

Running head: CHILD-CENTERED PLAY THERAPY

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Child-Centered Play Therapy in Elementary Schools

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Abstract

This thesis presents a rationale for providing counseling, and more specifically child-centered play therapy, to elementary school children. The purpose of this study was to measure the outcomes and evaluate the results of a community-based early intervention program that provided child-centered play therapy to students in three schools in a rural county in Western New York State. Teacher assessments, therapist reports, and parent reports were used to measure change in the students involved in the study. The importance of early intervention and preventive services is discussed, as well as the tenets and benefits of child-centered play therapy. The results of the 14 students studied demonstrated that child-centered play therapy is an effective modality for working with children. The author advocates for the implementation of the Early Intervention Program in more schools.

Child-Centered Play Therapy in Elementary Schools

Catholic Family Center (CFC) is a human service agency that serves 63,000 people in Monroe and Wayne Counties in Western New York (www.cfcrochester.org). The Wayne County Office comprises one of seventeen CFC locations. Catholic Family Center's mission is to "...empower individuals, families and communities and uphold personal dignity, by working to eliminate obstacles that impede people from realizing their full potential." The Early Intervention Program (EIP) has existed at Catholic Family Center's Wayne County office since the year 2000. This program provides child-centered play therapy (CCPT) services to elementary age children attending schools located in Wayne County.

Of the eighteen elementary schools in Wayne County, six received EIP services from Catholic Family Center therapists during the 2004-05 school year. Only one of the six schools provided funding for a full-time EIP counselor. Therapists in the other five schools worked part-time, providing counseling services one to three days per week.

This project originated in an attempt to increase the community's awareness of the effectiveness of CCPT in treating early childhood problems. Although word of mouth has spread throughout the community and school systems, enhancing the reputation of CFC's CCPT program, statistical data would be a useful and necessary tool to further endorse the program. The Early Intervention Program at CFC has not been empirically evaluated since its implementation. Thus, statistics and outcome measures are needed to prove the effectiveness and viability of CCPT in Wayne County.

Counselors at CFC and other community agencies are waging an uphill battle to maintain their employment from year to year. They struggle to defend the vital services

they provide in spite of ongoing budgetary cuts. Schools will be more apt to consider implementing additional counseling programs (and less apt to cut funding for quality mental health programs) if quantified data is available (i.e. research showing results and progress). In order for funding to be maintained or increased for programs such as this, positive results have to be shown.

This study focused on children in grades kindergarten through fourth grade who were referred for counseling due to emotional problems and maladjustment. In order for at-risk children to be successful, it is important to intervene at the elementary age, before their problems escalate (Lenhardt & Young, 2001). The goal of this study was to demonstrate the effectiveness of CCPT in treating a multitude of problems. It was hypothesized that the children in this study will become more prosocial and demonstrate less maladaptive behavior through CCPT. Children with nearly every type of problem can benefit from CCPT, even though their symptoms and problematic behaviors are not addressed directly by the therapist (Guerney, 2001). The study took place over a time span of eight weeks. The children were seen weekly for 45 minutes a session by qualified, trained counselors.

Review of the Literature

In the following literature review, the importance of preventive services is discussed, emphasizing the duty of the schools to attend to children's emotional health needs. The importance of play is discussed to highlight the need for children to receive developmentally appropriate counseling interventions. An overview of play therapy is provided, focusing specifically on child-centered play therapy and its benefits.

Importance of Preventive Services

There is a great need for children to receive counseling services at a young age. It is reported in the literature that 6 to 9 million children in the United States have serious mental health problems (Post, 2001). 14-22% of school age children have emotional disorders (Drewes, 2001). Although up to 25% of children experience moderate to severe adjustment problems that warrant intervention, only one in five of them receive services (Prodente, Sander, & Weist, 2002). Roberts, Attkisson, & Rosenblatt (1998) examined four decades of research consisting of 52 studies to determine the prevalence of psychopathology among children and adolescents. They discovered that 74% of 21 year olds with mental disorders had prior problems that could have possibly been prevented had they been treated when they were young.

David Satcher, the Surgeon General of the United States in 2001 (U.S. Department of Health and Human Services [USDHHS]) reported that the United States is facing a national children's mental health crisis and that children's emotional needs are not being met effectively. Satcher advocated for promoting public awareness of children's mental health issues. He stressed the importance of recognizing, identifying and treating mental health issues early on. Satcher advocated for early mental health preventive services, stating that mental health services need to be more effectively integrated into our educational institutions.

The prognosis for change decreases as children age and their problems become more ingrained (Post, 2001). Children whose emotional problems go untreated experience academic difficulties, increased risk for substance abuse, mental health problems, relationship difficulties, and an increased risk for criminal activity (Post,

2001). Children's emotional needs cannot be ignored (McMahon, 1992). Neglecting the mental health needs of children results in the continuation and persistence of their problems into adulthood. It would be of greater benefit to society in the long run to prevent the onset of mental health disorders (Burns, Hoagwood, & Mrazek, 1999).

Preventive efforts have not been emphasized in schools as urgently as they should be (Prodente et al., 2002). Durlak (1998) advocated for an increase in primary prevention mental health programs, summarizing data from over 225 studies to prove that early intervention is successful at preventing problems. Providing mental health services to children when they are young can help to break the cycle of poverty, abuse, and violence. However, there continues to be a gap between research and practice (USDHHS). Interventions that have been proven effective are underutilized.

Counseling services for elementary age school children need to be offered at every school in order to identify and treat problems before they escalate (Lenhardt & Young, 2001). Unfortunately, many schools do not provide counseling and mental health services (www.schoolcounselor.org). Although every elementary school in New York State is required by law to have a counseling program, the presence of certified and licensed counselors to operate these programs is not mandated (Lenhardt & Young, 2001). The current growth of elementary school counseling programs is inadequate to meet the increasing needs of students.

Only 15 states mandate elementary school counseling, and most school districts do not recognize the need for counselors (Lenhardt & Young, 2001). The lack of counseling programs is due to the fact that the primary mission of schools is to educate and instruct (Adelman, 1998). Mental health needs are not the foremost item on a

school's agenda. Mental health services are often viewed as something that distracts or takes away from the school's main goal of educating. A public policy shift is needed to enable schools to move in new directions that incorporate mental health services into their primary agenda (Adelman, 1998).

One implication for social policy is that the United States contributes the majority of its health care dollars to treating people with established problems; only 3% of its budget goes toward prevention (Durlak, 1998). Primary prevention has been proven to be successful, and therefore deserves to be integrated more effectively into existing social systems. Communities need to become aware of the mental health needs of children and the limitations of existing programs at providing quality services. Public advocacy efforts are needed that will increase financial support for programs.

School-based Counseling

Schools provide an optimal setting for providing counseling services (Drewes, 2001). Schools offer consistency, predictability, and comfort to a child. More families and children are able to be served in schools than in community settings. It is often emotionally and financially difficult for parents to consult outside counseling services and follow through with referrals made to community providers (Drewes, 2001). Parents are often unaware that their children are in need of services. In addition, parents from distressed, low-income environments are often unable to provide the support their children need in coping with stressors. The majority (between 70 and 80 percent) of the 1,015 children surveyed in the Great Smoky Mountains Study of Youth received mental health services from the school, with the education system being the only source of care

(Burns et al., 1995). This attests to the need for increased mental health resources in the schools.

Students referred for services in a school are much more likely to receive services than those referred in other community programs (Prodente et al., 2002). Some administrators may think that schools are not the appropriate setting for mental health services, but the school may be the only resource available (Vanderbleek, 2004). The school has a duty to attend to a child's emotional health. The first step toward redefining mental health in schools is to "...increase education reformers' understanding of the impossibility of raising student achievement scores without addressing social and emotional barriers to learning" (Vanderbleek, 2004, p. 215).

Schools need to adapt a proactive, preventive approach in counseling children (USDHHS, 2001). Teachers need to be aware of the early signs of mental health problems in children. Many teachers wait to refer children until they have become completely unmanageable in the classroom. Schools need to intervene before problems have gotten out of control. In addition, students with unobservable problems such as depression or anxiety often go untreated (Prodente et al., 2002).

School-hired staff and community providers need to collaborate and establish an interdisciplinary, team-based approach to provide easily accessible mental health services (Prodente et al., 2002). According to the American Counseling Association (www.counseling.org), the average student-to counselor ratio is 477:1 for elementary and secondary schools. The recommended ratio is 250 students per counselor. Due to high caseloads, student are often unable to get needed counseling (www.schoolcounselor.org).

School counselors are often overwhelmed with a multitude of tasks and

administrative duties in addition to counseling (www.schoolcounselor.org). Because of this, community based counselors are often utilized in the schools to provide counseling. To reach the optimal number of children, many schools hire counselors from community agencies to provide preventive services, as school counselors are often overburdened and unable to provide intensive counseling to children on a regular basis (Drewes, 2001).

The link between emotional and intellectual development is often underscored (McMahon, 1992). Emotional development should be given the same amount of attention as intellectual development. Emotional problems need to be attended to in order to help children achieve optimal academic success (Drewes, 2001). Cognitive development has been emphasized at the expense of emotional and social readiness (USDHHS, 2001). Educators are not always eager to cooperate with school-based mental health programs, as they are concerned that these services will interfere with a child's education (Prodente et al., 2002).

The primary aim of school mental health programs may be viewed as enabling learning by addressing those emotional and behavioral problems that can hinder the educational process (Adelman & Taylor, 1998). Mental health services need to be viewed as an essential, not separate, task of the school's agenda (www.smhp.pscyh.ucla.edu). Landreth (2002) agreed that therapy offered in schools, and more specifically child-centered play therapy, helps children to increase their readiness and preparedness for classroom learning.

Importance of Play

Play is children's primary and natural mode of communication and self-expression; it is their language (Landreth, 2002). Children have limited verbal abilities.

Piaget (1962) asserted that children are unable to think and reason abstractly until age 10. Piaget also suggested that children do not have access to their feelings at a verbal level until they are 11 years of age. Thus, play is a natural method that children use to communicate their feelings and express their needs and concerns.

“Play is the singular central activity of childhood, occurring at all times and in all places” (Landreth, 2002, p.10). Play is a spontaneous activity. Children do not need to be instructed or directed to play; they play naturally. Play behavior has multiple, complex functions, including biological, intrapersonal, interpersonal, and sociocultural functions (Schaefer & O’Connor, 1983). A vital part of a child’s emotional development is play (McMahon, 1992). Through play, children are able to explore their world, releasing energy, anxiety and tension in the process. Children succeed at mastering conflicts and gain control of their situations through play.

Play not only reflects a child’s current developmental stage but also produces development by helping children to learn and practice cognitive and social skills (Cheah, Nelson, & Rubin, 2001). Play promotes problem-solving and organizational skills, as children try to figure things out and gain mastery and control of their surroundings through play. Children can work through separation anxiety by utilizing objects symbolically in their play. Play helps children to “...make sense of their experience in order to make it part of themselves” (McMahon, 1992, p. 2). Of course, to children, the number one function of play is to have fun; it is assumed that they are not conscious of these other functions (Carroll, 2001).

Play helps children to make sense of their emotionally laden experiences by working through their emotional conflicts and concerns in play (Landreth, 2002). Play

helps children to communicate symbolically with toys what they are unable to communicate with words. Play helps to "...bridge the communication gap..." between children and adults (McMahon, 1992, p. 27). Through the shared experience of play, an adult joins a child side by side, communicating in their language.

Children learn to self-regulate during unstructured, spontaneous play (Bergen, 2002). "High-quality pretend play is an important facilitator of perspective taking and later abstract thought" (Bergen, 2002, p. 3). Unfortunately, there is an increasing emphasis on test performance in schools and a decreasing emphasis in the amount of time children are given to engage in social pretense play, despite the evidence supporting the positive relationship between play and cognitive, social and academic competence (Bergen, 2002). It is becoming increasingly challenging for teachers, even in preschool, to devote an adequate amount of time to play in their curriculum because of accountability constraints.

Elementary school children require specialized interventions targeted at where they are developmentally (Shen & Sink, 2002). The verbally based counseling methods that work for teenagers and adults do not necessarily work for children. Landreth, Baggerly, and Tyndall-Lind (1999) advocated for a paradigm shift in counseling children. "Modifying basic adult counseling skills to work with children requires that the child adopt the communication style that is most comfortable for the adult" (p. 274). Rather than adapting adult counseling skills (verbally based processes) to make them applicable for working with children, counselors need to go "into the world of the child" (Landreth et al., 1999, p. 274). Counselors need to communicate with children at their level rather than expect children to accommodate to their preferred mode of communication.

Landreth (1987) stated that "...it is not a question of whether the elementary school counselor should use play therapy but, instead, of how play therapy should be used in the schools" (p. 255). Crow (1994) agreed that play therapy should be considered as "...an adjunct to the total education process" (p.18). Campbell (1983) affirmed that play media and techniques should be used as both a therapeutic and educational tool by elementary school counselors. Play helps to create a warm, supportive atmosphere and enables children to deal with conflicts and stressors that interfere with their emotional, social and academic progress (Campbell, 1983).

Play Therapy

Schaefer and O'Connor (1983) reviewed the history of play therapy, beginning with the work of Freud in 1909. Freud incorporated play into psychoanalytic therapy sessions with children. Klein developed "play analysis," also known as structured therapy, in 1920, where the therapist interprets play directly. Klein (1955) believed that play had a symbolic meaning related to the child's unconscious. In 1939, Levy developed release play therapy, a directive form of therapy. In release therapy, the therapist recreates a traumatic event through the selection of toys that trigger the child's feelings concerning the event (Levy, 1939). This recreation allows the child to integrate the stressful event rather than deny it or let it overcome him or her.

Relationship play therapy, the third significant movement in play therapy, was developed by Jesse Taft (1933) and Frederick Allen (1934). In relationship play therapy, the emotional relationship between the child and therapist was stressed as being most important for growth. The unconscious and the child's past experiences were deemed less important than the present therapist-client emotional relationship. In relationship

play therapy, "...the therapist concentrates on those difficulties that concern the child, rather than on those concerning the therapist..." (Landreth, 2002, p. 34). Virginia Axline's child-centered, non-directive play therapy approach was the fourth development in play therapy, conceptualized in 1947. The safety of the therapeutic relationship was emphasized in all forms of play therapy (Schaefer & O'Connor, 1983).

There are multiple forms of non-directive and directive play therapy that use play materials as the basis for communicating with children. While adults may talk out their problems in therapy, children play out their problems (Axline, 1947). Each play therapy approach is derived from a specific counseling theory (Cochran, 1996). For example, Psychoanalytic play therapists view play as an expression of unconscious conflicts (Cochran, 1996). In psychoanalytic play therapy, one of the roles of the therapist is to encourage the child to redirect their thoughts and feelings onto the therapist (Astramovich, 1999). The therapist directly interprets the meaning of the child's play to gain insight into the child's unconscious desires and motives. Interpretation helps the child to gain self-understanding, feel less anxious, and feel free to express him or herself.

Another type of play therapy is Adlerian play therapy (Kottman, 1993). Adlerian play therapists explore a child's lifestyle, family atmosphere, and family constellation, often using questions or drawings to clarify the child's role in his or her family. Early recollections and memories are also gathered from the child to gain insight into the child's beliefs about self and others. The counselor may ask a child to tell a story and then retell the story in a new way to show the child new ways of interacting with others. Adlerian play therapy differs from child-centered play therapy in that Adlerian therapists

directly interpret the child's play and draw inferences about a child's life based on the content of their play (Kottman, 1993).

Child-centered Play Therapy

Developed by Virginia Axline (1947), child-centered play therapy (CCPT) is a non-directive approach based on the premise that people have an inner drive toward self-actualization. CCPT is a derivative of Carl Rogers' client-centered therapy (Guerney, 2001). Axline was a student of Rogers that applied his philosophy of counseling to working with children ages 3 to 12. Few changes have been made to Axline's approach since its creation in 1947 (Guerney, 2001).

Child-centered play therapy (CCPT) is based on the fact that children communicate primarily through play (Landreth, 2002). Toys are the words children use to express their feelings. Children are able to grow, mature, and achieve their full potential when given the freedom to be themselves, accept themselves, and make their own choices (Axline, 1947). Anxiety naturally occurs when children are given freedom, responsibility and decision-making power, but it is through this anxiety that change and growth occurs.

The child-centered approach to play therapy experiences children as people in their own right who should be respected as unique individuals (Landreth, 2002). CCPT is more than a theory; it is a way of being with children. It is based on the belief that children are self-directive and are intrinsically motivated toward mental health, adjustment, and autonomy (Landreth et al., 1999). The child, not the therapist, directs the play therapy session, and the child determines when and how he or she should play.

CCPT helps children to overcome obstacles and barriers that impede self-actualization, or the realization of the self (Guerney, 2001). Children gain self-confidence and self-realization through successfully overcoming and working through conflicts in the context of a supportive, accepting, nurturing therapeutic relationship (Axline, 1947). Inner conflict and maladjustment are produced when incongruence exists between a child's internal self and external behavior (Axline, 1947). Maladjusted children lack sufficient self-confidence to channel their anxiety in productive ways. Thus, an objective of CCPT is to help children's behavior and attitudes to become congruent. Through therapy, children learn to modify their behavior to match their internal self (Guerney, 2001).

The child-centered approach is not problem-oriented in that the child, not the child's problem, is the focus of therapy (Landreth et al., 1999). The therapist behaves the same regardless of the child's presenting problems (Schaefer & O'Connor, 1983). For CCPT to succeed, therapists must have an abiding faith in the power of the process and an unwavering belief in the child's inner strength (Guerney, 2001). Commitment to maintaining the integrity of the therapy and adherence to the methods is essential (Schaefer & O'Connor, 1983).

A child-centered play therapist provides unconditional positive regard, empathy, warmth and acceptance (Axline, 1947). The therapist must be patient with the process. Under optimum conditions, a therapist would work with a child for 15 to 20 50-minute sessions to see maximum growth. Accepting the child completely and establishing an atmosphere of permissiveness and trust enables the child to feel free to express himself. The therapist aims to "...help the child feel safe enough to change or not to change, for

only when the child feels free not to change is genuine change possible” (Landreth, 2002, p. 105).

Nondirectiveness does not equate to passivity (Landreth, 2002). There is not a complete and total atmosphere of permissiveness in the playroom. Boundaries are set on what behaviors are acceptable and unacceptable. “All feelings, desires, and wishes of the child are accepted, but not all behaviors are accepted” (Landreth, 2002, p. 249).

Limitations are established by the therapist and introduced only when needed to “...anchor therapy to the world of reality and make the child aware of his responsibility in the relationship” (Axline, 1947, p. 130). The relationship must be built on a mutual respect between the therapist and child.

Limits on behavior are minimal and set only when necessary to keep the child and therapist safe and the toys from being damaged (Guerney, 2001). When setting limits, the therapist reflects with empathy the child’s desire to defy the playroom rules, which conveys to the child that the therapist accepts their feelings about wanting to break the limits (Guerney, 2001). For example, if a child angrily picks up a car and looks as if he is going to throw it at the therapist, the therapist might say: “Jonny, you’re angry and you really want to throw that car at me, but one of the things you can’t do is throw toys at me.” The child’s need to act out a behavior is often reduced when the feelings undermining the behavior are dealt with (Schaefer & O’Connor, 1983).

There are no limits set on what a child can say; children are free to say anything they want in the playroom (Landreth, 2002). The majority of the structuring takes place in the first session. Children are told that the playroom is their special place where they can say anything they want and do *almost* anything they want to do (Landreth, 2002).

There is a time limit to the session that the therapist informs the child about. Most play sessions are approximately 50 minutes in length, although sessions can be shorter if time constraints exist.

The therapist does not pressure a child to change, and there is no judgment, positive or negative, of the child's play behavior (Schaefer & O'Connor, 1983). The therapist remains neutral, neither praising nor criticizing the child's play (McMahon, 1992). The therapist does not intervene in the child's play, offers no opinions or suggestions, and only plays when asked by the child (Axline, 1947). The therapist does not initiate or direct but reacts to the child (Schaefer & O'Connor, 1983).

Axline (1947) discussed the importance of maintaining respect for the child's ability to make his own choices and solve his own problems. The non-directive approach necessitates that the child be given the power to direct the session by choosing their actions. The counselor attends to the child's play (verbalizations and actions) and to the child's emotions and reflects back to the child what is observed, which helps the child to feel respected and understood. This also helps the child to gain insight into his behavior. The therapist conveys understanding and acceptance which helps the child to gain strength to uncover his or her innermost self (Axline, 1947). Children's self-esteem increases as they begin to feel valued and respected (McMahon, 1992).

Rather than forcing children to talk about things they may not be ready to talk about, CCPT respects the child's pace and readiness level (Drewes, 2001). Unlike behaviorally oriented techniques that are controlled, directed and imposed by adults, CCPT therapists proceed at the child's pace, following the child's direction (McMahon, 1992). The child is the most important person in the playroom. He or she has the

authority and control to freely play, “neither restrained nor hurried” (Axline, 1947, p. 16). The playroom is a unique setting because the child gets to choose how to live his or her life without adult suggestions or interference (Axline, 1947).

The relationship between the therapist and the child determines the success or failure of the therapy (Landreth et al., 1999). A safe, trusting therapeutic relationship and atmosphere is established in CCPT that enables a child to confront their difficulties when they are ready, which facilitates healthy emotional growth (Ogawa, 2004). Through the power of play, children are able to bring their unconscious, repressed feelings into conscious awareness so they can confront and resolve them (McMahon, 1992). The child decides when he or she is ready to handle these feelings. The play therapist strives to create for the child a sense of security and control where the child decides how much emotional distance he or she needs.

The Efficacy of Child-centered Play Therapy

Although countless studies have demonstrated the effectiveness of CCPT, some studies indicate mixed support for its effectiveness. Post (1999) found that 4th, 5th, and 6th grade students who received play therapy over the course of a school year did not show an increase in self-esteem or locus of control. However, students in the control group who did not receive play therapy showed a decrease in these variables. Casey and Berman (1985) reviewed the outcomes of 75 studies conducted between 1952 and 1983 that measured the outcome of psychotherapy with children. Based on their evidence, they concluded that psychotherapy for children is effective, as it produced better treatment outcomes when compared with groups of children who received no counseling

However, they could not conclude that nonbehavioral treatments such as play therapy were more or less superior than behavioral treatments.

Scott et al. (2003) conducted weekly CCPT sessions with 26 sexually abused children for 10 sessions and found that 8 of the 26 children improved in terms of mood, self-concept and social competence. Fall, Navelski, and Welch (2002) conducted a study with 66 children who received six CCPT sessions. Their study showed no significant differences in self-efficacy between children who received CCPT sessions and those who did not. However, the students who received CCPT demonstrated a decrease in problematic behaviors as rated by their teachers.

While many researchers have shown that play therapy helps abused children and children who have witnessed domestic violence (Mann & McDermott, 1983; Perez, 1987; Kot, Landreth, & Giordano, 1998; Saucier, 1986; Griffith, 1997), Rasmussen (1995) argued that directive approaches are more beneficial than nondirective methods when used with abused children. Rasmussen (1995) asserted that children will not deal with the issues surrounding their abuse unless they are confronted about it directly through the use of focused techniques. However, Rasmussen agreed that non-directive methods of rapport building and an accepting, empathic therapeutic relationship are necessary in order for the focused techniques to work.

Children are able to develop skills in the playroom that will benefit them in all other areas of their lives, including academics (Drewes, 2001). Academics improve when behavioral and emotional barriers are eliminated. It is necessary to tend to children's emotional problems in order to help them achieve optimal academic success (Crow, 1994). Child-centered play therapy provides the opportunity for children to work

through their emotional issues that interfere with their learning. CCPT helps children to learn problem solving skills, social skills, and reduces behavioral problems. CCPT helps kids to gain self-control and self-confidence, and improves self-esteem (Landreth, 2002).

Reading plays a significant role in a child's learning (Crow, 1994). If students' psychological needs are not met, they will continue to struggle academically. CCPT also provides an outlet for children to channel their frustrations related to academic difficulties. Crow's (1994) study with first-grade students who were low achievers in reading demonstrated that although play therapy did not appear to increase students' reading abilities, it did help to improve their overall self-concept, thereby increasing their capacity to learn. Crow (1994) concluded that students with reading problems and other learning difficulties can benefit from CCPT as these students often have unmet emotional needs as well as feelings of low self-worth. CCPT can provide students who are struggling academically with a sense of control, personal worth and significance (Crow, 1994).

Despite the fact that CCPT does not address symptoms and problematic behaviors directly, it has proven to be effective for virtually all childhood problems (McMahon, 1992). Children who suffer from abuse, trauma, divorce, depression, separation, loss, developmental delays, language difficulties, social maladjustment, attention-deficit hyperactivity disorder, mood disorders, anxiety disorders, oppositional behavior, and dysfunctional family situations can benefit from the healing power of CCPT (Landreth, Homeyer, Glover & Sweeney, 1996). CCPT can help children who are culturally diverse to overcome educational barriers, as it does not place an emphasis on verbalization

(Cochran, 1996). Play therapy also helps children who have difficulty speaking to gain the social skills and confidence they need to be able to express their feelings.

CCPT has been proven effective in treating enuresis and encopresis (Cuddy-Casey, 1997). CCPT has also been proven effective in building assertiveness skills, social maturity and interpersonal skills (Landreth, 2002). Children are more apt to accept others when they are able to accept themselves (Post, 1999). The only two groups where CCPT has not been proven to be effective are with children who have severe autism or schizophrenia (Guerney, 2001). CCPT can even be modified to work with developmentally disabled adults struggling with emotional and behavioral difficulties (Demanchick, Cochran, & Cochran, 2003).

CCPT does not necessarily have to be a long process. School counselors are often pressured to come up with a “quick fix” (Drewes, 2001). Short-term play therapy can be helpful for children without serious emotional issues who do not need intensive prolonged counseling (Landreth, 2002). Children are resilient and can make significant progress in a short time frame with the help of an accepting, caring therapeutic relationship. Two or three sessions can help children to manage troublesome emotions or difficult situations in their lives. Short-term play therapy can help children cope with difficult transitions in their life and prevent their problems from worsening. Short-term group play therapy is also an option for reaching larger numbers of children in a shorter amount of time (Landreth, 2002). Children can learn interpersonal and social skills in a group format.

CCPT not only benefits the individual child but can also benefit the entire family system, creating an “...upward spiral in the parent child interaction” (Wilson & Ryan,

2001, p. 216). Children's relationships with their parents often improve as a result of CCPT, as parents respond positively to their children's improvements in attitude and behavior. Children who receive individual play therapy often become more manageable at home and are able to accept parental control and discipline, which decreases the amount of negative interactions between parent and child.

Involving parents in the treatment of their child positively affects students' behaviors and therapy outcomes (Vanderbleek, 2004). Parents often need education, training, and support to become a part of the solution to their child's problems. Although parent skills training is preferred in conjunction with CCPT, children can still benefit without their parents being involved in therapy (Landreth, 2002).

Some critics may think that CCPT is too time consuming to be an effective intervention in schools, and may recommend referring children to outside agencies instead (Golden, 1985). However, the reality is that the only emotional help children may receive is what the school can offer them (Campbell, 1993). Child-centered play therapy is a proven method for treating a wide range of children's problems, and with a collaborative, interdisciplinary team effort, can be effectively integrated into schools.

Method

In this section, the characteristics of the site and the participants will be described. The instruments used to evaluate progress will be described. Teacher assessments, therapist progress notes, and parent verbal reports were used to measure student change. Toys and materials used are briefly described. Procedures about how the data were collected will be described followed by a discussion of the data presented.

Site

Three rural elementary schools (Schools A, B, and C) in Western New York were the setting in which the study took place. The student enrollment in the three schools consisted of 479, 498, and 514 children, respectively. School A contained grades K-6 while the other two schools were comprised of grades K-5. Each school employed one school psychologist. School A also employed one school social worker. The ratio of students to teacher was 15:1 at School A and 12:1 in Schools B and C. At School A, 37% received free/reduced lunch. 79% of the students were Caucasian. At Schools A and B, 12% received free or reduced lunch and 96% of the student population was Caucasian.

Participants

The participants in this study were elementary school children in grades kindergarten through 4th grade who were referred by school personnel (i.e. teachers, school social workers, school psychologists, principals) due to observable mental health problems or distressing home or family conditions. The school contacted the parents to open the door for communication to occur between therapists and parents. Before children could begin therapy, the therapists reviewed confidentiality practices and obtained consent for treatment from the parents (as part of CFC protocol). This consent form served as permission for their children to be included in the present study (Appendix A). Parents also were asked to sign an information release form to facilitate collaboration between the schools and the Early Intervention Program (Appendix B).

The students in the present study were referred for a variety of reasons. These included: social immaturity, anxiety, irritability, depressed mood, lack of self-

confidence, low self-esteem, witness or victim of domestic violence, low frustration tolerance, bullying, aggression, defiance, poor impulse control, poor attention span, inattentiveness in class, encopresis, enuresis, and divorce/separation/incarceration of parents.

All of the students who were referred received CCPT, though not all students that received CCPT were automatically included in the study. The participants consisted of 14 of the 26 new referrals that were made to the EIP program. The sample was delimited to students that began CCPT in the fall of 2004. Students that received play therapy in previous years or that moved during the course of the school year were not included. Some students were excluded from the study due to teacher assessments not being submitted or completed in a timely manner. The final sample of this study consisted of 14 students attending three small, rural, Western New York public elementary schools. Five of the students attended School A, six attended School B and three attended School C.

The median income for Wayne County families is \$44,000, with 13.5% of families with children under the age of 17 living in poverty (www.census.gov). The average income of the families served in this study was \$27,000. Thirty-eight percent of the families in this study lived below the poverty level. The average family size in Wayne County is 2.6. The families in the study had an average family size of 4.5. Seventy-five percent of the students in the study lived in single-parent households; 56% had little to no contact with their father.

Ninety-four thousand people reside in Wayne County (www.census.gov). Ninety-four percent of the population is White, 3% is African-American, 1.3% is bi-racial, and

less than 1% is American Indian and Asian. Nine of the students (64%) in the sample were Caucasian and 5 (36%) were bi-racial (2 African-American/Caucasians, 2 Hispanic/Caucasians, 1 American Indian/African American). The final sample included 3 females (mean age = 6.3) and 11 males (mean age = 6.8). The sample consisted of 8 kindergarten students, 1 second grader, 4 third graders and 1 fourth grader. There were no first grade students involved in the study. The disparity in the sample between the number of males and females was accounted for due to the majority of referrals being males. This is partially due to the fact that males tended to have more disciplinary problems than females and exhibited more acting-out, aggressive behaviors.

Therapists

A total of three counselors (white females ranging in age from 27-49) were involved in the study; two worked at School A and one worked at Schools B and C. The counselors utilized the same play room every week to provide consistency to the children. Two of the counselors work at the Catholic Family Center Wayne County Office and are certified play therapists with master's degrees in counselor education. The third counselor (the author), is an intern at CFC, pursuing a master's degree in counselor education and planning to graduate in May 2005. The counselors took the same graduate level course in child-centered play therapy and attended the same college for their graduate education. The counseling experience of the counselors ranged from three to seven years. All three counselors practiced CCPT in the way they were trained, though sessions were not audio or video taped. The counselors met weekly to discuss cases and provide feedback and support to one another. The author assumed responsibility for overseeing and supervising the data collection from the other two therapists.

Toys and Materials

Although the three playrooms differed in size in each school, the toys and materials remained similar. The toys in the playrooms provided for a wide expression of feelings and exploration. They included: tool kit, puppets, kitchen/cooking/food materials, chalkboard/easel, pillows, dress up materials (i.e. hats, masks, jewelry, sunglasses, telephone, handcuffs), crafts materials (i.e. markers, crayons, blank paper, scissors, glue), play dough/clay, doll house/family, baby dolls, cash register/money, medical kit, musical instruments, balls, legos/blocks, vehicles/planes, stuffed animals, rubber snakes, farm animals, dinosaurs, toy soldiers, and action figures. For an exhaustive list of recommended toys and materials, the reader can refer to Chapter 7 of Garry Landreth's book, *Play Therapy* (2002). Landreth emphasized that the toys should communicate a message of, "Be yourself in playing," rather than a message of "Be careful" (2002, p. 132). In addition, board games should not be in the playroom, as children should not need the therapist in order to play with something.

Instruments

Teacher assessments were utilized in the study to gauge a students' progress. The teacher assessments were site specific forms that were developed by Catholic Family Center in 2000 and required to be completed for all students served in the EIP program. A limitation of the teacher assessment form was that it was not psychometrically validated. The assessment consisted of 23 variables.

Initial teacher assessments (Appendix C) were completed by the teacher prior to the child's initial CCPT session. Eleven different teachers were involved in the study. Counselors distributed the forms to the teachers in their school mailboxes or in person

and asked that they be completed and returned within one week. For the initial assessment, teachers indicated whether a specific variable was never, rarely, moderately, often or usually a problem for the child. Follow-up teacher assessments (Appendix D) were completed after the child's eighth session. The follow-up assessments were distributed in the same manner as the initial assessments. On the follow-up assessments, teachers rated the child on the same 23 variables, indicating whether the specific variable worsened, improved, stayed the same, or was no longer problematic. There was also an optional comments section on the bottom of the form where teachers could provide additional remarks.

Play therapy session notes (Appendix E) were completed weekly by therapists. Therapists indicated on the progress notes predominate feelings and significant verbalization expressed by the child in each session. Therapists rated the child on a scale of 1 to 10, with 10 being the best rating a child could receive and 1 being the worst. The nine continua the children were rated on were:

1. Sad/Depressed/Angry to Content/Satisfied
2. Anxious/Insecure to Confident/Secure
3. Low Frustration Tolerance to High Frustration Tolerance
4. Dependent to Autonomous/Independent
5. Immature/Regressed/Hypermature to Age Appropriate
6. External Locus of Control to Internal Locus of Control
7. Impulsive/Easily Distracted to Purposeful/Focused
8. Inhibited/Constricted to Creative/Expressive/Spontaneous/Free
9. Isolated/Detached to Connected/Sense of Belonging

Counselors talked to the child's parents every six weeks (after the child had completed a sixth session) and consultation notes (Appendix F) were completed at that time as an additional, qualitative way to measure student change. Counselors talked with the parents in their homes, at the school, or over the phone. Parents were consulted with to discuss concerns, provide parenting skills training and exchange feedback as to their child's progress.

Results

Teacher Assessments

The results of the initial and follow-up teacher assessments are shown on Appendices G and H, respectively. 71% of the children (10/14) were rated as having increased self-confidence and independence/self-reliance. 64% (9/14) were observed by their teachers to have become more optimistic and have an improved ability to make friends. 57% of the students (8/14) showed improved motivation and became less quiet and withdrawn. 50% of the students (7/14) showed improvement in becoming less sullen/sad, making more eye contact and becoming more playful.

All of the students began the study with attention span and respectfulness being somewhat problematic, according to their teachers. At the end of the study, 5 of the 14 students (36%) were rated as having improved their attention span. For 8 students (57%), there was no change in this variable and for 1 student (7%), it was no longer problematic. None of the students' attention spans worsened. 35% (5/14) of the children were shown to have become more respectful of others by the end of the study. For 5 students (36%), respectfulness was not a problematic area. 29% (4/14) of the students showed no change in this area.

In the area of defiance, 29% (4/14) showed improvement and 14% showed no change. Defiance was no longer problematic for 57% (8/14) of the students at the end of the study. Twenty-nine (4/14) of the children showed improvement and 29% showed no change in terms of irritability. For 43% of the children (6/14), irritability was not a problematic variable at the end of the study.

Twenty-nine percent (4/14) of the children showed improvement in the variables of flat affect and anxiety and 43% (6/14) of the children were rated as not having a problem in these two areas. Twenty-one percent (3/14) of the students showed improvement in the areas of impulsivity, silliness, frustration tolerance, bullying behavior, and fear. Teachers rated all of the children as having some degree of a problem with impulsivity in the beginning of the study. By the end of the study, 4 of the children (29%) no longer had a problem with impulsivity. Secrecy and dishonesty was not initially rated as a problematic area for 11 of the 14 children. By the end of the study, it remained non-problematic for 9, 1 improved, and there was no change noted in 4 of the students.

There was no improvement noted in the area of perfectionism, although this was not a highly problematic area to begin with. Fifty percent (7/14) of the students showed no change on this variable and perfectionism was not problematic for the other 50%. Overactivity and restlessness was not a problematic variable for 50% of the students at the end of the study. For 43% (6/14) of the students, there was no change in this variable, and 7% (1/14) improved.

The results from the final assessments indicated that 7% of the students (1/14) in the study worsened according to the teachers on the following seven variables: easily

frustrated, self-confidence, bullies, sullen, anxious, makes eye contact, and fearful/afraid. Children did not worsen on 16 of the 23 variables.

Teacher Comments

The comments section on the teacher assessment form was optional. However, 10 of the 11 teachers wrote comments. Quotes from the teachers that made comments have been included as an additional source of information.

Teachers stated: “Susan” “...though still moody, tries more often and is less openly defiant;” “Sally” “...has shown positive social growth...she is more social with her peers, more inclined to speak up to grown-ups, and has periodic eye contact which is new for her, the kind of eye contact that says: “ok, maybe I’ll let you in a little bit.” Another teacher described “Jonny” as an “even-keel” kind of student in the beginning. Her final comments stated; “We see a happy “Jonny” in school.” Another teacher described “Zach” as “quiet” on the initial assessment. On the final assessment, the teacher commented that he had started “coming out of his shell,” was “social with classmates” and “shared things about himself” with others.

A kindergarten teacher’s comments on the final assessment about “Matt” stated the following: “Matt is making great progress socially. He seems to be getting a lot out of meeting with you [the counselor] and it carries over to interacting in the classroom.” Other teachers’ comments on the final assessments included: “Bobby” does a wonderful job; “Steve,” though still withdrawn, interacts with others more; “David’s” attitude toward school is much improved, and he seems to show effort in behaving in a responsible manner, though he still has challenges with interacting appropriately with peers.” “Tom” was described by his teacher in the beginning as a child whom “...peers

found it difficult to connect with.” On the final assessment, the teacher stated that although he still occasionally struggles with problematic behaviors, he was “...slightly more motivated and is working on developing friendships.”

“Sean’s” teacher remarked on the initial assessment that he seemed to have “low self-esteem.” On the final assessment, “Sean” was described as “more self confident.” “Tim” was described as “sad” by his teacher in the beginning. On the final assessment, he was described as “peaceful, optimistic, and continuing to try hard.” Another teacher stated: “Cory has really opened up. He has remained polite to peers and adults. He interacts well with boys and girls in our room. Although he still becomes frustrated with writing and spelling, he has made some positive growth in social areas which led to a sense of community and comfort in our classroom.”

Play Therapy Session Notes

After each weekly session, counselors completed play therapy session notes (Appendix E), rating each child on a 1 to 10 scale (nine scales altogether) indicating where she observed the child to be during their session. A rating of 1 was the worst rating a child could receive and 10 was the best. Appendix I shows the results of the scales. A mean score was calculated for each variable for each session. An overall mean score for each variable was derived from the individual mean scores for each of the eight sessions.

All of the scales show upward progression. Counselors viewed children as becoming more content and satisfied. On the sad/depressed/angry to content/satisfied scale, the overall mean score was 5.9. The mean score of the first session was 5.6 and the mean score of the final session was 6.1. The overall mean score of the anxious/insecure

to confident/secure scale was 5.3. Therapists viewed the students as becoming more confident and secure, starting with a mean score of 4.7 and ending with a mean score of 5.8. Students also increased their ability to handle frustration, as evidenced by an increase from 5.7 to 6.7 in the first and final sessions, respectively. The overall mean for the frustration tolerance scale was 6. Counselors observed the children as increasing in their level of autonomy as the sessions progressed. On the dependent/independent continuum, the children had an overall mean score of 5.8. The mean score of the first session was 5.1 and the final mean score was 6.4.

Children engaged in more age appropriate play as the sessions progressed, evidenced by a 5.1 mean score in the first session and a 5.9 mean score in the final session. The overall mean score for the immature/regressed/hypermature to age appropriate scale was 5.5. Children became more self-controlled through the course of their play therapy sessions, starting with a mean score of 5.9 and ending with a mean score of 6.6. The overall mean score for the locus of control scale was 6.3. According to the counselors, children became significantly more purposeful and focused and less impulsive by the end of their eight sessions. The mean score of the first session was 5.5 while the mean score of the final session was 7.2. The overall mean score for the impulsive to purposeful scale was 6.2.

Children became more creative and expressive and less inhibited and constricted through the course of therapy, as the mean score for this scale was 6.2. The first session had a mean score of 5.8 and the final session had a mean score of 6.9. On the final scale (isolated/detached to connected/sense of belonging), counselors observed the children to

become more connected and less isolated. The mean score for this scale was 6, with a 5.4 mean score in the first session and a 6.6 mean score in the final session.

Parent Consultations

Parent consultations were completed with 10 of the 14 parents of the children involved in the study. Parent consultations were conducted by the therapists after the child's sixth therapy session had taken place. In a few cases, therapists were unable to talk with parents despite documented efforts to do so. The parent reports were overwhelmingly positive. The following is a list of the ten parents' comments about their children's behavior that were noted by the therapists:

1. Helps with siblings, does homework without problems
2. Self-esteem and self-confidence improved
3. Less defiant, more cooperative at home
4. Increased respect, obedience
5. More well-behaved, cooperative, less acting out
6. Significant improvement in ability to express feelings appropriately; interacts more prosocially with siblings, asks for help when needed
7. Significant improvement in ability to deal with anger
8. Less stressed, more happy
9. Decrease in temper tantrums
10. Decreased hyperactivity

Significant Verbalization

Themes of competency, self-confidence, self-responsibility, and contentment to be in the playroom are apparent from the following children's verbalizations that were

noted by the therapists on their progress notes: “Next time I’m gonna work on this some more.” “I’m good at this.” “I really like this.” “I’m choosing.” “I know what I want to do.” “Are you coming for me tomorrow?” One little girl said: “Why did my mom get a note that we talked, ‘cause we just played?”

Other children’s’ comments included: “If I fall asleep, I can stay here.” “I’m strong.” “I did it myself.” “This is not tricky for me. Is it tricky for you [the counselor]?” “I’m the winner!” “I like math ‘cause I’m good at it.” “I can walk back to the classroom by myself.” “I love it in here [the playroom]; it’s so cool in here.” “This is the best day of my life.” “Why doesn’t [the principal] give us more time than this?” “I can make something out of anything.” “Everyone should play. Everyone should get along.” “I was hoping I’d have Project Playtime today.”

Discussion

This study was completed to examine the effectiveness of child-centered play therapy in elementary schools. It was hypothesized that children who received weekly 45 minute play therapy sessions from qualified therapists over the course of eight weeks would demonstrate increased prosocial behavior and decreased maladaptive behavior. The results showed that the majority of the children in the study improved in multiple areas, based on teacher, parent, and therapist reports.

Teacher Assessments

Of the 23 variables that were assessed by teachers, significant improvement was noted in the children’s self-confidence, self-reliance, optimism, ability to make friends and self-motivation. Moderate results were shown in the areas of attention span, defiance, irritability, respectfulness, anxiety, and flat affect. If given the proper, growth-

enhancing conditions, children are naturally motivated to become autonomous and self-reliant (Landreth et al., 1999). In this study, children became less anxious as they gained sufficient self-confidence to work through emotional difficulties in the playroom. They gained the strength and confidence to work through their difficulties in productive ways, rather than becoming defiant and irritable. Their increased self-confidence enabled them to become less withdrawn and interact with others in more socially appropriate ways, thus improving their ability to make friends.

The teacher comments were overwhelmingly positive in nature. Every teacher had something positive to say about their student's involvement in the Early Intervention Program. Most identified child-centered play therapy as a catalyst for improving prosocial behavior and decreasing maladaptive behavior. The teachers seemed to recognize that although problematic behaviors may not disappear completely as a result of CCPT, they decrease in frequency and intensity and are replaced with more responsible behaviors.

Play Therapy Session Notes

The counselors' play therapy session notes showed children's improvement on all nine rating scales. Coinciding with the teachers' results, the counselors noted improvement in the children's level of confidence, contentment, connectedness/sense of belonging, and independence. As they began to feel valued and cherished by their counselors, the children learned to value, respect, and accept themselves. Children who feel respected by others for who they are as a person tend to have more self-esteem (McMahon, 1992).

Counselors observed the children to become more creative, spontaneous and expressive as the sessions progressed. The safe and permissive playroom atmosphere enabled the children to feel unhindered and free to express themselves. The children were not judged, criticized or laughed at for how they chose to express themselves.

They also noted improvement in the children's level of self-control, ability to handle frustration, and engage in age appropriate activities. Children often become frustrated when they do not feel listened to, feel their opinions do not matter, or feel that they do not have control of their surroundings. The therapist in child-centered play therapy provides a warm, accepting environment where a child's frustration tolerance naturally increases as their feelings are validated and they are given control of their actions.

According to the counselors, the highest degree of change was found to be on the impulsivity to focused continuum. Children were rated an average score of 5.5 in the first session and a 7.2 in the eighth session, showing that they became increasingly more focused and less distracted in their play. Counselors' and teachers' observations seemed to differ in this area. Teachers rated three children as improving in impulsivity and seven not changing in this area. Teachers rated five children as improving in their attention span and eight not changing in this area. This difference could be due to the fact that the playroom is a unique place and is different from the classroom environment. Children were given the opportunity to do almost anything they want to do in the playroom, whereas in the classroom there are more limits and more structure imposed upon them.

Parent Consultations

The parent consultation reports were overwhelmingly positive. Of the 10 parents questioned, all 10 had positive things to say about their children. Of course, some may say that parents are eager to paint their children in a positive light and want to be viewed by others as “good parents.” Another explanation that could be made for the positive consultation reports is that child-centered play therapy positively impacted the parent-child relationship. As the children became more manageable at home, the parents disciplined less, which created a happier, less hostile family atmosphere.

All of the parents indicated that although the problematic behaviors did not disappear completely, the frequency and intensity of them decreased immensely. For example, one parent said that although her daughter occasionally has a “small tantrum” when asked to clean her room, it’s better than when she used to throw things and push people.

Four of the parents were unable to be contacted. Due to their marginal incomes, some families did not have phones. Others may have changed addresses frequently if they were evicted from their apartments, which made it difficult to mail letters home.

Potential Limitations

Little, if any, attention is given in the research to obtaining children’s reports as to their perceptions and opinions of their counseling experience. Thus, conclusions are made based on outsiders’ perspectives rather than listening to the child’s voice. Indirect methods (i.e. improvement noted in school and home by teachers, parents and caregivers) provide some insight into the effectiveness of a modality, but clients’ reports can provide a wealth of information into the heart of the counseling process. In this study, significant

verbalizations made by children (noted by therapists in their progress notes) were included as an attempt to have some measure of the child's perception of the therapeutic process.

A limitation of this study was the lack of a control group. An opportunity for future research would be to conduct a similar study utilizing a control group who did not receive counseling at all or who received a different type of counseling. The presence of a control group would enable CCPT to be compared to other counseling approaches. The majority of the students in the study showed improvement. On certain variables, there was no change evident. The question remains of whether the children's problems would have gotten worse had they not received the play therapy intervention. From their analysis of 75 studies, Casey and Berman (1985) concluded that providing counseling to children is more effective than the alternative of not providing counseling.

Another limitation of this study was the lack of validity or reliability estimates for the measurement tools used. Future researchers could consider using rating scales that has been proven to be psychometrically valid and reliable. The teacher assessments used in the present study were utilized as they were quick and easy for teachers to complete and did not require extensive time. The parent consultation notes were possibly too vague. A more specific, validated instrument might prove more beneficial for obtaining data from the parents.

In terms of the sample, it would have been helpful if more participants could have been involved in the study. The overall sample was not representative of the population, as it was overwhelmingly male. However, the sample was representative of the number of students referred for psychological services. It also included multiple ethnic groups.

Implications for Research

The present study consisted of a total of eight sessions. A follow-up battery could prove to be a valuable assessment tool. Studies encompassing a longer time range (i.e. over the course of a school year) could also prove useful in determining if continued progress would be made. A longitudinal study that assessed students' long term progress as a result of child-centered play therapy would also prove beneficial at showing whether therapeutic gains are maintained over time.

Future research might also examine student report cards and attendance reports to determine if a correlation exists between child-centered play therapy and other variables. Although the emotional needs of the children were being met in CCPT, it is uncertain as to whether the children's academics and ability to learn actually improved. The majority of the children (75%) in the study lived in single-parent households, which could also be a factor worth exploring further to determine the extent to which it impacts the emotional adjustment and overall well-being of the children.

It could also be beneficial for future researchers to talk face-to-face with each teacher to gather more qualitative information regarding the children's progress. Quantitative measures of parent observations of the child's behavior would also be helpful as an additional way to measure student change. In addition,

Implications for Practice

This research study suggests that child-centered play therapy is an effective intervention for children with a wide range of problems. Although the 14 children were each referred for different problems, all of them showed a decrease in problematic behaviors and an increase in prosocial behaviors as a result of CCPT. Children who

received play therapy in this study showed significant improvement in their self-motivation, self-reliance, optimism, self-confidence. They became less withdrawn, more social, and improved their ability to make friends.

This study also highlights the importance of preventive care and early intervention, especially in the schools. Schools have a duty to attend to children's emotional health. Mental health counseling needs to start in pre-schools and elementary schools so that problems can be prevented before they escalate. The schools need to meet the challenge of effectively addressing a child's academic and emotional needs (Adelman, 1998).

The results of this study coincided with previous studies documenting the effectiveness of CCPT. This study lends support to the findings of Ray et al. (2001), who analyzed 94 studies over the past 60 years, in concluding that CCPT does effectively treat children's problems. The non-directive atmosphere and the therapeutic relationship are the main factors that bring about change. In addition, the importance of play cannot be underscored. Play should naturally be incorporated into counseling with children as it is their natural method of communication.

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Appendix A
Consent Form

Acknowledgements:

I hereby acknowledge that I received a copy of the agency’s **Notice of Privacy Practices**.

Yes: _____ No: _____

I would like to receive a copy of any amended **Notice of Privacy Practices**.

Yes: _____ No: _____

I hereby acknowledge that I received a copy of the **Statement of Mutual Rights and Responsibilities of Clients and Catholic Family Center (CFC)**. I have reviewed this Statement with my worker and I understand my rights and responsibilities as a client of CFC. I also understand that CFC has rights, as well as responsibilities toward me.

I understand that CFC routinely compares program enrollment lists from its various programs. I have been told that this is done to identify duplicate enrollments. I understand that this information is used only for this internal purpose so that care may be coordinated and so that CFC can produce accurate statistical reports. My confidentiality is protected throughout this process.

Yes: _____ No: _____

Consent for Treatment, Payment and Operations

I understand that as a condition to my receiving treatment Catholic Family Center (CFC) may use or disclose my personally identified information for treatment, to obtain payment for the services provided, and as necessary for operations of this agency.

Yes: _____ No: _____

Fund Raising and Marketing

I consent to Catholic Family Center using my personally identifiable information for fund raising.

Yes: _____ No: _____

I consent to Catholic Family Center using my personally identifiable information for marketing.

Yes: _____ No: _____

Signed: _____ Date: _____

Printed Name: _____ Telephone: _____

Witness: _____ DOB: _____

Appendix B
Information Release

I, _____, for _____ hereby consent
(Parent) (Child)
to and authorize Catholic Family Center's Early Intervention Program to disclose to _____,
(Name of School)

Information pertaining to: (check those that apply):

- Presence in EIP
EIP Evaluation Summary
Intake Sheet, Psych-Social History, Treatment Plan, Aftercare Plan, Discharge Summary, and Attendance
Other _____

This information is needed to facilitate collaboration with _____ School System

I, _____, for _____ hereby
(Parent) (Child)
consent to and authorize the _____ School system to disclose to
Catholic Family Center's Early Intervention Program, information pertaining to:

- Attendance Records
Academic Records
Disciplinary Records
Psychological Records
Other _____

This information is needed for the following purposes:

- To facilitate development and implementation of Client Service Plan.
To facilitate collaboration with Early Intervention Program.

I understand that my records are protected under the Federal Confidentiality Regulations and cannot be
disclosed without my written consent unless otherwise provided in the regulations. I also understand that I
may revoke this consent at any time except to the extent that action has been taken in reliance on it (eg:
probation, parole, etc.) and that in any event this consent expires automatically as described below.

Specification of the date, event, or condition upon which this consent expires: _____

Executed this _____ day of _____, 200__.

Signature of Witness

Signature of Parent/Legal Guardian

Appendix C

Initial Teacher Assessment

Student: _____

Teacher: _____

Date Completed: _____

	Never	Rarely	Moderately	Often	Usually
Short attention span					
Impulsive					
Secretive, dishonest					
Self motivated					
Perfectionistic					
Silly, "clowns around"					
Easily frustrated					
Independent, self reliant					
Openly defiant					
Complaining, irritable					
Self confident					
Optimistic, positive					
Quiet, withdrawn					
Makes friends easily					
Bullies (aggressive towards schoolmates)					
Is respectful of others					
Overactive, restless					
Sullen, sad					
Anxious (nervous habits)					
Makes eye contact					
Fearful, afraid					
Playful, smiles, laughs					
Flat affect (little emotional expression)					
Comments:					

Appendix D

Follow-Up Teacher Assessment

Student: _____

Date completed: _____

Teacher: _____

	Worsened	No change	Improved	Not Problematic
Attention span				
Impulsivity				
Secretive, dishonest				
Motivation				
Perfectionistic				
Silly, "clowns around"				
Easily frustrated				
Independent, self reliant				
Openly defiant				
Complaining, irritable				
Self confident				
Optimistic, positive				
Quiet, withdrawn				
Makes friends				
Bullies (aggressive towards schoolmates)				
Is respectful of others				
Overactive, restless				
Sullen, sad				
Anxious (nervous habits)				
Makes eye contact				
Fearful, afraid				
Playful, smiles, laughs				
Flat affect (little emotional expression)				

COMMENTS:

Appendix E

Play Therapy Session Note

III. ASSESSMENT: General Impressions/Clinical Understanding

A. Dynamics of Session: (Rate 0=low, 10=high): Child's play/activity level: __ Intensity of Play:

Inclusion of therapist/level of contact:

Destructive	1	2	3	4	5	6	7	8	9	10	Constructive
Messy/Chaotic	1	2	3	4	5	6	7	8	9	10	Neat/Orderly

B. Mental Status Exam:

Physical Appearance: Kempt Unkempt Disheveled Bizarre Other

Mood: WNL Depressed Anxious Angry Euphoric Irritable Apathetic

Affect: Appropriate Ingruent Constricted Flat Depressed Labile Inappropriate

Orientation: Alert Person Place Date Stuporous

Speech: WNL Rapid Slowed Slurred Incoherent Pressured Sparse Mute

Behavior: Cooperative Withdrawn Guarded Hostile Manipulative Combative

Insight: Poor Good Age Appropriate

Judgment: Poor Good Impulsive Impaired Age Appropriate

Memory: S/T Intact Impaired L/T Intact Impaired

Hallucinations/Delusions: None Present/Type: _____

Suicidal/Homicidal Ideation: Y / N if Yes, What?: _____

Suicidal/Homicidal Plan: Y / N if Yes, What?: _____

Suicidal/Homicidal Intent: Y / N if Yes, What?: _____

C. Overall Child's Behavior/affect was:

Sad/Depressed/Angry	1	2	3	4	5	6	7	8	9	10	Content/Satisfied
Anxious/Insecure	1	2	3	4	5	6	7	8	9	10	Confident/Secure
Low Frustration Tolerance	1	2	3	4	5	6	7	8	9	10	High Frustration Tolerance
Dependent	1	2	3	4	5	6	7	8	9	10	Autonomous/Independent
Immature/Regressed/Hypermature	1	2	3	4	5	6	7	8	9	10	Age Appropriate
External Locus of Control	1	2	3	4	5	6	7	8	9	10	Internal Locus of Control (self-controlled)
Impulsive/Easily Distracted	1	2	3	4	5	6	7	8	9	10	Purposeful/Focused
Inhibited/Constricted	1	2	3	4	5	6	7	8	9	10	Creative/Expressive/Spontaneous/Free
Isolated/Detached	1	2	3	4	5	6	7	8	9	10	Connected/Sense of Belonging

D. Stage of Progress:

Rapport Advanced Rapport Early Working Working Early Mastery Mastery

IV. CONSULTATION:

A. School/Collateral/Parent Contact _____

B. Plan: _____

Therapist Signature: _____

Supervisor Signature: _____

Appendix F

Parent Consultation Note

Child's Name: _____ Date: _____

Participants: _____ Location: _____

D. Parent Report (concerns, sleep/appetite)

E. Recommendations

F. Plan

Clinician: _____

Signature: _____

Supervisor Signature: _____

Appendix G

Initial Teacher Assessment Results

	Never	Rarely	Moderately	Often	Usually
Attention Span	0	3	5	3	3
Impulsivity	0	7	4	2	1
Secretive, dishonest	6	5	0	2	1
Motivation	1	3	4	5	1
Perfectionistic	4	5	4	1	0
Silly, "clowns around"	2	5	5	2	0
Easily frustrated	2	5	4	1	2
Independent, self reliant	2	4	3	4	1
Openly defiant	5	4	3	1	1
Complaining, irritable	4	4	4	2	0
Self confident	1	6	3	3	1
Optimistic, positive	0	4	6	2	2
Quiet, withdrawn	1	5	4	3	1
Makes friends easily	2	2	6	3	1
Bullies	7	4	0	2	1
Is respectful of others	0	1	6	3	4
Overactive, restless	2	6	3	1	2
Sullen, sad	2	1	7	3	1
Anxious	3	3	6	1	1
Makes eye contact	0	3	8	1	2
Fearful, afraid	4	7	1	1	1
Playful, smiles, laughs	0	2	6	3	3
Flat affect	4	6	1	1	2

Appendix H

Follow-Up Teacher Assessment Results

	Worsened	No Change	Improved	Not Problematic
Attention Span	0	8	5	1
Impulsivity	0	7	3	4
Secretive, dishonest	0	4	1	9
Motivation	0	5	8	1
Perfectionistic	0	7	0	7
Silly, "clowns around"	0	5	3	6
Easily frustrated	1	6	3	4
Independent, self reliant	0	4	10	0
Openly defiant	0	2	4	8
Complaining, irritable	0	4	4	6
Self confident	1	2	10	1
Optimistic, positive	0	4	9	1
Quiet, withdrawn	0	3	8	3
Makes friends easily	0	4	9	1
Bullies	1	3	3	7
Is respectful of others	0	4	5	5
Overactive, restless	0	6	1	7
Sullen, sad	1	4	7	2
Anxious	1	3	4	6
Makes eye contact	1	4	7	2
Fearful, afraid	1	3	2	8
Playful, smiles, laughs	0	5	7	2
Flat affect	0	4	4	6

Appendix I

Play Therapy Session Notes Results

Session #	1	2	3	4	5	6	7	8	overall mean
Scale 1	5.6	5.6	5.9	5.9	6.4	5.9	6.1	6.1	5.9
Scale 2	4.7	4.8	5.1	4.9	5.9	5.9	5.8	5.8	5.3
Scale 3	5.7	4.9	5.9	5.9	6.1	6.1	6.3	6.7	6
Scale 4	5.1	5.6	5.9	5.6	5.7	5.8	6.2	6.4	5.8
Scale 5	5.1	5.4	5.4	5.4	5.6	5.5	5.7	5.9	5.5
Scale 6	5.9	6.3	6.4	6.3	5.9	6.4	6.6	6.6	6.3
Scale 7	5.5	6.1	5.8	6.5	6.1	6.2	6.4	7.2	6.2
Scale 8	5.8	5.7	5.8	6.1	6.3	6.1	6.6	6.9	6.2
Scale 9	5.4	5.5	5.6	5.4	6	6.3	6.9	6.6	6

Scale 1 = Sad/Depressed/Angry to Content/Satisfied

Scale 2 = Anxious/ Insecure to Confident/Secure

Scale 3 = Low Frustration Tolerance to High Frustration Tolerance

Scale 4 = Dependent to Autonomous/Independent

Scale 5 = Immature/Regressed/Hypermature to Age Appropriate

Scale 6 = External Locus of Control to Internal Locus of Control

Scale 7 = Impulsive/Easily Distracted to Purposeful/Focused

Scale 8 = Inhibited/Constricted to Creative/Expressive/Spontaneous/Free

Scale 9 = Isolated/Detached to Connected/Sense of Belonging