., 2011). Without intervention, the greatest concern of childhood poverty is the manifestation of social and mental health problems upon entry into adulthood (Mann & Randolph, 2014).

The adverse consequences of poverty are often present in the educational realm for African American children. According to the Alliance for Excellent Education (2011), over 60% of African American children attend schools with a majority of students identified as living in poverty. Poverty is linked to many academic related challenges in the school environment such as retention difficulties, maladaptive social-emotional behaviors, and drop out rates (American Psychological Association, 2012). According to Evans (2004), in comparison to children in affluent schools, African American children in poverty-stricken schools face the risk of limited resources, unqualified teachers, and less rigorous curriculum. Evans (2004) explained children in schools of poverty are 20% less likely to have qualified teachers than those in higher income districts. Furthermore, the turnover rate for teachers and absenteeism is higher in low-income school districts, limiting student relationships with school personnel. Therefore, children are at greater risk for problems related to self-esteem, self-regulation and internalized behaviors (American Psychological Association, 2012). Additionally, African American children are theoretically not provided with the necessary tools to help them navigate the school environment.
(Fenning & Rose, 2007). As a result, children are less likely to maximize their potential and capabilities.

Academic Concerns of African American Children

African American children have a long history of unmet needs and falling academically below other ethnic groups beginning as early as the preschool years (Darling-Hammond, 2004). The noticeable difference in academic performance and achievement in comparison to peers, particularly Caucasian Americans, is most prevalent by second grade (Harris & Graham, 2013). This is problematic as the school environment plays a vital role in psychosocial development. The degree of educational readiness and academic adjustment impacts mental health (Mann & Randolph, 2011). Successes in school contribute to healthy development whereas failures interfere with a child’s academic functioning (Perry-Burney, 2007).

African American children have made gains in academic achievement in reading and math proficiency over recent years but the inequalities of educational achievement for African American children continue to persist (Vanneman, Hamilton, Anderson, and Rahman, 2009). African American students still perform lower on academic grades and standardized testing than Caucasian American children (Diamond & Huguley, 2011). This academic gap is attributed to the public school system’s inability to meet the academic needs of African American children. African American children are increasingly predisposed to academic barriers due to the interaction of social, economic, and familial factors (Harris & Graham, 2014). In particular, African American children are confronted with negative attitudes, lower expectations, negative peer influences, and lower parental involvement in the school realm. African American children often internalize these experiences resulting in learned helplessness and frustration, which further complicates academic performance. As a result, African American children in the public school
system are ill-prepared to develop academic and critical thinking skills. This is problematic as lower academic performance is associated with lowered self-esteem and negative self-concept (Harris & Graham, 2014).

African American children have the greatest percentage of behavioral problems in the school setting (Rudd, 2014). The high rates of discipline infractions for African American children begin as early as preschool. African American children are frequently described in the school setting as overly aggressive, hyperactive, and disruptive (Harris & Graham, 2014). African American children are more likely to face expulsion, suspension, and behavioral reprimands than any other cultural group. African American children of all ages are three times more likely to be suspended and expelled from school than Caucasian students (U.S. Department of Education, 2014). The average suspension rate for African American children is 16% yet 5% for Caucasian students. African American boys are most vulnerable to academic discipline. They have the highest rate among all of their peers including African American girls. In elementary school, the expulsion and suspension rate is 20% for African American boys and 12% for girls in preschool through 12th grade (U.S. Department of Education, 2014).

Suspensions and expulsions have short- and long-term effects on African American children, such as losing class time, persistence in behavioral problems, and increased probability of future academic discipline (Splett & Hawks, 2011). These factors are problematic for emotional and social development with peers and teachers. Furthermore, African American students often react to discipline infractions with perceptions of negative attention and feelings of alienation (Harris & Graham, 2014). The long-term consequences include increased risks for later delinquency and school dropout (Splett & Hawks, 2011). These particular long-term consequences are associated with adulthood drug abuse, incarceration, and problems related to mood.
Behavioral, Emotional, and Mental Health Problems

*Perspectives and Stigma of Behavioral and Emotional Problems*

African American parents tend to hold many misconceptions about the nature and etiology of mental illnesses (Dixon & Vaz, 2005). Aspects of shame and stigma are involved in the views of African American parents. Specifically, African American parents tend to blame themselves and child rearing practices for emotional and behavioral problems of children (Holm-Hansen, 2006). Additionally, African American parents view mental health challenges as linked to religious and spiritual disconnections (Dixon & Vaz, 2005). Therefore, for African Americans, mental health challenges are commonly viewed as character flaws rather than as psychologically- and biologically-related (Boyd-Franklin, 2006). The African American view of mental illness and help-seeking are not only perceived as weaknesses but a disturbance of character (Dixon & Vaz, 2005). Due to their perspectives, mental health services are not generally considered viable options for African American parents. The typical method of help seeking is grounded in family, religion, and community support for any issues related to mental health. Due to these systemic resources, African Americans may view outside help as unnecessary. However, some issues become severe and prolonged, requiring more intensive services for emotional and behavioral problems.

*African American Child Behavioral Problems*

African American children are susceptible to psychological dysfunction and behavioral problems due to racial challenges, socio-economic, and environmental factors (Belgrave & Allison, 2013). These factors interfere with overall development and well-being of African American children (Perry-Burney, 2007). Historically, African American children are reported to commonly display behavior problems, such as hyperactivity, problems with self-regulation,
aggression, and disobedience (Barbarin & Soler, 1993). The knowledge about behavioral problems are primarily derived from parent and teacher observations of African American children. Thus, the manifestations of these reported behavioral traits are largely based on perceptions of behavior within social context. For example, Barbarin & Soler (1993) examined the prevalence of behavioral, emotional, and academic problems of a non-clinical population of 1,458 African American children. Barbarin and Soler (1993) analyzed the frequency of reported problems by age, gender, and family structure. Utilizing the Child Behavior Checklist, they found the most reported clinical problems by African American parents were hyperactivity, oppositional behavior, and agitation. After assessing for the effects of gender, Barbin and Soler (1993) found the most frequent problems reported for African American males were behaviors related to self-regulation. They found that parents of males reported more problems than females related to misbehavior, acting without thinking, being cruel, and destroying property. These behaviors were most common among African American children aged 11 and younger as compared to adolescents aged 13-17 years old. Post hoc comparisons revealed African American children residing in single-parent homes reported a greater amount of antisocial, problems with peers, and overall total problems than those children in two-parent homes did. They concluded African American children 11 and younger are at risk for many social-emotional problems. These problems are further exacerbated by gender and family make-up. African American males had higher incidences of behavior, social, and emotional problems than the females in the sample. Additionally, children residing in single parent homes had higher parent reports of behavioral problems.

Belgrave and Allison (2013) theorized that in comparison to parents, teachers are more likely to report observations of behaviors problems among African American children compared
to other cultural groups. Teachers tend to report increased observations of conduct and disruptive behaviors for African American children. McDermott and Spencer (1997) explored the prevalence of teacher observations of 1,400 Caucasian, African American, and Latino American children using the Adjustment Scale for Children and Adolescents. Findings of the study indicated that teachers reported more observations of aggression and oppositional defiance for African American children as compared to Caucasian and Latino American children. They concluded that the findings related to African Americans are likely attributed to socio-environmental risks (e.g. negative racial stereotyping, poor teacher-student relationships, and educational disparities) and the need for adaptive coping measures due to the limited availability of social support. Sbarra and Pianta (2001) found similar findings concerning problematic behaviors displayed by African American children in comparison to Caucasian American children. Using a sample of 359 Caucasian children and 181 African American children, Sabarra and Pianta (2001) examined teacher reports of student behavior and competence problems in kindergarten through first grade as measured by the Teacher-Child Rating Scale (TCRS). Results indicated that behavior problems (e.g. conduct and shy/anxious behaviors) of the African American children remained consistent from kindergarten to first grade, whereas, reported behavior problems decreased for the Caucasian American participants. However, results revealed the difference was not statistically significant. Further results revealed that teachers reported significantly lower ratings of competence (e.g. difficulties following directions and frustration tolerance) for African American children than the Caucasian children. Teachers rated competence of African American children dropped from kindergarten to first grade, whereas, the competence ratings remained stable for Caucasian American children. The authors concluded
that the differences in teacher observations are likely impacted by teacher expectations and misinterpretations of African American behaviors.

Puig et al. (1999) found similar findings regarding teacher report of disruptive related behaviors displayed by African American children. Utilizing a sample of 48 African American children and 54 Jamaican children aged 6-11. Puig et al. (1999) examined teacher reports and observations of emotional and behavioral problems. U.S. teachers rated the African American children and Jamaican teachers rated the Jamaican children. Puig et al. (1999) found statistically significant differences between African American and Jamaican children on the aggressive and delinquent behavior subscales with medium effects. Puig et al. (1999) concluded that teachers of the African American children reported significantly higher scores for aggressive and delinquent behaviors. Further analyses revealed the teachers of the African American students reported significantly higher total problems than the teachers for the Jamaican students with large effects. They concluded teachers of African American children reported twice as many behavioral problems than Jamaican children. Puig et al. (1999) theorized the differences were attributed to the social understanding of African American behaviors and limited resources.

In addition to perceived conduct and aggressive behavioral traits, physical movement is another behavioral observation and characteristic of African American children (Belgrave & Allison, 2013). According to Hosp and Hosp (2001), African American children tend to have higher need for movement and interactive verbal exchange than Caucasian children. These physical characteristics may be viewed as disruptive, particularly in the school environment. The need for physicality is often associated with behavioral concerns and ADHD symptomology. Teachers report more observations of ADHD symptomology in African American children than
Caucasian children. Miller, Nigg, and Miller (2009) conducted a mini meta-analysis of five studies (4 teacher-rated and 1-parent rated studies) in order to examine the racial difference in ADHD. Miller et al. (2009) found teacher reports yielded higher scores on ADHD ratings for African American children than Caucasian children with a medium effect. They concluded socio-environmental risks, classroom environment, and teacher perspectives predispose African American children to higher ADHD ratings. The problem with ADHD ratings may be the need for physicality versus restrictiveness in the school environment. These behavioral characteristics of African American children predispose them to problems with self-regulation, rule-breaking, and relationships with peers. The consequences of these characteristics result in emotional maladjustment such as loneliness, anxiety, and depressed mood (Rubin, 1998).

African American Children and Emotional Problems

The manifestations of emotional problems in African American children are additionally influenced by gender and sociocultural factors (Belgrave & Allison, 2013). African American children may face emotional challenges because of a high degree and range of emotional expression (APA, 2008). Ward (2000) theorized that Caucasian American children tend to have more emotional restraint, whereas, African American children exhibit more comfort with expressing a variety of emotions. This theory is grounded in the observed socialization of African American children to engage in freedom and spontaneity of emotional expression. However, African American children are likely perceived by adults outside of their cultural group as overly emotional and reactive (Ward, 2000). Thus, African American children might frequently face the challenge of emotional self-regulation in accordance with larger societal norms rather than cultural expectations for optimal functioning (APA, 2008). Emotional
regulation is a critical task for African Americans as frequent or intense emotional experiences inhibits the ability to manage emotions in socially desired ways (Lemerise & Arsenio, 2000).

The prevalence of emotional challenges is high for African American children due to neighborhood characteristics, single-parent family structure, and poverty (Barbarin & Soler, 1993). These challenges can result in maladaptive emotional behaviors and responses. African American children experience more depressive symptomology related to interpersonal problems and ineffectiveness than their Caucasian American peers (Barbarin, 1999). Gender plays a significant role in emotional problems with African American children. Boys may typically be socialized to restrict and suppress their emotions with the exemption of anger (Allen, 2011). Belgrave and Brevard (2015) hypothesized that depression and anxiety might manifest as anger and aggression in African American males. Thus, emotional disturbances are present but may be less noticeable in African American African males. Children with low levels of emotional expressivity may be at risk for maladaptive behaviors such as aggression (Sullivan, 2010). Belgrave and Brevard (2015) explained African American boys might carry themselves as tough and aggressive in order to gain respect and protection against threats. However, these characteristics are not conducive in some social settings, particularly the school environment. African American girls appear more likely identified and observed as anxious, irritable and depressed (Barbarin, 1999). Palapattu et al. (2006) studied a sample of 114 adolescents to examine the gender differences in anxiety symptoms. Results revealed that the African American females reported higher levels of anxiety than the African American males. The researchers hypothesized the differences may be attributed to psychosocial and biological factors such as parental attitudes about emotional expression, coping skills, and manifestation of anxiety.
Research regarding African American children reveals that they are more at risk and have higher incidences of behavior problems when compared to peers of different races and ethnicities (Belgrave & Allison, 2013). Socio-environmental factors such as neighborhood violence, low-income, and single parent families are linked to behavioral and emotional problems such as anxious and depressive symptomology, hyperactivity, and misconduct (APA, 2008). These factors not only affect the self-esteem of African American children but their ability to cope and manage their emotions (APA, 2008). The resulting consequences may include dysfunction related to self-management, healthy peer relationships, family dynamics, and in functioning in social environments (Belgrave & Allison, 2013). Without high self-esteem, children are unable to manage effectively their responses to negative reactivity directed at the self-structure such as stereotypical assumptions and evaluations from others based on race. Furthermore, because self-esteem for African Americans is linked to relation to others, poor self-esteem affects belongingness, attentiveness to others, and satisfying peer and family relationships. Poor self-esteem prevents African American children from confronting developmental challenges compounded by racial and cultural experiences in their daily environments.

Social-Emotional Competencies

Social emotional competence is one of the key markers for mental health, cognitive function, and healthy relationships with others (Webster-Stratton, & Reid, 1999). Social emotional competence is a multidimensional construct and entails characteristics such as self-awareness, friendship skills, emotional competence, behavior management, and interpersonal skills (Merrell, 2011). These characteristics involve the attributes of self-regulation, empathy, self-responsibility, and social competence (Darling-Kuria & Bohlander, 2014). Social emotional competencies enable children to interact positively with others, effectively communicate
emotions, and regulate behaviors (Barbarin et al., 2008). The development of social emotional competence is important for all children but particularly for African American children (APA, 2008). African American children are confronted with socioenvironmental risks, limited resources, racism, and discrimination as early as the preschool years. Consequently, African American children have to rely even more on their social emotional attributes when facing daily challenges, particularly those related to negative racial messages about physical appearance, intelligence, and self-worth. Thus, social emotional attributes may help counteract adverse risks. They may enable children to develop critical socio-emotional skills for coping and adapting to challenges. Well-developed social-emotional competencies are linked to increased confidence, interest in relationships, positive communication skills, and persistence with challenging experiences (Darlin-Kuria & Bohlander, 2014). Therefore, social emotional competence may serve as a protective factor against maladaptive development for African American children (Carter, Briggs-Gowan, & Davis, 2004). Children with undeveloped social emotional competence have more problems and challenges in their homes, schools, and outside environments (Barbin et al., 2008). The most common social emotional competence problems are related to conduct and antisocial behaviors (Peth-Pierce, 2000). Children with social emotional competence problems are more likely to experience rejection from peers, negative feedback from adults, and off task behaviors (Carter et al., 2004). Overall, children with less developed social emotional competence struggle to attend, adapt, and respond to their environmental experiences (Carter et al., 2004).

Attributes of Social Emotional Competence

Social-emotional competencies are adaptive attributes critical for children’s personal and academic success (Merrell, 2011). The competencies include characteristics such as empathy,
responsibility, self-regulation, and social competence. When children develop these competencies, they create a sense of personal accomplishment, harmonious relationships with others, and the ability to cope with challenges and stressors (Epstein & Sharma, 1998). Therefore, social-emotional competence serves as strengths for children as they navigate in their life experience and challenges (Merrell, 2011). However, undeveloped competencies lead to problems with accepting responsibility, regulating, emotions and behaviors, and empathizing with the feelings of others.

**Empathy.** Empathy is a critical aspect of overall social-emotional competence (Merrell, 2011). Empathy is an interpersonal skill that involves awareness and ability to take the perspective and respond to the emotions of others (Harris & Graham, 2014). This attribute promotes the capacity to respond sensitively to others, engage in cooperation, and develop close relationships (Masterson & Kersey, 2013). By preschool, children typically have the ability to recognize different feelings and ideas of others (Masterson & Kersey, 2013). As they progress to early elementary, children have the ability to take the perspectives of others and use them to problem solve. As a result, children increase in their self-confidence to help and engage in responsibility to others. Empathy has been postulated as a protective factor against conduct and disruptive behavior characteristics (Harris & Graham, 2014). Empathy is positively associated with prosocial behaviors (Eisenberg et al., 1991; McMahon, Wernsman, & Parnes, 2006; Roberts & Strayer, 1996). This attribute motivates altruistic behaviors and perspective taking (de Waal, 2008). Furthermore, empathy is associated with social skills. Research indicates empathy may protect against difficulties with cooperating and interacting with others (Saliquist et al. 2009; Zhou et al. 2002). Thus, empathy enhances a child’s ability to optimally function with others. Deficits of empathy in children are indicators of impaired functioning. According to Supplee,
Skuban, Shaw, and Prout (2009), early struggles with empathy are associated with later maladaptive externalizing behaviors and underachievement. Prolonged empathy dysfunction increases risks for mental health disorders such as oppositional defiant and conduct disorder (de Weid, Gipsen-de Weid, & Van Boxtel, 2010). Research indicates empathy is negatively correlated with aggression and anger (Eisenberg, Eggum, Giunta, 2010; Jolliffe & Farrington, 2006; Strayer & Roberts, 2004). Undeveloped empathy is linked with difficulties interpreting social cues, engagement in maladaptive conflict, and poor social interactions, and problems with self-regulation (Kersey & Masterson, 2013). Well developed empathy reduces the maladaptive behaviors and interactions with others (McMahon, 2006).

**Social competence.** Social competence is another ability integral to overall social emotional competence (Vahedi, Farrokhi, Farajian, 2012). Social competence is the ability to maintain friendships with peers, engage others verbally, and experience a sense of comfort with peers (Merrell, 2011). This competency attribute requires children to be aware of how their behaviors affect others in their environments and sensitivity to needs of others (Vahedi et al., 2012). Well-developed social competence involves social assertiveness, cooperation, and friendliness. This attribute results in peer acceptance, emotional health, and psychological resilience. As a result, socially competent children tend to fare well in social interactions and academic performance. Children with developed social competence have increased scholastic abilities. Social competence provides children with the needed emotional and social support in their environments. Research supports social competence is positively correlated to happiness, quality of life, respect for self and others, and positive self-concept (Frydenberg, Deans, O'Brien, 2012). Higher social competence in early elementary school is linked to being twice as likely to graduate from high school, obtain college degree, and maintain a full-time job (Jones,
Greenberg, & Crowley, 2015). However, undeveloped social competence is linked to adverse consequences. Children with poor and delayed social competencies are more likely to have emotional and behaviors problems (Harris & Graham, 2014). Primary difficulties include aggression, withdrawal, and scholastic abilities (Belgrave & Allison, 2014). The long-term effects of persistent poor social competencies are the most alarming. In a longitudinal study, Jones, Greenberg, & Crowley (2015) found kindergarteners with persistent poor social competencies had higher incidences of adult arrest, drug use, and lower incomes in adulthood. Undeveloped social competencies further complicate adjustment and self-regulation into adulthood.

**Self-regulation.** Self-regulation is a critical facet of social emotional competence (Merrell, 2011). The capacity for self-regulation begins at preschool age and improves throughout childhood (Eisenberg & Sulik, 2012). Self-regulation is vital for success in many aspects of development. Self-regulation is a socio-cognitive process, which entails monitoring and evaluating behavior and effectively expressing emotions (Winne & Hadwin, 2011). This social emotional competence skill requires children to translate their previous knowledge to regulate their thoughts, behaviors, and emotions (Eisenberg & Sulik, 2012). Well-developed self-regulation prepares children for success. Children with self-regulation skills tend to have better behavior adjustment and academic performance (Caughey, Mills, Owens, & Hurst, 2013). Children who have strong impulse control are seemingly able to engage in turn-taking, concentrating, following directions, and attending to environmental stimuli; important characteristics needed to learn and thrive in school environments and developing relationships with others. Noria et al. (2008) concluded second grade children with self-regulation skills demonstrated better behavior adjustment and academic skills than those students with less
developed self-regulation skills. Poor self-regulation appears to have consequences that are more adverse for children. Short-term problems include increased academic challenges, conflict with peers, and externalizing problems (Martinez-Pons, 2002). Long-term problems with self-regulation are linked to depression, addiction, suicidal ideation, and antisocial behaviors in later development.

In summary, social emotional competencies are essential for concurrent and future development across the lifespan (Merrell, 2011). Social emotional competencies are important developmental markers for overall adjustment and functioning, as they act as buffers against developmental stressors and challenges. Social emotional competence allows children to rely on their interpersonal traits and skills in their daily experiences. Well-developed social emotional competencies promote academic, behavior, and psychological resiliency (Caughey et al., 2013; Jones et al., 2015; Noria et al., 2008). Children with social emotional competencies are likely to engage in self-management, adaptive problem solving, and satisfying relationships with their peers. With social emotional competence, children may be able to emotionally attend to their environments more effectively, communicate positively, and maintain adaptive behaviors. Thus, children may exhibit fewer emotional and behavioral characteristics because of reliance on their social emotional competencies. On the contrary, undeveloped social emotional competencies in children appear to increase academic struggles, problematic behaviors (e.g. aggression, peer conflict, hostility), and emotional dysregulation (Eisenberg et al., 2010; de Weid, et al., 2010). These consequences have the potential to persist into adult delinquent behavior, emotional distress, and difficulties in social interactions.

African American Children and Social Emotional Competence
The social, environmental, and economical factors related to African American children contributes to risks for impaired socioemotional and cognitive functioning. Many of the academic, behavior, and emotional struggles are linked to undeveloped social emotional competence (Barbarin, 2013b). These risks inhibit the development and adjustment of African American children. The availability of research regarding social emotional competencies with African American children is scarce (Belgrave & Allison, 2013). However, available research is consistent with findings from other populations suggesting the critical importance of social emotional attributes on overall development (Harris & Graham, 2014). Despite the limited research of social emotional competencies among African American children, the implications regarding the importance of the attributes are evident in current research.

Research related to African American Children and Social Emotional Competence

Empirical research has supported that social-emotional competence is related to academic performance and positive scholastic attitudes in African American children. For example, Barbarin (2013b) investigated the relationship between social emotional competence and academic skills for African American and Latino children beginning in kindergarten through second grade. The results of regression analyses showed higher social emotional competence (e.g. self-regulation, social competence, and peer relationships) was a significant predictor of higher reading and math scores. Iruka, Burchinal, and Cai (2010) found similar results with social competency and achievement, confirming that parental report of close relationships and high social skills in kindergarten predicted higher math and reading scores in the third grade for African American children.

In further exploration of empathy as a social emotional competency, McMahon, Wernsman, and Parnes (2006) examined empathy and gender as predictors for prosocial
behaviors among African American children in fifth through eighth grades. After collecting data from 150 children and their teachers, the results showed higher teacher ratings of prosocial behaviors for children who rated themselves with high empathy. Furthermore, McMahon et al. (2006) found empathy and gender predicted prosocial behavior. Results revealed that African American males with higher self-reports of empathy were rated with higher prosocial behaviors than females. The authors attributed the gender differences to male tendency to interact in larger groups with peers with varying beliefs and values. However, girls tend to have smaller peer friendship groups and empathize more with those inside their group than those outside. The results also indicated higher levels of empathy for both African American males and females were negatively correlated with aggressive behaviors.

In exploration of self-regulation as a social emotional competency among African American children, Sullivan, Helms, Kliewer, & Goodman (2010) examined the associations of self-reports of emotional and self-regulation of 358 African American children in middle school. Results of regression analyses showed predictive relationships between the ability of the African American children to regulate anger and expression of physical aggression. Sullivan et al. (2010) found that children who demonstrated ability to regulate their anger had fewer incidences of physical aggression. The children with difficulties regulating their sadness engaged in more relational aggression. Further analyses showed that African American children who reported difficulties expressing their emotions to others (e.g. “I prefer to keep my emotions to myself”; “When I get upset, I am afraid to show it”) as measured by the Emotion Expression Scale were more likely to engage in relational aggression. Sullivan et al. (2010) emphasized the importance of emotional and self-regulation in behavior adjustment and relationships with peers.
Literature regarding African American children and social emotional competencies remains limited. However, current empirical literature with African American children shows promise for the protective nature of social emotional competence. Literature supports social emotional-related competencies predict adaptive behaviors. The culmination of studies with African American children presents empathy, self-regulation, and social relationships as protective factors for aggression, emotional dysfunction, and academic struggles. African American children with higher levels of empathy, self-regulations, and social skills had fewer behavioral, social, and emotional problems.

**Child Centered Play Therapy**

*Basic Tenets of Child Centered Play Therapy*

Child-Centered Play Therapy (CCPT) is a theoretical treatment modality for working with children (Ray, 2011). This theoretical approach is designed to facilitate a nurturing environment for children to self-direct their play and express themselves in various ways for the purpose of reality testing, learning adaptive coping skills, enhancing self-esteem, and increasing decision-making (Ray, 2011). Axline (1947) developed nondirective play therapy, later coined CCPT, as a developmentally appropriate application of Rogers’ (1951) person centered approach used with adults. The main tenet of CCPT is the innate capacity of individuals to self-actualize when provided an atmosphere characterized by full acceptance and maintenance of the therapeutic relationship (Landreth, 2012). Rogers’ philosophy of human personality, growth and adjustment, and motivation provide the foundation of CCPT. Rogers (1951) developed 19 propositions to provide the basis for the nature of relationship and the facilitation of therapeutic change. Rogers’ propositions included the following:

1. Every individual exists in a continually changing world of experience of which he or she is the center.
2. The organism reacts to the field as it is experienced and perceived. This perceptual field is, for the individual, “reality.”

3. The organism reacts as an organized whole to this phenomenal field.

4. The organism has one basic tendency and striving-to actualize, maintain, and enhance the experiencing organism.

5. Behavior is basically the goal-directed attempt of the organism to satisfy its needs as experienced, in the field as perceived.

6. Emotion accompanies and in general facilitates such goal-directed behavior, the kind of emotion being related to the seeking versus the consummatory aspects of the behavior, and the intensity of the emotion being related to the perceived significance of the behavior for the maintenance and enhancement of the organism.

7. The best vantage point for understanding behavior is from the internal frame of reference of the individual.

8. A portion of the total perceptual field gradually becomes differentiated as the self.

9. As a result of the interaction with the environment, and particularly as a result of the evaluational interaction with others, the structure of the self is formed—an organized, fluid, but consistent conceptual pattern of perceptions of characteristics and relationships of the “I” or the “me,” together with the values attached to these concepts.

10. The values are attached to experiences, and the values are part of the self-structure, in some instances are values experienced directly by the organism, and in some instances are values introjected or taken over from others, but perceived in distorted fashion, as though they had been experienced directly.
11. As experiences occur in the life of the individual, they are (a) symbolized, perceived, and organized into some relationship to the self, (b) ignored because there is no perceived relationship to the self-structure, or (c) denied symbolization because the experience is inconsistent with the structure of the self.

12. Most of the ways of behaving that are adopted by the organism are those that are consistent with the concept of the self.

13. Behavior may, in some instances, be brought about by organismic experiences and needs that have not been symbolized. Such behavior may be inconsistent with the structure of the self, but in such instances the behavior is not “owned” by the individual.

14. Psychological maladjustment exists when the organism denies to awareness significant sensory and visceral experiences, which consequently are not symbolized and organized into the gestalt of the self-structure. When this situation exists, there is a basis for potential psychological tension.

15. Psychological adjustment exists when the concept of the self is such that all sensory and visceral experiences of the organism are, or may be, assimilated on a symbolic level into a consistent relationship with the concept of the self.

16. Any experience that is inconsistent with the organization or structure of the self may be perceived as a threat, and the more of these perceptions there are, the more rigidly the self-structure is organized to maintain itself.

17. Under certain conditions, involving primarily complete absence of any threat to the self-structure, experiences that are inconsistent with it may be perceived and
examined, the structure of the self-revised to assimilate and include such experiences.

18. When the individual perceives all his sensory and visceral experiences and accepts them into one consistent and integrated system, then he is necessarily more understanding and accepting of others as separate individuals.

19. As the individual perceives and accepts into his self-structure more of his organic experiences, he finds that he is replacing his present value system-based so largely on introjections that have been distortedly symbolized with a continuing organismic valuing process. (pp. 483-524).

These 19 propositions explain personality development, influences of emotions, thoughts, and behaviors, causes of maladjustment, and how growth occurs (Ray & Landreth, 2014). Through these propositions, Rogers emphasized the existence of humans in a world where they are the centers of their perceived experiences (Ray & Landreth, 2014). These interactions are the basis of self-actualization and enhancement of self. As individuals interact with others, their senses of self and self-worth evolves from their perceived experiences and acceptance with others and the environment. The resulting behaviors, thoughts, and feelings are consistent with how individuals view themselves and their perceived experiences. Thus, these facets are directed toward maintaining and enhancing the self. Adjustment is characterized by behaving in ways congruent with self-concept. Contrarily, maladjustment occurs when individuals deny experiences and behave in ways inconsistent with the self-concept.

Axline (1947) created eight basic principles as a framework for working with children by integrating the core philosophy of the 19 propositions. These principles, when utilized genuinely
and consistently, provide an environment conducive for children to move toward autonomy and self-direction. Axline described the following principles as:

1. The therapist must develop a warm, friendly relationship with the child, in which good rapport is established as soon as possible.
2. The therapist accepts the child exactly as he is.
3. The therapist establishes a feeling of permissiveness in the relationship so that the child feels free to express his feelings completely.
4. The therapist is alert to recognize the feelings the child is expressing and reflects those feelings back to him in such a manner that he gains insight into his behavior.
5. The therapist maintains a deep respect for the child’s ability to solve his own problems if given an opportunity to do so. The responsibility to make choices and to institute change is the child.
6. The therapist does not attempt to direct the child's actions or conversation in any manner. The child leads the way; the therapist follows.
7. The therapist does not attempt to hurry the therapy along. It is a gradual process and is recognized as such by the therapist.
8. The therapist establishes only those limitations that are necessary to anchor the therapy to the world of reality and to make the child aware of his responsibility in the relationship. (pp. 73-74)

The eight basic principles are essential to the therapist’s way of being, attitudes and beliefs, and development of relationships with children (Landreth, 2012). The principles convey trust in a child’s resilience and ability to move constructively toward self-enhancement. Therefore, CCPT allows children the freedom to fully be themselves and express their feelings
and expressions. This perspective facilitates self-discovery and self-exploration needed for emotional and self-growth. Growth is supported through therapeutic conditions of genuineness, unconditional positive regard, and empathic understanding conveyed by the therapist. Genuineness is a fundamental aspect of the therapeutic relationship. This condition entails congruence between feelings and expression along with self-understanding and self-acceptance. Unconditional positive regard is an attitude experienced by the play therapist that conveys the value and worth of children, allowing them to fully be themselves. Empathic understanding is described as sensing the client’s internal experience and feelings in the present moment. Therefore, in the presence of sensitive understanding, children are free to explore, test limits, and share aspects of themselves (Landreth, 2012).

The therapeutic goals and objectives of CCPT are focused on the child and the self-structure (Landreth, 2012). The broad goals of CCPT include a) develop a more positive self-concept, b) assume greater self-responsibility, c) become more self-directing, d) become self-accepting, e) become more self-reliant, f) engage in self-determined decision making, g) experience self-control, f) become sensitive to the process of coping, g) develop an internal source of evaluation, and e) become more trusting of self. These goals emphasize and facilitate the child’s efforts toward self-enhancement, relationship with the therapist, and adapting to challenges. The combination of the therapeutic conditions and goals contribute to a nurturing environment for children to guide their play and express themselves in various ways for the purpose of reality testing, learning adaptive coping skills, enhancing self-esteem, and increasing decision making.
Research Related to the Effectiveness of Play Therapy

A large body of literature exists describing and theorizing play therapy as a treatment modality (LeBlanc & Ritchie, 2001). Over the past 40 years, play therapy has become widely used and accepted for children with various emotional and behavioral symptomology (O’Connor, 1991; White & Allers, 1994). CCPT is the most heavily studied theoretical approach to play therapy (Landreth, 2012). CCPT has proven effectiveness in a variety of settings with children presenting with a wide range of problems.

LeBlanc and Ritchie (2001) conducted the first meta-analysis of child therapy outcomes with an exclusive focus on play therapy. Previous meta-analyses of child therapy outcomes focused on verbally- or behaviorally-based psychotherapy with children and play-based therapy (Casey & Berman, 1985; Kazdin et al. 1990; Weisz, 1987; Weisz et al., 1995). In meta-analysis of 42 controlled outcome play therapy studies, LeBlanc and Ritchie (2001) found a moderate treatment effect of .66 for the effectiveness of play therapy.

Bratton, Ray, Rhine, and Jones (2005) conducted a later meta-analysis to determine the overall efficacy of play therapy and the factors that might impact effectiveness. Bratton et al. (2005) assessed 93 controlled outcome studies published between the years 1953-2000. The results indicated an overall large treatment effect of .80. The large effect size indicates that children participating in play therapy performed 0.80 standard deviations above children not receiving play therapy. Furthermore, moderate to large treatment effect were found on outcomes related to externalizing (0.81), internalizing (0.79), and combined (0.93) presenting problems. Additionally, Bratton et al. (2005) found comparable outcomes of play therapy across age and gender. The result of the study provided evidence of CCPT as an effective treatment for various presenting problems.
Lin and Bratton (2015) conducted a recent meta-analysis of 52 CCPT outcomes studies published between 1995 and 2010 in order to determine the overall effectiveness of CCPT. Results from the meta-analysis demonstrated a statistically significant overall moderate treatment effect of CCPT at 0.47. Based on the treatment effect, children receiving CCPT performed half of one standard deviation above those who received no treatment. Lin and Bratton (2015) concluded CCPT to be an effective treatment modality for children. Moreover, Lin & Bratton (2015) assessed treatment effects of various presenting issues. They found moderate to large treatment effects on outcomes of self-efficacy (.63) and caregiver-child relationship (.59) for children participating in CCPT. These findings suggest positive impact of CCPT on outcomes related to self-enhancement and the parent-child relationship. Lin and Bratton (2015) also assessed the impact of CCPT on different ethnic groups. A moderate treatment effect (.76) was found for Non-Caucasian groups (African American, Latino/Hispanic, Asian/Asian American, and other minority groups combined across the studies) in comparison to a small treatment effect for Caucasian children (.33) receiving play therapy. This finding suggests CCPT is viable treatment modality for diverse populations. Overall, the meta-analysis provided evidence of the benefits of child-centered play therapy for a variety presenting problems, ages, and ethnicities.

Ray, Armstrong, Balkin, and Jayne (2015) conducted a recent meta-analysis of 23 CCPT studies to examine the effectiveness of the treatment modality in elementary schools. Ray et al. (2014) found statistically significant differences with small to medium treatment effects on outcomes of externalizing problems (d=0.34), internalizing problems (d=0.21), and total behavior problems (d=0.33). The researchers also found statistically significant differences with small to medium effects on outcomes of self-efficacy (d=.29), academics (d=.036), and other problematic behaviors (d=0.38). The authors concluded that CCPT helped reduce the
problematic behaviors of elementary school children in comparison to those who did not receive intervention. Additionally, Ray et al. reported their sample as 32% African American, 23% Hispanic, and 37% Caucasian, concluding that CCPT can be effective with children from diverse backgrounds and proposing that CCPT researchers are sensitive to the need for intervention for children of different cultures.

*CCPT with African Children*

Outcome research is needed to determine the effectiveness of certain treatments for African American children (Mann & Randolph, 2011). The body of play literature strongly supports the importance of addressing multicultural issues and identifying culturally relevant treatments for diverse child population (Baggerly & Parker, 2005; Ritter & Chang, 2002; Sheely-Moore & Bratton, 2010). However, there is a lack of play therapy studies directly focused on meeting the specific mental health needs of African American children. Despite the lack of research with African Americans, CCPT has shown cross-cultural effectiveness. Garza and Bratton (2005) examined the effectiveness of CCPT as a culturally responsive intervention with Hispanic children. The Hispanic children participating in CCPT demonstrated significant reduction in internalizing (d=0.58) and externalizing behavior (d=0.76) problems with moderate to large effects. Cultural observations provided the researchers with ways play therapy should be sensitized to Hispanic children. In addition, CCPT has been proven to be effective with cultural groups outside of the U.S. on the reduction of anxiety among Chinese earthquake survivors in group play therapy (Shen, 2002); internalizing problems among Iranian children participating in non-play therapy (Bayat, 2008); and externalizing problems of Asian children participating in CCPT (Ogawa, 2006). These findings indicate the effectiveness of CCPT on various
internalizing and externalizing problems with children in diverse cultural groups. CCPT demonstrate positive intervention effects and meets the cultural needs of ethnic populations.

To this date, no studies have examined the application and sensitivity of CCPT to the needs of African American children. Currently, one play therapy study exists with a large percentage of African Americans but lacks an exclusive focus on the cultural group. Post (1999) conducted a quasi-experimental study to determine the impact of CCPT on the self-esteem, locus of control, and anxiety of at-risk children in fourth through sixth grade. A total of 168 children were included in the study. The ethnic background of the students included 82% of African American, 8% White, 7% Asian, and 3% identified as other racial group. Of the 168 participants, 77 were assigned to the experimental group and 91 in the control group. Using ANOVAs and Tukey post hoc analysis, Post (1999) found that children participating in CCPT group maintained levels of self-esteem and locus of control after 4 sessions, while those children with no intervention demonstrated significant decreases in self-esteem and locus of control as measured by the Cooper-Smith Self-Esteem Measure and Intellectual Achievement Responsibility Scale. The results indicated CCPT can be used a preventative treatment modality to help children reduce the risk of low self-esteem and lowered sense of external locus of control. The biggest limitation of the study was the lack of random assignment to the experimental and control groups. This limitation indicates a need for random assignment of participants to determine the efficacy of CCPT with a full sample of African American children. Additionally, there have been no studies exploring the use of CCPT as a culturally responsive intervention for African American children.
Impact of CCPT on Social Emotional Competencies

Social-emotional competencies are the attributes related to children’s abilities to utilize interpersonal skills to engage in social relationships with others and display emotional competence through emotional expression and empathy (Merrell, 2011). CCPT is a developmentally appropriate intervention with demonstrated effectiveness in addressing interpersonal problems and skills (Bratton, et al., 2005; Lin & Bratton, 2015). In CCPT, play therapists provide children with many opportunities to develop increased empathy and self-regulation of emotions and behaviors (Landreth, 2012). The benefits of increased empathy and self-regulation are twofold. The results of these attributes are fewer disruptive ways of behaving and relating and enhanced ability to maintain relationships with others. This process of interpersonal growth in CCPT occurs through empathic and reflective responding, limit setting, returning responsibility, and freedom of expression (Ray, Stulmaker, Lee, & Silverman, 2013). These therapist characteristics enhance the child’s trust, emotional expression, and physical security (Landreth, 2012). As a result, children are more trusting of themselves, develop positive self-regard, enhance mastery of self and environment, and they are able to work toward self-enhancement (VanFleet, Sywulak, Sniscak, 2010).

The available CCPT research has demonstrated CCPT as an effective intervention for increasing and maintaining social emotional competencies. The most recent study conducted by Cheng (2015) examined the effects of Child Centered Group Play Therapy (CCGPT) with 43 kindergarten children demonstrating apparent problems or emerging deficits in social-emotional assets. Study participants were randomly assigned to a CCGPT treatment intervention group (n=21) or a waitlist control group (n=22). Cheng (2015) conducted two mixed between-within ANOVAs and three post hoc analyses to determine the impact of CCPT on social emotional
assets. Cheng (2015) found statistically significant differences between the CCPT intervention and waitlist control group on empathy (ES=0.63) and social competence (ES=0.79) with moderate effects as reported by parents on the The Social-Emotional Assets and Resilience Scales (SEARS). Results indicated parental-noted benefits of CCPT on the overall social emotional assets, empathy, and social competence over those in the waitlist control group. CCGT appears to provide a therapeutic atmosphere for the enhancement of social emotional competence through interactions with the therapist and other group members.

Ray et al. (2013) found similar findings related to benefits of CCPT on social emotional competencies. Ray et al. (2013) conducted a pilot study with 37 children aged five to eight years old. The purpose of the study was to examine whether children participating in CCPT demonstrated improved levels of functional impairment when referred for a wide range of behavior and emotional problems. Of the 37 participants, 17 were randomly assigned to the CCPT intervention group and 20 were assigned to the delayed-start control group. In the first phase, children in the intervention group received individual CCPT twice a week for eight weeks. Following the intervention period for the second phase, the delayed-start group received individual CCPT and the intervention group continued with weekly sessions. In phase one, using a between-within subjects ANOVA, Ray et al. (2013) found significant differences between the groups on overall impairment with a medium level of practical significance. These results indicated that children in the CCPT group demonstrated decreased levels of overall impairment over those children in the delayed-start control group. In phase 2, using one-way repeated measures ANOVAs, the results revealed statistically significant differences with large effects for overall impairment, peer relationships, teacher relationship, and classroom problems across the three time periods for the CCPT intervention group. These findings demonstrate the impact of
CCPT on the reduction of problematic behavior, relationships with peers and teachers, and overall impairment. The children in the delayed-start group worsened or demonstrated the same impairment during the no-intervention stage. However, during the intervention stage, the children in the delayed-start group demonstrated statistically significant improvements for peer relationships and classroom problems. These results indicated the CCPT intervention helped improve relationships with peers and classroom behaviors.

Conclusion

African American children are exposed to environmental circumstances such as racism, poverty, single parenthood, and under resourced schools. These factors greatly impact the social and emotional development of children. This is problematic because children who exhibit deficits in social emotional competencies increase their risk for problematic relationships, disruptive behaviors, academic struggles, and difficulties regulating their behaviors and emotions. Social emotional competencies are foundational as children need them to successfully navigate their home, school, and community environments. African American children are uniquely confronted with additional tasks of overcoming prejudice, discrimination, and negative stereotypes. These tasks further complicate the development of social emotional competencies in African American children. Furthermore, the self-esteem and concept of African American children are influenced by social emotional threats to the self-structure due to negative racial stereotypes. CCPT is an effective treatment intervention for various social and emotional related problems across cultural groups. The therapeutic nature of CCPT helps foster development of social emotional competence through empathy, unconditional acceptance, limit setting, and esteem building. These aspects help, children regulate their behavior and emotions, develop healthy relationships, and improve self-concept. However, despite the many benefits of CCPT,
this treatment modality has yet to be explored as a culturally responsive and effective intervention for African American children.
Research supports the efficacy of CCPT as an intervention for children presenting with a range of emotional, social, and behavioral problems (Bratton, Ray, Rhine, & Jones, 2005). Additionally, CCPT has cross-cultural applications among Hispanic, Japanese, Chinese, and Iranian groups (Ray, 2014). Despite success of CCPT with these cultural groups, little is known about the effectiveness and cultural sensitivity of CCPT with the needs of African American children. African American children face many socio-environmental risks, which affect their socio-emotional development (Persson, 2005). CCPT is a successful treatment modality for children exhibiting externalizing behaviors with large positive effects based on over 90 outcome studies (Bratton et al., 2005). More specifically, CCPT has demonstrated success with outcomes related to interpersonal skills, empathy, self-regulation, and self-esteem. Despite notable effectiveness of CCPT on various externalizing and internalizing problems, to date, no randomized controlled studies directly target African American children. The purpose of this study is to examine the effects of CCPT on the social-emotional competencies and self-esteem of African American children presenting with problem behaviors. The current study was part of a larger randomized controlled trial exploring the effects of CCPT across four elementary schools. The following research methodology contains the research questions, definition of terms, participants, instruments, procedures, analysis of data, and limitations of the study.

Research questions include:

1. How does participation in CCPT impact the social emotional competencies of African American children who are identified with problem behaviors as reported by parents?
2. How does participation in CCPT impact the social emotional competencies of African American children who are identified with problem behaviors as reported by teachers?
Definition of Terms

*African American* for this study includes any child identified by a parent as Black, Black American, African American, or of African descent residing in the United States.

*Social emotional competencies* are defined as the adaptive attributes that are critical for children’s success at school, at home, and in the outside world (Merrell, 2011). These attributes include characteristics such as friendship skills, empathy, interpersonal skills, social support, problem-solving, emotional competence, social maturity, self-concept, self-management, social independence, cognitive strategies, and resilience. In this study, social-emotional competencies were operationalized as the total scores on the parent and teacher forms of the Social Emotional Assets and Resilience Scale (*SEARS*).

*Empathy (E)* is defined as the ability to recognize, understand, and take the perspective of another (Merrell, 2011, p. 4). For this study, empathy was operationally defined as the Empathy score on the parent and teacher forms of the *SEARS*.

*Self-Regulation (SR)* is defined as awareness and ability to control self, emotions, and behaviors (Merrell, 2011, p. 4). Self-regulation for this study was operationally defined as the Self-Regulation score of the *SEARS-Teacher* and Self-regulation/Responsibility score on the *SEARS-Parent*.

*Social competence (SC)* is defined as the ability to maintain friendships with peers, utilized effective verbal communication, and display comfort interacting with peers (Merrell, 2011, p. 4). Social competence was operationally defined as the social competence scores on the *SEARS-T* and *SEARS-P*.

*Problem behaviors* are defined as any emotional, behavioral, social characteristics that influence a child’s relationships, conduct, academics, and daily functioning.
CCPT is a non-directive and developmentally appropriate treatment modality for children with various presenting problems (Ray, 2011; Landreth, 2006). CCPT is a therapeutic modality based on play, the child’s natural communication style, to facilitate the child’s expression of thoughts, feelings, behaviors, and desires. CCPT therapists utilize the therapeutic relationship characterized by empathy, unconditional positive regard, and genuineness. Additionally, through the relationship, CCPT therapists facilitate self-healing, responsibility, positive self-concept, and socially appropriate self-expression. For the purpose of this study, CCPT is operationally defined by the therapeutic procedures of the CCPT manual (Ray, 2011).

Participants

Participants were children enrolled in Kindergarten through 4th grade at four Title I local elementary schools in the southwest United States. According the U.S. Department of Education (2006), the Title I designation is given to any public school with 40% or more children from low SES families. Demographic data of each school is listed in Table B.1 and was obtained from the 2014-15 Texas Academic Report developed by the Texas Education Agency. Upon receiving approval from the Institutional Review Board (IRB), the researcher asked school personnel to refer children with disruptive classroom behaviors. The participant inclusion criteria for this study included: a) Parent/guardians identified the children as African American; b) Children were 5-10 years old; c) Children were enrolled in grades Kindergarten through 4th grade; d) Children were referred by the teacher or school counselor due to problematic classroom behaviors; e) Children received consent from parent or guardian; f) Children agreed to participate in the study; g) Teachers and parents of children agreed to complete assessments and participate in the study; and i) Children did not receive concurrent play therapy or counseling services for the duration of the study.
A priori power analysis using G*Power 3.1 indicated a sample size of 34 participants was required in order to achieve a medium effect size of $f = .25$, power of .80, at an alpha level of .05. Initially 44 parents and teachers of potential participants gave their consents for the study. During the duration of the study, seven participants (Intervention group = 4, Control group = 3) were dropped from the study due to relocation to another school resulting in a sample size of 37. I used block randomization procedures by blocking for school and then I randomly assigned participants to either the intervention group ($n = 21$) or the waitlist control group ($n = 17$). The breakdown of participants at each school included 6 children at School 1, 15 children at School 2, 11 children at School 3, and 5 children at School 4. All of the participants identified as African American. Twenty-nine of the participants were male and 8 were female. The ages of the participants included eleven 5-year-olds, eight 6-year-olds, five 7-year-olds, six 8-year-olds, six 9-year-olds, and one 10-year-old. Of the 37 participants, 12 were in Kindergarten, 7 were in the first grade, 7 were in the second grade, 5 were in the third grade, and 6 were in the 4th grade. The distribution of age, grade, gender, and ethnicity across the two groups is displayed in Table B. 2.
Table B. 1

Demographic Data for 4 Title 1 Elementary Schools

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>School 1</th>
<th>School 2</th>
<th>School 3</th>
<th>School 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>African American</td>
<td>6.8%</td>
<td>16.0%</td>
<td>26.5%</td>
<td>11.3%</td>
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<tr>
<td>Latina/o</td>
<td>60.0%</td>
<td>39.0%</td>
<td>43.4%</td>
<td>63.3%</td>
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<tr>
<td>White</td>
<td>29.3%</td>
<td>38.1%</td>
<td>27.3%</td>
<td>21.0%</td>
</tr>
<tr>
<td>American Indian</td>
<td>1.2%</td>
<td>2.0%</td>
<td>0.3%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Asian</td>
<td>1.0%</td>
<td>2.6%</td>
<td>0.6%</td>
<td>2.1%</td>
</tr>
<tr>
<td>Pacific Islander</td>
<td>0.3%</td>
<td>0.6%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Two or More Races</td>
<td>1.4%</td>
<td>1.8%</td>
<td>1.9%</td>
<td>2.3%</td>
</tr>
<tr>
<td>Economically Disadvantaged</td>
<td>81.2%</td>
<td>71.1%</td>
<td>89.0%</td>
<td>64.2%</td>
</tr>
<tr>
<td>Study Participants</td>
<td>16.2%</td>
<td>29.7%</td>
<td>40.5%</td>
<td>13.5%</td>
</tr>
</tbody>
</table>

Note. Texas

Note. 2014-15 Texas Academic Report developed by the Texas Education Agency
Table B. 2

Demographic Data for Study Participants

<table>
<thead>
<tr>
<th>Variable</th>
<th>CCPT Group (n = 20)</th>
<th>Waitlist Control Group (n = 17)</th>
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<td>3</td>
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<td>Race Ethnicity</td>
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<tr>
<td>African American</td>
<td>20</td>
<td>17</td>
</tr>
<tr>
<td>Age</td>
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<td></td>
</tr>
<tr>
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<td>5</td>
</tr>
<tr>
<td>School 3</td>
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<td>6</td>
</tr>
<tr>
<td>School 4</td>
<td>1</td>
<td>4</td>
</tr>
</tbody>
</table>

Instrumentation

I used two assessment instruments to measure the effectiveness of CCPT with African American children for each of the two constructs. The parent and teacher forms of the Social Emotional Assets and Resilience (SEARS) were utilized to examine the effects of CCPT on social emotional assets (Merrell, 2011).

Social Emotional Assets and Resilience Scale (SEARS)

The SEARS is a strengths-based social emotional assessment measure for children and adolescents ages 5 to 18 years old (Merrell, 2011). The SEARS has a unique cross-informant
feature to allow for multiple perspectives of the social emotional competencies of children. The SEARS assessment tool focuses on the positive social, emotional, and behavioral attributes and characteristics of children rather than deficits. The strengths-based emphasis is different from the traditional pathology focus of social emotional assessment tools from children (Merrell, 2011).

*Social Emotional Assets and Resilience Scale-Parent (SEARS-P)*

The SEARS-P is a 39 item self-administered parent, guardian, and caregiver report of social emotional competencies among children aged 5 to 18 years old (Merrell, 2011). Respondents are asked to rate children on 4-point rating scale based on the degree to which the statement presented is true. The ratings include “never,” “sometimes,” “often,” or “always” true for the child during recent months. The SEARS-P includes three subscales that comprise the total score. The three subscales assess social emotional competencies that promote success in children in home and community contexts: 1) Self-Regulation/Responsibility (22 items), 2) Social Competence (10 items), and 3) Empathy (7 items). Well developed levels of self-regulation, social competence, and empathy promote a child’s ability to form and maintain relationships and display fewer disruptive behaviors. These social emotional competencies allow children to understand themselves and others, engage in satisfying relationships, and take responsibility and self-manage their thoughts, behaviors, and emotions. Self-Regulation/Responsibility measures the parent’s assessment of the child’s self-awareness, metacognitions, interpersonal insight, self-management, ability to accept responsibility, and ability to think before acting. Social competence measures the parent’s assessment of the child’s ability to maintain friendships with his or her peers, engage in effective communication, and feel comfortable around peers. Empathy measures the parent’s assessment of the child’s ability to understand and relate to others’ situations and feelings (Merrell, 2011). SEARS T-scores are converted to percentiles, which fall
into three different tiers of functioning (Merrell, 2011). Scores at or below the 5th percentile fall in Tier 3 and indicate “high risk” for socio-emotional deficits. Scores in the 6th to 20th percentile fall in Tier 2 and indicate children are “at risk” for some socio-emotional deficits. SEARS scores in the 21st-100 percentile fall in Tier 1 and indicate average socio-emotional competencies (Merrell, 2011).

The SEARS-P has strong psychometric properties. Internal consistency reliability estimates are strong for all three subscales and the total score with alpha coefficients ranging from .87 to .95. The Total score yielded a .96, .95 for Self-Regulation/Responsibility, .89 for Social Competence, .87 for Empathy. Test-retest reliability for the SEARS-P is adequate with moderate to high coefficients for all of the subscales. The Total score yielded a .93, .92 for Self-Regulation/Responsibility, .88 for Social Competence, .90 for Empathy after a 2-week interval. The SEARS-P has shown strong content and convergent construct validity. The results of the exploratory and confirmatory analyses yielded factor structures of .48 to .75 for the twenty-two items on the Self-Regulation/Responsibility subscale; .45 to .82 for the ten items on the Social Competence subscale; and .48 to .71 for the seven items on the Empathy subscale. The SEARS-P has moderate to large correlations on the subscales of other social emotional parent assessment tools, Social Skills Rating System (.42 to .74) and Home and Community Social Behavior Scales (.60 to .87) (Merrell, 2011). In the current study, Cronbach's alpha demonstrated a .96 for all participants on the SEARS-P pretest.

Social Emotional Assets and Resilience Scale-Teacher (SEARS-T).

The SEARS-T is a 41-item teacher report of perceived social-emotional competencies for children aged 5 to 18 years old (Merrell, 2011). Respondents are asked to rate students on a 4-point rating scale based on the degree to which the statement presented is true. The ratings
include “never,” “sometimes,” “often,” or “always” true for the child during recent months. The
SEARS-T includes four subscales that comprise the total score: 1) Self-Regulation (SR), 2)
Social Competence (SC), 3) Empathy (E), and 4) Responsibility (R). These four constructs are
integral to social emotional competence because they create a sense of self-management;
promote interpersonal skills and satisfying relationships with others; increase adaptive coping
and resilience, and promote academic and personal development (Merrell, 2011). Well-
developed levels of self-regulation, social competence, and empathy promote a child’s ability to
form and maintain relationships and display fewer disruptive behaviors. The items on each of the
four subscales measure the child’s social emotional competencies in school and classroom
environments. Self-regulation measures the teacher’s assessment of a student’s awareness and
ability to control emotions and behaviors. Social Competence measures the teacher’s assessment
of a student’s ability to maintain positive relationships and communication with peers. Empathy
measures the teacher’s assessment of a student’s ability to recognize and understand the
experiences and feelings of others. Responsibility measures the teacher’s assessment of a
student’s ability to think and behave responsibly. SEARS scores are converted to percentiles,
which fall into different tiers (Merrell, 2011). Scores at or below the 5th percentile fall in Tier 3
and indicate “high risk” for socio-emotional deficits. Scores in the 6th to 20th percentile fall in
Tier 2 and indicate children are “at risk” for some socio-emotional deficits. SEARS scores in the
21st-100 percentile fall in Tier 1 and indicate average socio-emotional competencies (Merrell,
2011).

The SEARS-T has strong psychometric properties. Reported internal consistency is
strong with Cronbach’s alpha coefficients of .98 for the Total score and .91 to .95 for the four
subscales (SEARS, Merrell, 2011). Test-retest reliability is adequate with moderate to high
coefficients of .94 for the Total score and .84 to .90 after a 2-week interval. In the current study, Cronbach's alpha demonstrated a .86 for all participants on the SEARS-T pretest.

In reference to validity, readability analyses were conducted and content validation occurred through a panel of six clinical professionals to ensure appropriateness of questions. Additionally, the SEARS-T has adequate convergent validity with moderate to high positive correlations with two teacher measures with reported strong psychometrics, Social Skills Rating System (SSRS) and School Social Behavior Scales (SSBS). The correlations coefficients for the total scores and subscales range from .39 to .82 with the median correlation as .70. Results of exploratory and confirmatory analyses yielded factor structures of .58 to .81 for the ten items on the Responsibility subscale; .39 to .87 for the twelve items on the Social Competence subscale; .34 to .87 for the thirteen items on the Self-Regulation subscale, and .30 to 60 on the Empathy subscale (Merrell, 2011).

Procedures
I gained approval from Denton Independent School District and the University of North Texas Institutional Review Board (see Appendix E) prior to recruiting participants for this study. The researcher first met with school personnel to discuss the background, description, and how to identify potential participants for the study. School counselors and teachers at each of the schools were asked to identify African American children who displayed problematic behaviors such as problems with teachers and peers, interpersonal difficulties, misconduct, maladaptive coping strategies, destroying property, and non-compliance based on classroom observations.

After counselors and teachers referred potential participants, school counselors were asked to send home consent forms (see Appendix E) to the parents and guardians to read, sign, and return. The consent forms provided parents and guardians with explicit details of the study
including rationale and procedures. I contacted the parents of those children referred by the teachers and counselors to review aspects of the study and answer any questions. Interested parents and guardians were asked to return the signed consent form to the school counselor or the child’s teacher. The research team collected all forms from each of the schools and began the process of determining the appropriateness of child participation in the study. Demographic information related to age, ethnicity, and race was collected at the time of obtaining consent from parents.

Upon receiving informed consent from parents, the researcher obtained consent from the teachers (see Appendix E) and assent from the children (see Appendix E). After completion of all consents and assent, teachers completed the Social Emotional Assets and Resilience Scale-Teacher (SEARS-T) during their planning periods. The parents completed the Social Emotional Assets and Resilience Scale-Parent (SEARS-P).

In accordance with randomized controlled trial procedures, children who met criteria were randomly assigned to the CCPT experimental group or the waitlist control group. In each of the four schools, block randomization was utilized to account for school and time differences in receipt of parent and teacher reports. Once I received blocks of consent forms for children meeting criteria, I randomized the participants into either the CCPT intervention group or waitlist control group using a random number generator. Following random assignment, I assigned children to therapists to immediately begin treatment. Children in the CCPT experimental group were scheduled to receive 30 minutes of CCPT twice a week for eight weeks. The CCPT play therapy sessions were conducted in the student’s school in a fully equipped playroom in accordance with Ray’s (2011) CCPT treatment manual. Due to student absences and school breaks, participants in the intervention group received between 8-16 sessions with a mean of
13.20 sessions. Children randomly assigned to the waitlist control group did not receive play therapy during the eight-week intervention period but were offered play therapy following the intervention period after the data collection was complete.

At the end of the 8-week intervention period, teachers and parents of participants in the CCPT and wait-list control groups completed the SEARS-T and SEARS-P as posttest measures. All participant data was kept confidential. The names of child participants, parents, and teachers were removed from all documentation or reports related to this study. Additionally, all pre and post data was recorded and coded for each participant to further ensure confidentiality for a master list. Clinical files were retained in accordance with human subjects approval.

**CCPT Experimental Group Procedures**

Participants assigned to the CCPT experimental group (n=20) were scheduled to participate in 16 sessions over 8 weeks for a total of 30 minutes at the child’s school. CCPT is a developmentally appropriate treatment modality using the therapeutic nature of play, the child’s natural communication, to facilitate the child’s expression of thoughts, feelings, behaviors, and desires. The CCPT therapists provided treatment according to the guidelines outlined in the CCPT treatment manual (Ray. 2011). Counselors responded with tracking verbal and non-verbal content and play behaviors, encouragement, empathic responses, esteem-building, returning responsibility, and therapeutic limit setting. Counselors used these skills to facilitate a warm, empathic, genuine, and permissive environment for full expression. I followed the recommendations of Landreth (2012) and Ray (2011) to determine playroom assembly, toys, and materials chosen for each of the playrooms in the four schools. The toys and materials selected for the playroom represented different categories such as nurturing, mastery, creative and expressive, aggressive, and relational. These categories of materials were chosen specifically
with the purpose to allow children a wide range of expression with or without verbal communication. Additionally, the toys were adapted to capture the African American culture such as African American dolls, figures, and religious symbols following the recommendation of (Chang & Ritter, 2005). Toys representative of a child’s culture allow children to play out culturally related feelings and work through them within the play therapy relationship (Hind, 2005). The dolls for this study included a variety of skin tones and hair textures. The figures utilized included extended family members such as grandparents. Hinds (2005) argued due to the role of grandparents in African American families, play therapists should consider including them in their playrooms. Concerning spirituality and religion, I included religious symbols such as crosses and church pews.

Counselors conducting play therapy included doctoral level students and one faculty member from the University of North Texas. Counselors included one African American female, seven Caucasian females, and one Caucasian male. As recommended by the CCPT treatment manual (Ray, 2011), all counselors met the following criteria: 1) one or more years of experience conducting play therapy, 2) master’s degree in counseling, 3) successful completion of two play therapy courses, and 4) successful completion of counseling practicum with supervised experience in play therapy. Prior to providing play therapy treatment, all counselors participated in direct training on delivering the CCPT treatment protocol to participants.

In order to ensure fidelity of protocol, the researcher adhered to the guidelines outlined in the CCPT treatment manual (Ray, 2011). All play therapy sessions for the research were video-recorded for the purpose of required weekly supervision conducted by two play therapy faculty members with advanced experiences. The Play Therapy Skills Checklist (PTSC; Ray, 2011) was utilized to conduct fidelity and adherence to the CCPT protocol. I randomly selected one video
for each child participant and completed the PTSC whereby responses from the play therapist were coded according to CCPT categories. Video review indicated that play therapists adhered to protocol in XX% of responses, exceeding Ray’s guidelines of 90% adherence.

*Wait-list Control Group Procedures*

Children randomly assigned to the wait-list control group did not receive treatment during the 8-week intervention. After the completion of the 8-week intervention and data collection, children on the wait-list group received weekly play therapy. The counselors providing the treatment included doctoral level counselors with experience in play therapy. Furthermore, the counselors participated in weekly supervision.

*Data Analysis*

After the study was completed, all measures were scored utilizing scoring software for parent and teacher forms of the SEARS. The pre and post data results were entered in IMB SPSS Statistics 22. I planned two factorial ANOVAs to determine differences across time (pre-test and post-test) between groups (CCPT and wait-list control) on the SEARS-P and SEARS-T Total scores. The SEARS-P and SEARS-T Total scores were utilized as dependent variables, the intervention and waitlist control groups were utilized as between subjects variables, and time across pretest and posttest as the within subjects variable. Before conducting analyses, I assessed the following assumptions to determine appropriateness of factorial ANOVAs: 1) absence of significant outliers, 2) normal distribution of the dependent variable, 3) random sample, and 4) independence of observations. If statistical or practical differences were found between groups over time for the total score on each factorial ANOVA, I planned to conduct further post-hoc analyses on subscales.
The alpha level for statistical significance was set at .05 to examine statistically significant differences between the means across time. Partial eta squared ($\eta_p^2$) effect sizes were reported in order to assess the practical significance of the results through variance accounted for. According to Henson (2006), statistical testing only has the capability to determine if an effect exists; however, effect sizes are helpful in determining the magnitude of differences in a more practical way. The Publication Manual of the American Psychological Association (APA, 2010) explained the necessity of exploring and reporting effect sizes in quantitative research to provide information about the strength of observed effects. According to Cohen’s (1977) guidelines, eta squares ($\eta^2$) were interpreted as .01 is small, .06 is medium, and .14 is large effect.
APPENDIX C

UNABRIDGED RESULTS
The following results are intended to answer the following questions; 1) How does participation in CCPT increase the social emotional competencies of African American children who are identified with problem behaviors as reported by parents? 2) How does participation in CCPT increase the social and emotional competencies of African American children who are identified with problem behaviors as reported by teachers? The following results are presented according to research questions, assumptions, and data analyses.

Parent Report for SEARS

In order to address how participation in CCPT increases the social emotional competencies of African American children who are identified with behavioral problems as reported by parents, a factorial analysis of variance (ANOVA) was conducted to examine parents’ reports of African American children who participated in the CCPT group on overall social emotional competence compared to children on the waitlist control group across pretest and posttest. The experimental group was utilized as the independent variable and the SEARS-P Total score as the dependent variable. The assumptions for level of measurement, random sampling, independence of observations, homogeneity of variance, normal distribution, and homogeneity of interrelations were all reasonably met. The pre and posttest mean scores and standard deviations for both groups’ SEARS-P Total scores are included in Table B.3.
Table B.3.

**Mean Scores and Standard Deviations on SEARS-P Total for Each Group**

<table>
<thead>
<tr>
<th></th>
<th>Intervention Group (n = 20)</th>
<th>Waitlist Control Group (n = 17)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Posttest</td>
</tr>
<tr>
<td><strong>Score</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>M</strong></td>
<td>37.30</td>
<td>40.45</td>
</tr>
<tr>
<td><strong>SD</strong></td>
<td>10.993</td>
<td>12.037</td>
</tr>
</tbody>
</table>

**Note.** An increase in mean scores indicates an improvement in social emotional competencies.

Results showed a statistically significant interaction between treatment group and time, $F(1, 35) = 4.87, p < .05$, with a medium to large effect size of $\eta_p^2 = .122$. The main effect of time was not statistically significant, $F(1, 35) = 3.105, p = .081$, yet there was a medium effect size of $\eta_p^2 = .072$. The main effect between groups was not statistically significant, $F(1, 35) = .011, p = .91$, $\eta_p^2 = .942$. Based on statistical and practical significance, we examined the means of the groups over time (see Figure 1), observation indicates a trend in which the scores of the play therapy intervention group were improved and scores of the control group decreased (marking deterioration). Table B.4 displays a summary of the factorial ANOVA for the SEARS-P Total scores. Figure 1 depicts the graphic representation of changes in group over time.

Table B.4

**Factorial ANOVA for SEARS-P Total**

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>SS</th>
<th>MS</th>
<th>F</th>
<th>p</th>
<th>$\eta_p^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
<td>1</td>
<td>2.195</td>
<td>2.195</td>
<td>.011</td>
<td>.916</td>
<td>.942</td>
</tr>
<tr>
<td>Time</td>
<td>1</td>
<td>35.946</td>
<td>35.946</td>
<td>3.105</td>
<td>.087</td>
<td>.081</td>
</tr>
<tr>
<td>Group*Time</td>
<td>1</td>
<td>56.378</td>
<td>56.378</td>
<td>4.870</td>
<td>.034*</td>
<td>.122</td>
</tr>
<tr>
<td>Within Cells</td>
<td>35</td>
<td>405.216</td>
<td>11.578</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>37</td>
<td>6787.346</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Note.** *Statistically significant at p < .05
In order to further examine the statistically and practically significant results with Total score on the SEARS-P, I conducted three separate factorial ANOVAs as post hoc analyses with the following subscales that comprise the Total score on the SEARS-P: Self-Regulation/Responsibility, Social Competence, and Empathy. The treatment and intervention groups (k=2) were utilized as the between-subjects variable and times across pretest and posttests.
(k=2) were utilized as the within-subjects variable. These post hoc analyses served to provide additional understanding regarding the statistically significant changes on the Total score on the SEARS-P.

*Factorial ANOVA on SEARS-P Self-Regulation/Self-Responsibility*

For the SEARS-P Self-Regulation/Self-Responsibility subscale scores, the assumptions for level of measurement, random sampling, independence of observations, homogeneity of variance, normal distribution, sphericity, and homogeneity of interrelations were all reasonably met. Table B.5 includes the pre and post tests’ mean scores and standard deviations for both groups’ Self-Regulation/Self-Responsibility subscale on the SEARS-P.

**Table B.5**

*Mean Scores and Standard Deviations on SEARS-P Self-Regulation/Self-Responsibility Subscale*

<table>
<thead>
<tr>
<th>Total Score</th>
<th>Intervention Group (n = 20)</th>
<th>Waitlist Control Group (n = 17)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Posttest</td>
</tr>
<tr>
<td><em>M</em></td>
<td>35.80</td>
<td>39.25</td>
</tr>
<tr>
<td><em>SD</em></td>
<td>10.247</td>
<td>11.593</td>
</tr>
</tbody>
</table>

Results of the factorial ANOVA showed no significant interaction effect between treatment group and time, *F*(1, 35) = 2.821, *p* = .102, yet there was a medium effect size of *η*<sub>p</sub><sup>2</sup> = .075. The main effect of time was statistically significant, *F*(1, 35) = 10.030, *p* = .033, with a large effect size of *η*<sub>p</sub><sup>2</sup> = .209. The main effect between groups was not statistically significant, *F*(1, 35) = .013, *p* = .911, *η*<sub>p</sub><sup>2</sup> = .731. Based on practical significance, we examined the means of the groups over time (see Figure 2), observation indicates a trend in which the scores of the play therapy experimental group and waitlist control improved. Table B.6 displays a summary of factorial ANOVA results for the Self-Regulation/Self-Responsibility subscale on SEARS-P as
the dependent variable. Figure 2 depicts the graphic representation of changes in group over time.

Table B.6

**Factorial ANOVA for SEARS-P Self-Regulation/Self-Responsibility**

<table>
<thead>
<tr>
<th>Source</th>
<th>Df</th>
<th>SS</th>
<th>MS</th>
<th>F</th>
<th>P</th>
<th>$\eta^2_p$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
<td>1</td>
<td>2.232</td>
<td>2.232</td>
<td>.013</td>
<td>.911</td>
<td>.000</td>
</tr>
<tr>
<td>Time</td>
<td>1</td>
<td>93.406</td>
<td>93.406</td>
<td>10.030</td>
<td>.003*</td>
<td>.223</td>
</tr>
<tr>
<td>Group*Time</td>
<td>1</td>
<td>26.271</td>
<td>22.271</td>
<td>2.821</td>
<td>.102</td>
<td>.075</td>
</tr>
<tr>
<td>Within Cells</td>
<td>35</td>
<td>405.216</td>
<td>11.578</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>37</td>
<td>6208.416</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note. Statistically significant at $p < .05$

![Graph](image.png)

*Figure 2.* Means between intervention and waitlist control groups over time on SEARS-P Self-Regulation/Responsibility
Factorial ANOVA on SEARS-P Social Competence

For the Social Competence scores, the assumptions for random sampling, independence of observation, homogeneity of variance, normal distributions, and homogeneity of intercorrelations were reasonably met. Table B.7 includes the pre and posttests’ mean scores and standard deviations for both groups’ Social Competence subscale on the SEARS-P.

Table B.7

Mean Scores and Standard Deviations on SEAR-P Social Competence

<table>
<thead>
<tr>
<th>Total Score</th>
<th>Intervention Group (n = 20)</th>
<th>Waitlist Control Group (n = 17)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Posttest</td>
</tr>
<tr>
<td>M</td>
<td>41.80</td>
<td>43.25</td>
</tr>
<tr>
<td>SD</td>
<td>11.781</td>
<td>11.706</td>
</tr>
</tbody>
</table>

Results of the factorial ANOVA for the Social Competence subscale showed no statistically significant interaction between treatment group and time, $F(1, 35) = 2.980, p = .093$, yet there was a medium effect size of $\eta^2_p = .078$. The main effect of time was not statistically significant, $F(1, 35) = .202, p = .656$, with a small effect size of $\eta^2_p = .006$. The main effect between groups was not statistically significant, $F(1, 35) = .043, p = .837, \eta^2_p = .947$. Based on practical significance, when examining the means of the groups over time (see Figure 3), observation indicates a trend in which the scores of the play therapy experimental group were improved and scores of waitlist control group decreased. Table B.8 displays a summary of the factorial ANOVA results for the Social Competence subscale on SEARS-P as the dependent variable. Figure 3 depicts the graphic representation of changes in group over time.
Table B.8

Factorial ANOVA for SEARS-P Social Competence

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>SS</th>
<th>MS</th>
<th>F</th>
<th>P</th>
<th>$\eta^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
<td>1</td>
<td>9.043</td>
<td>9.043</td>
<td>.043</td>
<td>.837</td>
<td>.947</td>
</tr>
<tr>
<td>Time</td>
<td>1</td>
<td>4.786</td>
<td>4.786</td>
<td>.202</td>
<td>.656</td>
<td>.006</td>
</tr>
<tr>
<td>Group*Time</td>
<td>1</td>
<td>70.624</td>
<td>70.624</td>
<td>2.980</td>
<td>.093</td>
<td>.078</td>
</tr>
<tr>
<td>Within Cells</td>
<td>35</td>
<td>829.593</td>
<td>23.703</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>37</td>
<td>7334.416</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Figure 3. Means between intervention and waitlist control groups over time on SEARS-P Social Competence.

Factorial ANOVA on SEARS-P Empathy

For the SEARS-P Empathy subscale scores, the assumptions for level of measurement, random sampling, independence of observations, homogeneity of variance, normal distribution,
sphericity and homogeneity of interrelations were all reasonably met. Table B.9 includes the pre and post tests’ mean scores and standard deviations for both groups’ Empathy scores on the SEARS-P.

Table B.9

Mean Scores and Standard Deviations on SEARS-P Empathy

<table>
<thead>
<tr>
<th>Total Score</th>
<th>Intervention Group (n = 20)</th>
<th>Waitlist Control Group (n = 17)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Posttest</td>
</tr>
<tr>
<td>M</td>
<td>43.10</td>
<td>45.25</td>
</tr>
<tr>
<td>SD</td>
<td>13.795</td>
<td>12.573</td>
</tr>
</tbody>
</table>

Results of the factorial ANOVA for Empathy showed a significant interaction effect between treatment group and time, $F(1, 35) = 4.335, p = .045$, and a medium to large effect size of $\eta^2_p = .110$. The main effect of time was not statistically significant, $F(1, 35) = .009, p = .926$, with a small effect size of $\eta^2 = .002$. The main effect between groups was not statistically significant, $F(1, 35) = .006, p = .938, \eta^2_p = .884$. When examining the means of the groups over time (see Figure 5), observation indicates a trend in which the scores of the play therapy intervention group increased (improvement) and the scores of waitlist control group decreased (deterioration). Table B.10 displays a summary of the factorial ANOVA results for the Empathy on SEARS-P as the dependent variable. Figure 5 depicts the graphic representation of changes in group over time.
Table B.10

Summary of Factorial ANOVA for SEARS-P Empathy

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>SS</th>
<th>MS</th>
<th>F</th>
<th>P</th>
<th>η²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
<td>1</td>
<td>1.606</td>
<td>1.606</td>
<td>.006</td>
<td>.938</td>
<td>.884</td>
</tr>
<tr>
<td>Time</td>
<td>1</td>
<td>.189</td>
<td>.189</td>
<td>.009</td>
<td>.926</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Group*Time</td>
<td>1</td>
<td>93.126</td>
<td>93.162</td>
<td>4.335</td>
<td>.045*</td>
<td>.110</td>
</tr>
<tr>
<td>Within Cells</td>
<td>35</td>
<td>752.216</td>
<td>21.492</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>37</td>
<td>9066.766</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note. Statistically significant at p < .05

Figure 4. Means between intervention and waitlist control groups over time on SEARS-P Empathy.
Teacher Report for SEARS

In order to address how participation in CCPT increases the social emotional competencies of African American children who are identified with behavioral problems as reported by teachers, a factorial analysis of variance (ANOVA) was utilized to examine teachers’ reports of African American children who participated in the CCPT group on overall social emotional competence compared to children on the waitlist control group across pretest and posttest. Experimental group was utilized as the independent variable and the SEARS-T Total score as the dependent variable. The assumptions for level of measurement, random sampling, independence of observations, homogeneity of variance, normal distribution, sphericity, and homogeneity of interrelations were all reasonably met. Table C.1 includes the pre and posttests’ mean scores and standard deviations for both groups’ SEARS-T Total scores.

Table C.1

Mean Scores and Standard Deviations on SEARS-T Total for Each Group

<table>
<thead>
<tr>
<th>Total Score</th>
<th>Intervention Group (n = 20)</th>
<th>Waitlist Control Group (n = 17)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Posttest</td>
</tr>
<tr>
<td>M</td>
<td>38.75</td>
<td>41.60</td>
</tr>
<tr>
<td>SD</td>
<td>4.667</td>
<td>6.328</td>
</tr>
</tbody>
</table>

Results showed no statistically significant interaction between treatment group and time, $F(1, 35) = 2.60, p = .116$, yet there was a medium effect size of $\eta_p^2 = .069$. The main effect of time was not statistically significant, $F(1, 35) = 3.621, p = .087$, with a medium effect size of $\eta_p^2 = .094$. The main effect between groups was not statistically significant, $F(1, 35) = 2.053, p = .161$, $\eta_p^2 = .990$. Based on practical significance, we examined the means of the groups over time.
(see Figure 5), observation indicates a trend in which the scores of the play therapy intervention group were improved and scores of the waitlist control group were slightly improved (marking improvement). Table C.2 displays a summary of the factorial ANOVA results for the SEARS-T Total score as dependent variable. Figure 5 depicts the graphic representation of changes in groups over time.

Table C.2

*Factorial ANOVA for SEARS-T Total*

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>SS</th>
<th>MS</th>
<th>F</th>
<th>p</th>
<th>η²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
<td>1</td>
<td>65.018</td>
<td>65.018</td>
<td>2.053</td>
<td>.161</td>
<td>.990</td>
</tr>
<tr>
<td>Time</td>
<td>1</td>
<td>43.736</td>
<td>43.736</td>
<td>3.621</td>
<td>.065</td>
<td>.094</td>
</tr>
<tr>
<td>Group*Time</td>
<td>1</td>
<td>31.412</td>
<td>31.412</td>
<td>2.600</td>
<td>.116</td>
<td>.069</td>
</tr>
<tr>
<td>Within Cells</td>
<td>35</td>
<td>422.804</td>
<td>12.080</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>37</td>
<td>1108.334</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Figure 5. Means between intervention and waitlist control groups over time on the SEARS-T

In order to further examine the practical significance of the SEARS-T results, I conducted four separate factorial ANOVAs as post hoc analyses with the following subscales that comprise the Total score on the SEARS-T: Self-Regulation, Social Competence, and Empathy, and responsibility. The treatment and intervention groups (k=2) were utilized as the between-subjects variable and times across pretest and posttests (k=2) were utilized as the within-subjects variable. These post hoc analyses served to provide additional understanding regarding the Total score for the SEARS-T.
Factorial ANOVA on SEARS-T Self-Regulation

For the SEARS-T Self-Regulation subscale scores, the assumptions for level of measurement, random sampling, independence of observations, homogeneity of variance, normal distribution, sphericity and homogeneity of interrelations were all reasonably met. Table C.3. includes the pre and posttests’ mean scores and standard deviations for both groups’ Self-Regulation scores on the SEARS-T.

Table C.3

Mean Scores and Standard Deviations on SEARS-T Self-Regulation

<table>
<thead>
<tr>
<th>Total Score</th>
<th>Intervention Group (n = 20)</th>
<th>Waitlist Control Group (n = 17)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Posttest</td>
</tr>
<tr>
<td>M</td>
<td>39.85</td>
<td>41.65</td>
</tr>
<tr>
<td>SD</td>
<td>4.030</td>
<td>4.987</td>
</tr>
</tbody>
</table>

Results of the factorial ANOVA for Self-Regulation showed no significant interaction effect between treatment group and time, $F (1, 35) = 1.249, p = .271$, with a small effect size of $\eta_p^2 = .034$. The main effect of time was not statistically significant, $F (1, 35) = .173, p = .680$, with a negligible effect size of $\eta_p^2 = .005$. The main effect between groups was statistically significant, $F (1, 35) = 4.147, p = .049$, $\eta_p^2 = .087$. Table C.4 displays a summary of the factorial ANOVA results for the Self-Regulation on SEARS-T as the dependent variable. Figure 6 depicts the graphic representation of changes in group over time.
Table C.4

*Summary of Factorial ANOVA for SEARS-T Self-Regulation*

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>SS</th>
<th>MS</th>
<th>F</th>
<th>p</th>
<th>η²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
<td>1</td>
<td>176.952</td>
<td>176.952</td>
<td>4.147</td>
<td>.049*</td>
<td>.987</td>
</tr>
<tr>
<td>Time</td>
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<td>4.381</td>
<td>.173</td>
<td>.680</td>
<td>.005</td>
</tr>
<tr>
<td>Group*Time</td>
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<td>31.624</td>
<td>31.624</td>
<td>1.249</td>
<td>.271</td>
<td>.034</td>
</tr>
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<td>Within Cells</td>
<td>35</td>
<td>885.835</td>
<td>25.310</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>37</td>
<td>1493.265</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note.* Statistically significant at p <=.05

*Figure 6.* Means between intervention and waitlist control groups over time on SEARS-T Self-Regulation

*Factorial ANOVA on SEARS-T Social Competence*
For the SEARS-T Social Competence subscale scores, the assumptions for level of measurement, random sampling, independence of observations, homogeneity of variance, normal distribution, sphericity and homogeneity of interrelations were all reasonably met. Table C.5 includes the pre and posttests’ mean scores and standard deviations for both groups’ Social Competence scores on the SEARS-T.

Table C.5

<table>
<thead>
<tr>
<th>Total Score</th>
<th>Intervention Group (n = 20)</th>
<th>Waitlist Control Group (n = 17)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Posttest</td>
</tr>
<tr>
<td>M</td>
<td>43.45</td>
<td>45.60</td>
</tr>
<tr>
<td>SD</td>
<td>6.605</td>
<td>7.074</td>
</tr>
</tbody>
</table>

Results of the factorial ANOVA for Social Competence showed no significant interaction effect between treatment group and time, $F (1, 35) = 3.295, p = .055$, yet there was a medium to large effect size of $\eta^2_p = .101$. The main effect of time was not statistically significant, $F (1, 35) = .072, p = .790$, with a negligible effect size of $\eta^2_p = .002$. The main effect between groups was not statistically significant, $F (1, 35) = .256 p = .616, \eta^2_p = .983$. Based on practical significance, we examined the means of the groups over time (see figure 7), observation indicates a trend in which the scores of the play therapy treatment group improved and scores of waitlist control group decreased. Table C.6 displays a summary of the factorial ANOVA results for the Social Competence on SEARS-T as the dependent variable. Figure 8 depicts the graphic representation of changes in groups over time.
Table C.6

Summary of Factorial ANOVA for SEARS-T Social Competence

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>SS</th>
<th>MS</th>
<th>F</th>
<th>p</th>
<th>$\eta_p^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
<td>1</td>
<td>18.217</td>
<td>18.217</td>
<td>.256</td>
<td>.616</td>
<td>.983</td>
</tr>
<tr>
<td>Time</td>
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<td>2.084</td>
<td>2.084</td>
<td>.072</td>
<td>.790</td>
<td>.002</td>
</tr>
<tr>
<td>Group*Time</td>
<td>1</td>
<td>113.65</td>
<td>113.65</td>
<td>3.925</td>
<td>.055</td>
<td>.101</td>
</tr>
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</tr>
<tr>
<td>Total</td>
<td>35</td>
<td>2488.946</td>
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<td></td>
</tr>
</tbody>
</table>

Figure 7. Means between intervention and waitlist control groups over time on SEARS-T Social Competence.
Factorial ANOVA on SEARS-T Empathy

For the SEARS-T Empathy subscale scores, the assumptions for level of measurement, random sampling, independence of observations, homogeneity of variance, normal distribution, sphericity and homogeneity of interrelations were all reasonably met. Table C.7 includes the pre and posttests’ mean scores and standard deviations for both groups’ Empathy scores on the SEARS-T.

Table C.7.

Mean Scores and Standard Deviations on SEARS-T Empathy

<table>
<thead>
<tr>
<th>Total Score</th>
<th>Intervention Group (n = 20)</th>
<th>Waitlist Control Group (n = 17)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Posttest</td>
</tr>
<tr>
<td>M</td>
<td>39.60</td>
<td>39.65</td>
</tr>
<tr>
<td>SD</td>
<td>7.308</td>
<td>7.343</td>
</tr>
</tbody>
</table>

Results of the factorial ANOVA for Empathy showed no significant interaction effect between treatment group and time, $F(1, 35) = 1.288, p = .264$, and with a small effect size of $\eta_p^2 = .034$. The main effect of time was not statistically significant, $F(1, 35) = .1.399, p = .245$, with a small effect size of $\eta_p^2 = .037$. The main effect between groups was not statistically significant, $F(1, 35) = 1.583, p = .217, \eta_p^2 = .928$. Table C.8 displays a summary of the factorial ANOVA results for the Empathy on SEARS-T as the dependent variable. Figure 8 depicts the graphic representation of changes in groups over time.
Table C.8

Summary of Factorial ANOVA for SEARS-T Empathy

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>SS</th>
<th>MS</th>
<th>F</th>
<th>p</th>
<th>$\eta_p^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
<td>1</td>
<td>102.386</td>
<td>102.386</td>
<td>1.583</td>
<td>.217</td>
<td>.928</td>
</tr>
<tr>
<td>Time</td>
<td>1</td>
<td>27.845</td>
<td>27.845</td>
<td>1.399</td>
<td>.245</td>
<td>.037</td>
</tr>
<tr>
<td>Group*Time</td>
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<td>25.628</td>
<td>25.628</td>
<td>1.288</td>
<td>.264</td>
<td>.034</td>
</tr>
<tr>
<td>Within Cells</td>
<td>35</td>
<td>696.534</td>
<td>19.901</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>35</td>
<td>2263.933</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Figure 8. Means between intervention and waitlist control groups over time on SEARS-T Empathy.

Factorial ANOVA on SEARS-T Responsibility

For the SEARS-T Responsibility subscale scores, the assumptions for level of measurement, random sampling, independence of observations, homogeneity of variance, normal
distribution, sphericity and homogeneity of interrelations were all reasonably met. Table C.9 includes the pre and posttests’ mean scores and standard deviations for both groups’ Responsibility scores on the SEARS-T.

Table C.9

*Mean Scores and Standard Deviations on SEARS-T Responsibility*

<table>
<thead>
<tr>
<th>Total Score</th>
<th>Intervention Group (n = 20)</th>
<th>Waitlist Control Group (n = 17)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Posttest</td>
</tr>
<tr>
<td>M</td>
<td>36.70</td>
<td>39.55</td>
</tr>
<tr>
<td>SD</td>
<td>4.390</td>
<td>5.889</td>
</tr>
</tbody>
</table>

Results of the factorial ANOVA for Responsibility showed a significant interaction effect between treatment group and time, $F (1, 35) = 4.642, p = .038$, with a medium to large effect size of $\eta_p^2 = .117$. The main effect of time was not statistically significant, $F (1, 35) = 1.413, p = .243$, with a small effect size of $\eta_p^2 = .039$. The main effect between groups was not statistically significant, $F (1, 35) = 1.314, p = .260, \eta_p^2 = .052$. Based on statistical and practical significance, we examined the means of the groups over time (see figure 9), observation indicates a trend in which the scores of the play therapy intervention group improved and scores of waitlist control group decreased. Table C.10 displays a summary of the factorial ANOVA results for the Responsibility on SEARS-T as the dependent variable. Figure 9 depicts the graphic representation of changes in groups over time.
Table C.10

Summary of Factorial ANOVA for SEARS-T Responsibility

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>SS</th>
<th>MS</th>
<th>F</th>
<th>p</th>
<th>ηp²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
<td>1</td>
<td>102.386</td>
<td>102.386</td>
<td>1.583</td>
<td>.260</td>
<td>.852</td>
</tr>
<tr>
<td>Time</td>
<td>1</td>
<td>27.845</td>
<td>27.845</td>
<td>1.399</td>
<td>.243</td>
<td>.039</td>
</tr>
<tr>
<td>Group*Time</td>
<td>1</td>
<td>25.628</td>
<td>25.628</td>
<td>1.288</td>
<td>.038*</td>
<td>.117</td>
</tr>
<tr>
<td>Within Cells</td>
<td>35</td>
<td>696.534</td>
<td>19.901</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>37</td>
<td>2263.933</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note. Statistically significant at p <.05.

Figure 9. Means scores between intervention and waitlist control groups on the SEARS-T Responsibility.
APPENDIX D

EXTENDED DISCUSSION
CCPT has shown positive results among cultural groups (i.e. Hispanic, Chinese, and Iranian) for a wide range of emotional, social, and behavioral challenges (Ray, 2014). However, to date, there has been no play therapy study directly exploring the use of play therapy with African American children. The current study sought to investigate the impact of CCPT on the social emotional competencies of African American children. Specifically, this study examined the effect of CCPT on increasing African American children’s overall social emotional competence as measured through pretest and posttest parent and teacher reports. Results of this study indicated that parents observed significant and practical changes in their children who participated in play therapy when compared with children who did not receive intervention. Teachers also indicated positive change for children who participated in CCPT as compared to children who did not receive intervention, yet to a lesser degree than parents. In this section I will discuss 1) social emotional competence, 2) play therapy with African American children, 3) implications of findings, 4) limitations of findings, and 5) recommendations for future practice.

The Social-Emotional Competencies

*Overall Social Emotional Competence*

The statistical and practical results suggest the positive impact of CCPT on overall social emotional competence based on parent report. Based on parent pretest and posttest results, children in the CCPT demonstrated improvements in social emotional competence compared to those in waitlist control group. Additionally, the medium effect size (\(\eta_p^2 = .12\)) indicated moderate to large improvement for the CCPT treatment group over time. This effect size is consistent with previous play therapy studies as discussed in Ray et al. (2015) and Lin and Bratton (2015). Contrarily, the children in the waitlist control group did not gain statistically significant improvements in their overall social emotional competence. The means of the parent report
indicate that the children in the waitlist control group slightly decreased in their overall social emotional competence. Alternatively, participation in CCPT appeared to enhance social emotional competence over time. These findings indicate that CCPT may be a viable treatment modality to support African American children in the healthy development of social emotional competence. Caughy et al. (2013) proposed that the development of social emotional competence for African American children is necessary to buffer the maladaptive effect of heightened socioeconomic risks. Overall, CCPT appeared to create a therapeutic environment for the advancement of social and emotional competence in African American children.

Although teachers’ reports did not result in statistically significant differences between CCPT and the waitlist control groups on overall social-emotional competence, a medium effect size was detected which indicates observable change in overall competence when reported by teachers. The CCPT intervention group demonstrated a 2.85 point increase in their mean score compared to control group which had a .23 point increase. Based on teacher pretest and posttest results, children in the CCPT intervention improved and those in waitlist control group slightly improved on social emotional competence over time. However, teachers did not report observed changes at the same level as parents. The non-statistically significant findings of teacher reports are consistent with previous play therapy research. Cheng (2015) investigated the effect of CCGPT on the social and emotional assets of 43 Kindergarteners. Parents reported statistically significant improvement in children’s social emotional competence whereas teachers did not report statistically significant differences. Cheng (2015) proposed the distribution timing of pretest at the beginning of a new school year and post-testing before a long break possibly interfered with the teachers’ ability to carefully all items. Those factors were similar in the current study.
In addition, Helker and Ray (2009) explained the challenges some teachers face in recognizing and accepting behavioral change. The results could be further complicated by cultural background of participants. According to Denn (2002), teachers’ expectations may sometimes be influenced by racial biases (Boyd-Franklin, 2002). The behaviors of African American children, particularly the high physicality and expressive nature of African American boys, are often misinterpreted as aggressive and disruptive (Hosp & Hosp, 2001). In addition, Belgrave and Allison (2013) theorized that in comparison to parents, teachers are more likely to report higher frequencies of problematic behaviors among African American children compared to other cultural groups. Often African American students are asked to refrain from culturally related behaviors and social styles which leads to psychological discomfort and school failures (Neil et al., 2003). Ferguson (2003) highlighted that once teachers have formed negative perceptions about the behaviors of African American students, their perceptions do not change a great deal. Ferguson (2003) explained that the lack of change in teacher perceptions for African students are attributed to low teacher expectations and misunderstanding of culturally informed behaviors. These claims suggest teacher perceptions of African American children might be difficult to change. Fenwick (2013) proposed that teachers, specifically non-African American teachers, often believe the problems of African American children are beyond what interventions can repair. Because the majority of teachers involved in the current study were non-African American, the preceding issues may have been influential in their reporting of observed behavior.
In the following paragraphs, I will further discuss the findings related to each of the following subscales for the SEARS parent and teacher report: Self-Regulation, Social Competence, Empathy, and Responsibility.

**Self-Regulation.** The scores for Self-Regulation were consistently the lowest of all subscales across teacher and parent reports. The parent and teacher reports on Self-Regulation were not statistically significant when comparing the CCPT intervention and waitlist control group. However, the results did result in practical significance and indicated the African American children in the CCPT group made some progress on self-regulation. Parent report yielded medium effects which can be interpreted as observable changes in self-regulation. The CCPT intervention group demonstrated a 3.45 point increase in their mean score when compared to the control group which had a 1.06 point increase by parent report. However, teacher reports resulted in small effects, which can be interpreted as real change in self-regulation but difficult to detect.

These findings are useful for identifying viable treatments for African American children. Self-regulation struggles are commonly reported challenges by parents particularly in systemic environments such as school and community settings (Tamis-LeMonda et al., 2008). African American children are likely to face difficulties with self-regulation of their emotional, behavioral, and social response when confronted with systemic reactivity (Kliwer et al., 2010). Thus, treatment modalities such as CCPT might serve as a treatment intervention for the advancement of self-regulation for African American children. CCPT therapists provide opportunities for full expression, reality testing, limit-setting, and decision-making for facilitating self-regulation (VanFleet, Sywulak, & Sniscak, 2010). African American children
often have maladaptive emotional and behavioral reactivity because the systems in which they interact are incongruent with their cultural needs (Harris & Graham, 2014). Limit-setting in particular is vital for the development of emotional and behavioral self-regulation in CCPT. The use of limit-setting provides children with the opportunity to choose alternative ways of handling their needs, desires, and impulses (VanFleet et al., 2010). The limit-setting process conveys acceptance of the child’s experiences despite their behaviors. As a result, children become more responsible for their reactions and behaviors when they are able to choose alternate ways of communicating their experiences. Interventions targeting aspects of self-regulation are important for African American children. African American children are at high risk exposure to stressors related to SES status, racial climate, and limited accessibility to resources (Perry-Parrish, Copeland-Linder, Webb & Sibinga, 2016). These stressors often lead to reliance on maladaptive behaviors and emotional responses. Although results were mixed, CCPT may serve as a therapeutic environment for African American children to develop appropriate emotional and behavioral self-regulation.

Social Competence

Social competence is particularly critical for African American children as they face risks for maladaptive psychosocial development related to institutional barriers, family disruptions, and unhealthy peer relationships (APA, 2008). These risks are further complicated by matters such as underresourced schools, systemic barriers, and racial stereotypes (Spencer et al., 2006). When African American children are exposed to these risks, it impacts their social reactivity and often results in negative social encounters with family, teachers, peers, and individuals within the community. Therefore, interventions addressing social competence are not only important for healthy psychosocial development but a protective factor for navigating racially focused
experiences. Healthy social functioning in African children fosters adaptive behaviors and emotional reactions for maintaining social relationships.

The Social Competence subscale resulted in the most consistent findings between teacher and parent reports. Although parent and teacher scores resulted in non-statistically significant findings, the scores of African American children in the CCPT group demonstrated practical significance. The scores indicated a medium effect for parent and medium to large effect for teachers. The results indicated observable changes in the level of social competence displayed by children who participated in CCPT. The practical significance of the Social Competence scores suggest the social benefits of CCPT. In CCPT, the relationship not only serves as the therapeutic agent for client change but also a model for the child’s relationships with others (Ray, 2011). The therapeutic relationship is characterized by empathy, congruence, and unconditional positive regard (Landreth, 2012). Through a child’s interactions with a therapist, she may begin to recognize acceptance, social rules, and effective communication patterns. As the therapeutic relationship evolves, children are able to freely explore and practice social skills in a safe environment. For the African American children in this study, the observed changes by parents and teachers might be influenced by the development of the therapist-child relationship in CCPT. It can be postulated that social interactions with the therapist positively impacted the child’s social behavior. According to Willis et al. (2004), close relationships with significant individuals in the lives of African American children fosters social development. The children’s experience of being accepted without specific conditions in CCPT might have resulted in reduction in negative social behaviors. Based on the philosophy of CCPT, the children in this study did not have to dismiss aspects of their cultural experience as an African American to be cared about and accepted within the context of the therapeutic relationship. These conclusions support the
importance of child-therapist relationship with African American children in CCPT. In dominant-culture institutional settings, the child-therapist relationship for African American children might be one of the few relationships characterized with genuineness, congruence, empathy, and absence of conditions.

*Empathy*

The Empathy subscale resulted in distinct differences between teacher and parent report. The teacher scores resulted in non-statistical findings on empathy with a small effect whereas parent report indicated statistical and practical significance. The lack of statistical and practical significance suggests teachers noted change to a lesser degree than parents. To date, only one study has investigated the effectiveness of play therapy on empathy (see Cheng, 2015). Cheng’s (2015) study resulted in statistical and practical significance on Empathy scores for children participating in the CCPT treatment intervention group as reported by parents. The results of the SEARS-P Empathy subscale for the current study provides additional support for CCPT as a treatment modality for the enhancement of empathy in African American children. The empathy scores also yielded moderate effect sizes. This suggests that CCPT may facilitate the development of empathy in African American children. Harris & Graham (2014) argued for the need of studies exploring prosocial behaviors such as empathy for African American children. Empathy is a critical interpersonal attribute for children (McMahon et al., 2006). Children who possess empathy are aware, considerate, and appreciative of the feelings of others (Ray et al., 2013). In CCPT, children are allowed to experience many opportunities for empathic reactions and responses from the therapist. Landreth (2012) explained conveying empathy is one of the most power therapeutic assets because it results in children feeling understood. Thus, the
empathic experiences provided in CCPT might lead to the child’s expression of empathy and emotionality, as indicated by the results of this study.

Responsibility

One of the main objectives of CCPT is to facilitate the development of self-responsibility (Ray, 2011). The statistical and practical findings of teacher Responsibility scores for children participating in CCPT support this objective. In CCPT, the therapist empowers and encourages children to experience their own capabilities by returning responsibility in the playroom. Returning responsibility conveys respect for children’s ability to solve problems, make choices, and do things for themselves. The results of the Responsibility subscale suggest support for CCPT as a viable intervention for the facilitation and enhancement of responsibility for African American children. Responsibility is a character attribute necessary for social and academic success in the classroom and at home (Merrell, 2011). Thinking and behaving responsibly reduce the risk of social emotional deficits. For African American children, the development of responsibility is important due to the mental health risks related to socioenvironmental influences. Because African American children are disproportionately impacted by poverty, violent communities, and access to limited resources, these factors increase risks for psychological stressors (Murry, Berkel, & Copeland-Linder, 2014). Psychological stressors reduce the ability for African American children to engage in responsible and adaptive behaviors. The development of responsibility can help African American children achieve goals and engage in problem solving despite adversity (Murry et al, 2014). CCPT can help African American children assume responsibility which would lead to a felt sense of greater self-direction and self-control in their interactions with family, teachers, peers, and individuals within the community.
Moreover, their experience in CCPT can help them be more responsible and contributing citizens in society where they experience a legacy of cultural oppression.

Play Therapy with African American Children

The exclusive study of African American children to understand the impact of CCPT is sparse in the play therapy literature. African American children have been included in previous play therapy studies but only in small percentages with the exception of Post’s (1999) study. Post’s (1999) study included 82% of African American children and resulted in positive benefits on self-esteem and internal locus of control. Despite the limited number of African Americans in play therapy studies, findings from Lin & Bratton’s (2015) recent meta-analysis indicated moderate treatment effects for children from different ethnic groups receiving play therapy. The results of the meta-analysis suggest that CCPT is a viable option for diverse populations. This study further supports the impact of CCPT with African American children. The African American children in this study improved in overall social emotional competence and in the areas of self-regulation, social competence, empathy, and responsibility. These improvements are important for academic and interpersonal successes. Improvements in these areas are critical given the common referrals for therapy are based on school related behavior concerns (Boyd-Franklin, 2006). McAdoo (2002) proposed therapy referrals are likely due to teacher and parent expectations. The results of this study suggests CCPT could be a culturally sensitive intervention for common struggles reported by significant individuals in the lives of African American children. According to Nader (2007), African American parents and teachers frequently report externalizing problems such as impulsivity, disobedience and physical aggression. CCPT can meet these concerns because the therapist builds a therapeutic relationship that allows children to fully express their thoughts and feelings in ways that are unique to their lived experiences. The
The premise of the therapeutic relationship might be helpful for African American children. The CCPT relationship is characterized by “I see you, I hear you, I understand, and I care (Landreth, 2012, p. 47).” This type of therapist relationship is especially important for African American children because they are often harshly evaluated for their cultural way of being in their social environments. The CCPT relationship can facilitate the prizing and valuing of African American children who often experience opposition with others in their environment. Additionally, within the context of the relationship, the therapist facilitates opportunities for children to develop self-regulation and self-control. These opportunities reduce the need for engaging in problematic behaviors. Furthermore, children are able to meet their needs in more adaptive and socially desirable ways which positively impacts their functioning in their home and school environments.

The educational setting of this study is important to consider for African American children. The need for a relationally-based intervention such as CCPT is well matched to the educational setting. Because African American children have the highest percentage of behavioral reprimands in schools when compared to other cultural groups (Rudd, 2014), the philosophical basis of CCPT on relationship and self-actualizing tendency of every child may offer an affirming experience to African American children who are struggling in schools. The therapeutic nature of CCPT allows for the development of adaptive coping, self-control, and self-direction to address behavioral struggles. African American children are frequently described as overly aggressive and disruptive by teachers and school personnel (Harris & Graham, 2014). Thus, African American children are more likely to experience suspension and expulsion related to externalizing behaviors exhibited in the school environment (Splett & Hawkins, 2011). The
high incidences suggest African American children are treated more harshly in the educational setting in comparison to their peers.

African American boys suffer the most behaviorally in educational settings leading to academic consequences such as poor self-confidence, problems with peers, and low academic achievement (Belgrave & Allison, 2013). The problematic views of African American behaviors were evident in the number of African American males referred for this study. African American boys were overrepresented in this study. Out of the 37 participants, 29 of them were teacher referred. In educational settings, African American boys are often devalued by institutional practices (e.g. lack of male teachers, teacher perceptions, and low expectations, APA, 2008). Davis (2001) theorized that problems African American children face due to institutional practices in the school system are more chronic and extreme. The negative societal portrayal of African American males as physically violent, unintelligent, and intimidating translate into the classroom (Davis, 2001). These negative views are more prevalent when African American children are the minority in a school setting such as the participants of this study. When African American children are the minority, their cultural demeanors and behaviors are often misunderstood and negatively evaluated by teachers (Belgrave & Allison, 2013). This is especially true when African American children attend schools with primarily non-African American teachers and personnel (Davis, 2001). These conclusions suggest the importance of the therapist’s role in CCPT for African American children. Play therapists need to ensure their verbal and non-verbal behaviors convey true acceptance and respect. This helps build trust and safety for the child to work through their experiences. Additionally, play therapists may act as social justice advocates for African American children in the school system to reduce educational oppressive practices by teachers and school personnel. Teachers benefit from
increased knowledge about cultural sensitivity and the status of African American children in society which helps to reduce educational disparities, cultural insensitivity, and negative perceptions.

*Therapist-Child Racial Experiences*

Drewes (2005) proposed that the behaviors and actions of play therapists are critical in providing play therapy to children in diverse populations. This is important to consider, as African American children are perceived to be more sensitive to verbal and non-verbal communication from others (Gil, 2005). Thus, the therapist-child interactions become critical for the effectiveness of the play therapy process (Drewes, 2005). Therapist-child interactions begin with the therapists’ experience, comfort, and perceptions of working with African American children. The therapists in this study included a majority of Caucasian American females. Most therapists in this study reported past clinical experiences and understanding of the African American culture in some capacity. However, in comparison to their clinical work with children from other ethnic groups, therapist experiences are limited. Many of the therapists shared concerns about the current racial and political climate affecting their level of sensitivity. The racial and political climate has the possibility to illuminate the minority status of the African American child with non African American therapist. Both the therapist and child might have preconceived notions about one another. Therefore, the racial climate impacts how and what therapists respond to in the room. Therapist responses are influenced by perceptions and views of African American children in today’s society. One therapist in particular explained concerns of being overly sensitive and the possibility of missing culturally related expressions. Despite therapists’ concerns, many therapists in this study expressed the importance and awareness of being culturally sensitive in their observations and reflections. Axline (1969) explained therapists
need to understand a child’s culture in order to be fully accepting in the play therapy relationship.

Cultural understanding is critical for African American children given the common mistrust and barriers to seeking mental health treatments. Hinds (2005) explained play therapists of all races - but particularly non-African American therapists need to understand the historical and cultural implications of being an African American child in today’s society. CCPT facilities a relationship for the therapist to validate and accept the experiences of African American children. This facilitation results in increased empathy and care for the child. Through the therapeutic relationship, the therapist does not attempt to restrict or control the child’s cultural behaviors but allows them freedom to express themselves. The relationship can help African American children experience feelings of being valued despite feedback from outside sources. Hinds (2005) suggested cultural competence training for therapists who work with African American children, specifically related to the African American experience in America. Books about raising African American children can also be helpful for play therapists to, not only increase their understanding, but assist parents and teachers in supporting the healthy growth and development of African American children.

As the primary researcher, I was the only African American researcher for the current study. I was culturally aware of verbal and non-verbal communication from the children. This cultural understanding was the result of my own cultural background and experiences with African American families. The children expressed both cultural and non-cultural experiences through their verbal and non-verbal communication. In my experiences with the African American males, I quickly recognized the need for more African American therapists,
particularly African American males. African American males can benefit from role models that provide relational experiences.

**Play Experiences**

Play for African American children is influenced by current and past cultural events, religion, and socioeconomic factors (Hinds, 2005). However, very few toys and expressive materials are representative of the African American culture (Hinds, 2005). For example, most dolls and figures have Eurocentric features. Thus, African American children are often limited to express their feelings, thoughts, and experiences with play materials that are not always truly representative of their culture. For this study, some of the recommended toys were adapted to include toys to provide more representation for the African American children receiving play therapy. For example, we were intentional with selecting dolls and figures with various hair textures. Beginning in childhood, hair for African Americans, particularly, African American females, influence the identity and beauty they ascribe to themselves (Brooks & McNair, 2015). African American girls have a variety of tight to loosely curled textures that become cultural identifiers throughout their lives. One therapist described a child as appearing drawn to the African American dolls in the play but playing equally with the dolls of other ethnicities. In addition, a few therapists reported that the children utilized the African American family figures to play out family dynamics. It is important to note, although cultural dolls and figures were included, it was difficult to find dolls that were truly representative of the African American culture. Traditional toy stores did not include doll choices for the African American culture. Therefore, this study required an extensive search to find culturally sensitive dolls and figures. Once dolls were located, there was a limited selection and they were more expensive compared to other dolls.
The role of religion and spirituality for African Americans was evident in the verbal and non-verbal play behaviors in the playroom. Historically, religion and spirituality has been a sense of support and strength for African American families (Hinds, 2005). Survey data on religion and race suggest that African Americans are the most religious racial group (Belgrave & Allison, 2014). In my own observations, I noticed that with or without directly playing with the religious symbols, many of the African American children made at least one or more mentions about church attendance or faith. However, I observed the African American children to engage in increased play or dialogue about their experiences of religiosity when they directly played with the religious symbols. In their verbal dialogues, they made mention of matters such as how often they attended church, church activities, and teachings about God. In their non-verbal behaviors, many of the children played out church activities. These observations suggest the importance of including religious symbols that are culturally aligned with the lives of African American families in play therapy. The symbols appeared to help further facilitate the verbal and non-verbal expressions of spirituality.

Limitations

Despite the valuable results and implications for CCPT as a viable treatment intervention for African American children, limitations are offered for consideration when interpreting data results.

1. This study was conducted with a small sample size in schools located in the southwest United States with primarily male students from lower income and single parent families. The sample limits the generalizability of the results for African American children across genders, geographic location, and SES status. Additionally, this sample was identified within schools where African American children were a clear minority. It might be
helpful to investigate the effects of CCPT on social emotional competence with larger samples sizes of males and females from various SES statuses and settings in order to generalize results for other African American groups.

2. The possibility of referrals for the study based on cultural biases from teacher report rather than true clinical impressions. Sbarra and Pinto (2001) proposed that teachers often have difficulties distinguishing cultural behaviors from problematic behaviors.

3. Due the lack of African American play therapists in the geographical area, the primary researcher was the only African American therapist for the study. The racial status of researcher may have lead to researcher bias. Additionally, this study was conducted in the midst of cultural tension in the media primarily related to African Americans. The racial climate could have lead to oversensitivity or cultural stereotypes.

4. The use of a waitlist control group instead of another treatment group restricts the results from being shown if CCPT with African American children is superior to another form of therapeutic treatment.

5. The teacher and parent findings may have resulted in rater bias (Rubin & Bellamy, 2012). The parents and teachers were not notified about group assignment in either the CCPT or waitlist control group; however; they might have become aware of assignment over time. As a result, teacher and parent awareness might have impacted their response on the SEARS assessment.

6. Results of statistical analyses should be interpreted with caution. Due to the exploration of sub-constructs of social emotional competencies, multiple analyses were conducted increasing the risk of Type I error.
Recommendations for Future Research

Based upon the findings and limitations of the current and previous studies, I present several recommendations for future research.

1. The current study was limited on geographic location, genders, and settings. Future research could benefit from studies that allow for more generalization for other African American groups. It might be helpful to target future studies at both Title I and non-Title I schools to capture more diverse presentation of African American males and females from various SES backgrounds and family make-up.

2. The lack of significant findings from teacher report in comparison to parent report is consistent with previous research (see Cheng, 2015; Garza & Bratton, 2005; Helker & Ray, 2009). The weaker findings regarding teacher report suggest the need for further investigation regarding the influences of teacher-child relationships. African American children in particular are impacted by the cultural discontinuity between their home and school environments. Research for African American children could benefit from examining the influences of teacher report on the social emotional competence of African American children participating in CCPT.

3. Due to the long-term impact of social emotional competence on future successes of children, future research with African American children would benefit from exploration of the maintenance and long-term benefits of participating in CCPT. Future researchers are encouraged to conduct follow up assessments for CCPT research exploring the impact on social emotional competences.

4. Future researchers are encouraged to enhance the integrity of data collection by parent and teacher respondents by strongly considering the environments for data
Researchers may consider providing designated times and uninterrupted opportunities for the completion of assessments. This will likely increase the accuracy of answer responses and reduce hurriedness or hectic environments.

5. Due to the cultural factors of African American children, future researchers are encouraged to explore the treatment outcomes of children participating in CCPT paired with therapists that are racially similar and dissimilar. Research exploring racial background of the therapist can help practitioners determine if there is a greater or similar impact of matching African American children with racially similar therapists.

6. The present study included a waitlist control for comparison, which indicated a positive impact of CCPT on social emotional competence for African American children. However, without a treatment comparison group, it is difficult to determine if CCPT is superior or as effective as another intervention. Due to the importance of culturally appropriate interventions for African American children argued in the literature, future researchers are encouraged to include treatment comparison groups such a curriculum guidance in relation to social emotional competencies.

Implications for Practice

Child-Centered Play Therapy (CCPT) has strong literature and research to support efficacy with children experiencing a variety of emotional and behavioral concerns (Bratton et al., 2005, Lin & Bratton, 2015; Ray et al (2005). However, to date, no experimental play therapy studies focused solely on African American children. Researchers have argued for the need of studies addressing culturally relevant treatments for diverse child populations (Baggerly & Parker, 2005; Ritter & Chang, 2002; Sheely-Moore & Bratton, 2010). African American
children are exposed to socio-environmental circumstances such as racism, poverty, single parenthood, and underserved school system (Belgrave & Allison, 2013). These socio-environmental circumstances greatly impact the social and emotional development of African America children (Babarin, 2013b). The results of this study present critical implications for practice and research with African American children.

CCPT is a developmentally appropriate intervention for children and results from the current study support its effectiveness with the enhancement of social emotional competencies. The available CCPT research on social emotional competencies. Cheng (2015) deemed CCGPT as effective intervention for kindergartners presenting with problematic social emotional assets as compared with children in a waitlist control group. Ray et al. (2013) found similar benefits in a pilot study with children participating in CCPT. Children who participated in CCPT demonstrated improved levels of functional impairment and relationships with their peers and teachers.

Findings of this study indicate CCPT supports the development of overall social emotional competence for African American children. The therapeutic nature of CCPT helps facilitate the social-emotional growth through therapists’ use of empathy, unconditional acceptance, limit setting, and esteem building conveyed to the child. As a result, children are provided with opportunities to regulate their behavior and emotions, develop harmonious relationships, and improve self-responsibility.

My observations and experiences suggest the importance of incorporating culturally diverse toys and materials in the playroom. Adapting toys to fit the culture will allow for representation and facilitation of the child’s true experiences. In the current study, we added dolls, figures, and religious symbols. Although not used in this study, practitioners should
consider adding diverse puppets, food, and dress-up clothes. According to Hinds (2005), African American children have highly imaginative play behaviors. The inclusion of more culturally focused toys can assist children in fully expressing their thoughts, feelings, and behaviors. Training for both play therapists and teachers are important implications of this study. African American children have unique experiences in society. Their experiences greatly impact their overall functioning and adjustment. Clinicians should first begin by identifying key stakeholders in the lives of African American children to better understand their needs and cultural styles. Clinicians should also consider attending cross-cultural training and workshops to increase their cultural competence. Lastly, clinicians need to seek out opportunities to engage in more clinical practice with African American children by providing counseling services in the environments where African American children spend the most time (i.e. schools, community centers, and church). These opportunities will allow clinicians to apply knowledge and understanding in practical ways. Additionally, real-world practice will help increase cultural sensitive and identification of unique therapeutic needs. For teachers, they will need specific training around how educators and school curriculum impacts the status of African American children in the school system. This type of training would help illuminate the perspectives of African American children and how it impacts their ability to be successful in the classroom.

Conclusion

The development of social emotional competence is particularly important for African American children given challenges related to socio-environmental risks, limited resources, and historical events (APA, 2008). These culturally related challenges can lead to emotional, social, and behavioral problems that can persist into adulthood (Belgrave & Allison, 2015). Social emotional competence acts as a buffer against severe emotional and behavioral problems that could
persist into adulthood (Harris & Graham, 2014). However, little is known about the interventions that are culturally sensitive to social emotional needs of African American children. This study sought to add to the body of literature regarding interventions and support of CCPT with African American children.

The exploration of CCPT on the improvements of social emotional competence of 37 African American children was examined by parent and teacher reports. The findings indicated statistically significant improvements on the overall social emotional competence. Further examination revealed the specific benefits of CCPT on the empathy of African American children. Parent findings indicated overall significant and practical improvements for children in CCPT when compared with children who did not receive intervention. Teacher results indicated some positive improvements for children in CCPT on social emotional competence when compared to children who did not receive intervention. The findings of this study support the positive benefits of CCPT found in previous research with other ethnic populations. Although, positive benefits were found, future research and practitioners should be mindful of cultural adaptations for the African American children to enhance the opportunity for full expression.
APPENDIX E

OTHER ADDITIONAL DOCUMENTS
July 14, 2015

Supervising Investigator: Dr. Dee Ray
Student Investigator: Brittany Wilson
Department of Counseling and Higher Education
University of North Texas

Re: Human Subjects Application No. 15293

Dear Dr. Ray:

As permitted by federal law and regulations governing the use of human subjects in research projects (45 CFR 46), the UNT Institutional Review Board has reviewed your proposed project titled “Effectiveness of Play Therapy for children with Disruptive Behaviors.” The risks inherent in this research are minimal, and the potential benefits to the subject outweigh those risks. The submitted protocol is hereby approved for the use of human subjects in this study. Federal Policy 45 CFR 46.109(e) stipulates that IRB approval is for one year only, July 14, 2015 to July 13, 2016.

Enclosed is the consent document with stamped IRB approval. Please copy and use this form only for your study subjects.

It is your responsibility according to U.S. Department of Health and Human Services regulations to submit annual and terminal progress reports to the IRB for this project. The IRB must also review this project prior to any modifications. If continuing review is not granted before July 13, 2016, IRB approval of this research expires on that date.

Please contact Shelia Bourns, Research Compliance Analyst at extension 4643 if you wish to make changes or need additional information.

Sincerely,

[Signature]

Chad R. Trulson, Ph.D.
Professor
Department of Criminal Justice
Chair, Institutional Review Board

CT/sb
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 Play Therapy for Children with Disruptive Behaviors.

**Principal Investigator:** Dee Ray, Ph.D., LPC-S, NCC, RPT-S, University of North Texas, Department of Counseling and Higher Education.

**Student Investigators:** Sarah Blalock, M.Ed., LPC-S, RPT-S, University of North Texas, Department of Counseling and Higher Education.

LaKaavia Taylor, M.Ed., LPC-Intern, NCC, University of North Texas, Department of Counseling and Higher Education.

Brittany Wilson, M.Ed., LPC-Intern, NCC, University of North Texas, Department of Counseling and Higher Education.

**Purpose of the Study:**
You are being asked to allow your child to participate in a research study which involves determining if individual or group play therapy is effective in helping children improve the way they act, feel, and interact with others at school. The study will also look at whether individual or group play therapy for children helps decrease disruptive behavioral problems at home as observed by parents.

**Study Procedures:**
Your child will be asked to participate in individual play therapy or group play therapy. Play therapy is designed for children to express themselves in their natural way of playing with toys. Some elementary-age children have difficulty working through problems with words, so play therapy can help facilitate the process by providing a play environment from which they can work through those issues that may limit their academic progress. Individual play therapy is a counseling intervention involving the child receiving individual attention from the therapist. Group play therapy is a counseling intervention combining the advantages of play therapy and group process. Through the interactions with the other group members and/or therapist, we hope your child will become more aware of their own and others’ feelings, thoughts, and needs, as well as learn to interact in socially appropriate ways.

Your child decides what materials to play with and what to discuss in play therapy. Your child will not be asked any questions that are not intended to facilitate his/her awareness or growth. Your child will not be 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 three groups:

Group 1: Children in this group will begin group play therapy immediately and will receive two 30-minute sessions of group play therapy each week for 8 weeks.

OR

Group 2: Children in this group will begin individual play therapy immediately and will receive two 30-minute sessions of individual play therapy each week for 8 weeks.

OR

Group 3: Children in this group will not receive any intervention during the 8 weeks of the study. Children in this group will begin either individual or group play therapy in January and will receive at least 8 sessions of play therapy.

You will be asked to complete one or two brief assessment (depending on whether your child is selected for group or individual play therapy) which require approximately 10 minutes each to complete. The assessment/s will be sent home to you through your child for you to complete. The assessment/s will need to be completed at two points in the study, the beginning and end of the 8 week period. The entire study will require approximately 20-40 minutes of your time to complete assessments.

If your child is assigned to the individual play therapy group, your permission allows your child to fill out two assessments which ask them to report their perceptions of their feelings of anger and their level of self-esteem. These assessments will require approximately 10 minutes each to complete. The assessments will need to be completed at two points in the study, the beginning and end of the 8 week period. The entire study will require approximately 40 minutes of your child’s time to complete assessments.

Your permission also allows your child’s homeroom teacher to fill out two assessments which ask the teacher to report perceptions of your child’s social and emotional development, and your child’s level of aggression within the classroom environment. The assessment will be delivered to your child’s teacher by therapist. Your child’s teacher will be asked to complete this instrument before and after the 8 week 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 group 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, whenever you or your child’s teacher observes any academic concerns due to your child’s participation in play therapy, you or your child’s teacher may request to withdraw your child from the study.

3. Because play therapy is a counseling method, your child may experience emotions that could be strong for him or her. The therapist will help your child express and work through these emotions. If any harmful effects upon your child are noted, the therapist will consult with the principal investigator, discuss with you and the child’s teacher, and then stop therapy for your child following your agreement. Harmful effects would include inability to maintain self-control or being so upset that your child is unable to behave appropriately in the group environment.

Benefits to the Subjects or Others:
Possible positive outcomes for children participating in the project may include being more aware of their own and others’ feelings, thoughts, and needs; learning to interact in appropriate ways; increasing ability to develop a sense of responsibility; forming and maintaining relationships; and exhibiting less problem behaviors. The results of this study may provide school counselors across the nation with knowledge that helps them enhance children’s social, emotional, and behavioral development so that children are happier and more successful in public school.

Procedures for Maintaining Confidentiality of Research Records:
All information will be kept in a locked cabinet in the clinic of the Counseling Program at the University of North Texas. Only the research team will have access to the locked cabinet. 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 video recordings 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.

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
Title of Study: Effectiveness of Play Therapy for Children with Disruptive Behaviors.

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

Student Investigators: Sarah Blalock, M.Ed., LPC-S, RPT-S, University of North Texas, Department of Counseling and Higher Education.
LaKaavai Taylor, M.Ed., LPC-Intern, NCC, University of North Texas, Department of Counseling and Higher Education.
Brittany Wilson, M.Ed., LPC-Intern, NCC, University of North Texas, Department of Counseling and Higher Education.

Purpose of the Study:
You are being asked to participate in a research study which involves determining if group or individual play therapy is effective in helping children improve the way they act, feel, and interact with others at school. Through interactions with other group members and/or the therapist in individual or group play therapy, children may have opportunities to become aware of their own others’ feelings, thoughts, and needs, as well as learn to interact in a socially appropriate ways. This study aims to explore whether participating in group or individual play therapy helps children decrease social, emotional, and behavioral problems at school as observed by teachers and parents.

Study Procedures:
After parents provide permission for their child’s participation in this study, each participating child will be assigned to one of three groups: Group 1 - Children in this group will begin group play therapy immediately and will receive two 30-minute sessions of group play therapy each week for 8 weeks or Group 2 - Children in this group will begin individual play therapy immediately and will receive two 30-minute sessions of individual play therapy each week for 8 weeks or Group 2 - Children in this group will not receive any intervention during the 8 weeks of the study. Children in this group will begin group or individual play therapy in January and will receive at least 8 sessions of group or individual play therapy.

Depending on assignment to either group or individual play therapy group, you will be asked to complete either one or two brief assessments for each participating child in your classroom at two points in the study: the beginning of the 8-week period, end of 8-week period. It will take
approximately 10 minutes to complete each assessment, totaling 20-40 minutes per child of your time for the entire study.

**Foreseeable Risks:** No foreseeable risks are involved in this study.

**Benefits to the Subjects or Others:** Possible positive outcomes for children participating in the project may include being more aware of their own and others’ feelings, thoughts, and needs; learning to interact in socially appropriate ways; increasing ability to develop a sense of responsibility; forming and maintaining relationships; and exhibiting less problem behaviors. The results of this study may provide school counselors across the nation with knowledge that helps them enhance child’s social, emotional, and behavioral development so that children are happier and more successful in public school.

**Compensation for Participants:** You will receive $10 cash at the end of the study when you have completed the two-four assessment instruments (pre and post).

**Procedures for Maintaining Confidentiality of Research Records:** All information will be kept in a locked cabinet in the clinic of the Counseling Program at the University of North Texas. Only the research team will have access to the locked cabinet. Names of teachers, 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. You may choose to withdraw your consent at any time and the data you provided 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.

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

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

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

Signature of Participant Date

For the Investigator or Designee:

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

Signature of Investigator or Designee Date
Child Assent Form

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

This study involves looking at whether group or individual play therapy is helpful to you. Group play therapy is a time when you will come to a playroom with one or two other children and a counselor who will ask 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. Individual play therapy almost the same as group play therapy except that you will come to a playroom by yourself with a counselor.

You will be asked to come to either group play therapy or individual play therapy two times a week for 8 weeks which will take about 1 hour per week, or you might be asked to come to play therapy one time a week later in the school year. No one gets to choose who goes to group or individual play therapy. It is decided by chance.

If you decide to be a part of this study, please remember you can stop participating 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 (insert name of child) was waived due to:

_________ Age

_________ Maturity

_________ Psychological State

________________________________________        _______________________
Signature of Parent/Guardian                      Date


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