

IMPACT OF CHILD-CENTERED PLAY THERAPY ON CHILDREN OF DIFFERENT  
DEVELOPMENTAL STAGES

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The purpose of this study was to determine the impact of child-centered play therapy on children of Piaget's preoperational and concrete operations developmental stages. Piaget's assertions about the contributions of play to cognitive, affective, and social development have provided a basis for the theoretical rationale for the use of play as a therapeutic intervention. The impact of child-centered play therapy was measured by a decrease in parent-child relationship stress as measured by scores on the Child Domain, Parent Domain, and Total Stress Score of the Parenting Stress Index. This study utilized a three wave repeated measures ANOVA design to analyze the impact of child-centered play therapy on children between the ages of 3-8 who received 19-23 individual child-centered play therapy sessions. A pretest, approximate midpoint, and posttest administration was collected for use in the analysis.

The population study comprised 24 children referred to the Child and Family Resource Clinic on the University of North Texas campus. Participating children were divided into two treatment groups based on their age at the time of treatment. The preoperational development treatment group consisted of 12 children aged of 3-6 years and the concrete operations development treatment group consisted of children aged 7-8 years. Nine hypotheses were tested using three wave repeated measures ANOVA and eta squared. The results of this study tentatively support the impact of child-centered play therapy with children of both the preoperational and concrete operations developmental stages. The data indicates a statistically significant difference in the impact of child-centered play therapy for children of different developmental stages.

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## CHAPTER I

### INTRODUCTION

The United States Surgeon General recognized the role of mental health as part of healthy child development and assessed fostering social and emotional health in children to be a national priority. Unmet emotional, behavioral, and developmental needs are negatively impacting the mental health of the nation's children (U.S. Department of Health and Human Services, 2001). An estimated 20 percent of children and adolescents have treatable mental health problems; however, an estimated two-thirds these children do not receive the services they need. Further, the U.S. Department of Health and Human Services (2001) asserted that untreated childhood disorders have the potential for long-term social and economic consequences. The Surgeon General's recognition of the role of mental health in the developmental process of children and the lingering effects of untreated mental health concerns into adulthood is a call to action for those who are committed to providing therapeutic interventions for children.

Knowledge of child development is a critical component of selecting appropriate mental health interventions for children. This assertion is based on research by developmentalists including Piaget (1962) and Vygotsky (1967) whose models of child development emphasized the role of play in children's cognitive, affective and social development. Frequently, mental health professionals struggle to accommodate the developmental needs and abilities of children. Landreth (2002) asserted that play therapy provides a developmentally appropriate therapeutic intervention for children by allowing children to utilize play as their natural means of self expression.

Piaget and Inhelder's (1969) assertion that the "child partly explains the adult" emphasizes how each stage of development provides a foundation for the following stage (p. 3). Piaget identified four stages of cognitive development in children and the corresponding play behaviors and ages where the developmental shifts occur. The first stage is sensori-motor intelligence observable in children from ages birth to 2 years and characterized by exercise play. Stage two, preoperational thought, extends from ages 3-6 years and is characterized by symbolic play. During stage three, concrete operations, children between the ages 7-11 years engage in games with rules. The final stage is formal operations beginning and begins at age 12 and is characterized by an ability to engage in abstract thought (Piaget and Inhelder, 1969).

While Piaget focused on cognitive development, he asserted that affective and social development follows a similar process because "the affective, social, and cognitive aspects of behavior are in fact inseparable" (Piaget & Inhelder, 1969, p. 114). Piaget asserted that children operate in a concrete world and do not have the ability to use language in an abstract manner until age 11. Therefore, language does not provide young children a developmentally appropriate format for self expression. Instead, Piaget believed that children create symbols to communicate their wishes, ideas, and emotions. This system of symbols characterizes symbolic play (Piaget & Inhelder, 1969).

The focus on the socio-cultural aspect of play behavior differentiated Vygotsky's theory of development from Piaget's. Vygotsky's (1967) definition of play recognized the importance of imagination. Vygotsky proposed that, the use of imagination, thus the inception of play itself, begins at age three. Play with an imaginary situation is a "novel

form of behavior in which the child is liberated from situational constraints through his activity in an imaginary situation” (Vygotsky, 1967, p. 11). Vygotsky also recognized the importance of play in children’s cognitive and affective development. “Play is essentially wish fulfillment, not, however, isolated wishes but generalized affects” (Vygotsky, 1967, p. 8).

Erikson recognized the role of play in emotional development and asserted that play provides a mode of emotional expression for children (Erikson, 2000). Similar to Vygotsky, Erikson believed play is a sociocultural activity. Observers must be aware of what children play according to their age and culture in order to decipher whether the child’s play represents a unique or common meaning (Erikson, 2000).

Allen (1942) discussed the impact of child development on the parent-child relationship. Differentiation from parents is a significant developmental milestone for children. Through the developmental process, children shift from an undifferentiated parental attachment to an awareness of themselves as separate beings. While this differentiation process is a significant developmental milestone for children, this struggle “can become the intense one commonly seen in clinical practice” (Allen, 1942, p. 40).

The parent-child relationship undeniably affects children’s development and is frequently a factor impacting the mental health of children. Axline (1969) noted that parents may be “an aggravating factor in the case of the maladjusted child” (p. 68). Landreth (2002) asserted that “the dynamics of the relationship between parent and child most assuredly affects children’s development” (p. 367). Landreth (2002) cited several studies indicating that different parental characteristics have a profound impact on children’s development. Indeed, Swick and Graves (1986) found that parent’s a

sense of competence and interpersonal support impacted their child's development. Similarly, Rohner (1986) reported that when a parent exhibits feelings of warmth, acceptance, and nurturance towards their child they positively affected their child's development.

Researchers have identified parenting stress as having a significant influence on child development. Several researchers asserted a circular relationship between parenting stress and children's behavioral and emotional problems (Abidin, Jenkins, & McGaughey, 1992; Cornelius 1987; Crnic & Greenberg, 1990; Hadadian & Merbler, 1996). Crnic and Greenberg (1990) cited several studies indicating that life stress (e.g., poverty, parent mental health, child behavior, and major negative life changes) has a significant impact on parenting. Further, greater life stress is significantly related to less positive parental functioning resulting in less positive parent-child interactions and lower child developmental competence (Crnic & Greenberg, 1990). Frequently, recommendations for immediate clinical intervention are made when significant parent-child relationship stress exists. Wilson and Ryan (2001) reported individual Child-centered play therapy coupled with parent consultations focusing on child's play themes, child behavioral changes, and recommendations for parental discipline strengthens the parent-child relationship. "Individual therapy [for children] may be helpful in bringing about changes in the family system, including changes in the parents' handling of their children and sometimes in their own sense of well being" (Wilson & Ryan, 2001, p. 216). Wilson and Ryan (2001) further addressed the systemic nature of working with children. Study results indicated that a decrease in children's behavioral

and emotional problems increased parental acceptance which consequently positively affected children's behavioral and emotional problems.

Developmentalists including Piaget (1962), Vygotsky (1967), and Erikson (2000) recognized the importance of play and the lack of language development in young children. Early psychoanalysts were aware of the limitations of utilizing words to analyze children. As a result, traditional talk therapies requiring an ability to use language as the primary form of expression were recognized to be inappropriate for young children (Landreth, 2002).

For nearly 100 years, play therapy has provided children a therapeutic alternative to talk therapy. Therapists beginning with Hug-Hellmuth (1921), Melanie Klein (1982), and Anna Freud (1946) incorporated play into the therapeutic process with children. Since its inception, play therapy has continued to evolve as a therapeutic intervention with children. A review of case studies and empirical research revealed the effective use of play therapy with a variety of childhood emotional and behavioral concerns. Ray, Bratton, Rhine and Jones (2001) published a meta-analysis of play therapy evaluating 94 research studies on play therapy, filial therapy, and combined play and filial therapy. The results of the analysis indicated that play therapy is an effective therapeutic intervention with children across age and gender, in various settings, and with a variety of emotional and behavioral difficulties (Ray et al., 2001).

### Statement of the Problem

The gap between the emotional, behavioral, and developmental needs of young children and the availability of mental health services for young children highlights the

necessity of finding appropriate therapeutic interventions. Young children can primarily be understood from a developmental perspective; therefore, knowledge of child development may assist in identifying appropriate therapeutic intervention with children. Piaget (1962) asserted that the symbolic play, found in the preoperational stage between the ages of three and six, is the pinnacle of play behavior and provides children a necessary form of self-expression. Piaget's assertions about the contributions of play to cognitive, affective, and social development have provided a basis for the theoretical rationale for the use of play as a therapeutic intervention.

Previous researchers have identified a need to determine the effects of play therapy for children of different ages and developmental stages (Bratton, Ray, Rhine, and Jones, 2005). Previous literature citing the effects of therapeutic interventions focus on children over the age of 8 years. As a result, this study will significantly contribute to the literature addressing therapeutic interventions with young children, defined as children between the ages of 3 and 8 years of age.

### Purpose of the Study

The purpose of this study is to examine the impact of child-centered play therapy with children at different developmental levels, specifically Piaget's preoperational and concrete operations stages. The relationships between child-centered play therapy and measures of parent-child relationship stress were examined. Results were measured by a decrease in parent-child relationship stress.

## Review of the Literature

This literature review incorporates a historical and research perspective related to three areas: (a) the role of play in development; (b) history and development of child-centered play therapy; (c) rationale for using child-centered play therapy; and (d) parent-child relationship stress.

### *The Role of Play in Development*

Researchers have established play as the primary form of communication in childhood (Piaget, 1962; Vygotsky, 1967; Erikson, 2000). Various definitions of play exist in the literature. Erikson (2000) defined play as, “a function of the ego, an attempt to synchronize the bodily and social processes with the self” (p. 103). Piaget (1962) identified six characteristics of play: (a) play is an end in itself; (b) play is spontaneous; (c) play is pleasurable; (d) play is free of organization; (e) play is free from conflict; and (f) play is symbolic. Landreth (2002) synthesized previous definitions of play stating, “play is voluntary, intrinsically motivated activity involving flexibility of choice in determining how an item is used. No extrinsic goal exists” (p. 16).

Researchers have demonstrated a relationship between play and child development. Gmitrova and Gmitrov (2004) concluded that child directed play is an important factor enhancing social and cognitive development in children. Including opportunities for child directed pretend play in a preschool curriculum appears to be necessary for children to develop academic readiness (Gmitrova & Gmitrov, 2004).



### *Play in Cognitive Development*

Piaget and Inhelder (1969) proposed that play provides a “zone of interference between cognitive and affective interests” (p. 129). The shifts in a child’s play behavior correspond with shifts in his or her cognitive, social, and affective development. Piaget identified three principal categories of play one leading to the next: exercise play, symbolic play and games with rules. Exercise play, the most primitive form of play, occurs during the sensori-motor level of development in children between birth and two years of age. No symbolism or particular play technique exists instead; exercise play consists of children pleurably repeating activities previously discovered by chance. For example, a child having discovered by chance the possibility of throwing an object repeats the action to understand it then continues the behavior pattern for pleasure (Piaget & Inhelder, 1969). Symbolic play corresponds with the preoperational developmental stage, and games with rules corresponds with the concrete operational developmental stage. An in-depth description of each follows (Piaget & Inhelder, 1969).

*Preoperational development.* As children transition from Sensori-Motor development into Preoperational development, a fundamental cognitive function becomes observable. Children gain the ability to represent an object or event by a differentiated symbol. Children’s behavior patterns imply the “representative evocation of an object or event not present” (Piaget & Inhelder, 1969, p. 53). The ability to use symbols or signifiers to represent a previously experienced or witnessed event distinguishes preoperational development from sensori-motor development by the following behavior patterns: (a) deferred imitation of previous events, (b) symbolic or

pretend play, (c) drawing, (d) mental image or internalized imitation, and (e) verbal suggestion.

Symbolic play, the second category of play, reaches its apogee during the preoperational stage in children between three and six years of age. Children's symbolic play behavior corresponds to their cognitive abilities and usually centers on imagined patterns and relationships. Symbolic play is an egocentric, solitary activity involving personal symbols (Piaget & Inhelder, 1969).

Symbolic play serves many functions in child development. For example, symbolic play affords children a means of self expression and an opportunity to resolve conflicts. Further, symbolic play assimilates reality and the ego. "Symbolic play is a direct satisfaction of the ego and has its own kind of belief, which is a subjective reality" (Piaget, 1951, p. 168). While make-believe is often associated with symbolic play, it is only after children move into concrete operations around the age of seven that play becomes make-believe. Prior to this shift, children's play is not make-believe, but an actual reflection of their own subjective reality (Piaget, 1962).

Vygotsky asserted that play does not merely reflect development, but contributes to cognitive development (Nicolopoulou, 1993). Play begins around age three and is always a social and symbolic activity. Further, Vygotsky (1967) believed that play provides children an opportunity to expand their world:

In play a child is always above his average age, above his daily behavior; in play it is as though he were a head taller than himself. As in the focus of a magnifying glass, play contains all the developmental tendencies in a condensed form. (Vygotsky, 1967, p. 16)

*Concrete operational development.* As children shift from preoperational to concrete operational development, new cognitive abilities become observable. The

abilities in this stage are called “concrete” because they refer directly to objects and not to verbally stated ideas or hypotheses. During this stage, children gain the ability to make classifications, such as mothers and fathers together make parents and understand conservation and reversible transformations for example the water in glass A is higher, but the glass is shorter so it is the same amount as in glass B.

The third category of play, games with rules, begins about the age of seven as children enter into a concrete form of intelligence. During concrete operations, play shifts from an egocentric to a socialized form, and symbols are replaced by rules (Piaget, 1962). Piaget and Inhelder (1969) identified games with rules as a more socialized form of play that is “transmitted socially from child to child and thus increase in importance with the enlargement of the child’s social life” (p. 59).

Schaefer and O’Connor (1983) asserted that games with rules differ from the standard definition of play because games have implied goals. Games are “viewed as an intermediate phase between the unregulated play of children and the often overregulated play of adults” (Schaefer & O’Connor, 1983, p. 4). This shift from egocentric, symbolic play to social play with rules provides an example of how the change in play behavior reflects changes in development and prepares children for adulthood.

### *Play in Social and Emotional Development*

Erikson (2000) and Vygotsky (1967) theorized about the role of play in social and emotional development. Play affects children’s social development by providing children an opportunity to integrate social rules into experience. Vygotsky asserted that children

of all ages follow social rules in their play. For example, when children pretend play as doctors and pretend a doll is the patient, they follow the social rules of a doctor's behavior (Vygotsky, 1967). This example supports Vygotsky's assertion that even when children play alone, their play themes possess socio-cultural elements. In this context, play is always a social activity (Vygotsky, 1967).

An awareness of cultural, social, and developmental play behavioral norms affords an observer the opportunity to decipher common from unique meanings in play. Children naturally express their emotions through toys that are socially and culturally accessible. Erikson (2000) identified the social aspects inherent in all play even when children play alone. Solitary play offers children an opportunity to cope with emotional discomfort resulting from social interactions. "The fact that a child can be counted on to bring into the solitary play arranged for him whatever aspect of his ego has been ruffled the most, forms the fundamental condition for our diagnostic reliance on 'play therapy'" (Erikson, 2000, p. 112).

### *History and Development of Child-Centered Play Therapy*

The origins of play therapy can be traced back to the inception of psychotherapy itself. Freud (1955) reported the first use of play as a therapeutic intervention with the case of Little Hans. Freud's Psychoanalytic play therapy resulted from the realization that applying traditional psychoanalysis to children was ineffective. Analysts found that children were different from adults in that they were not able to verbally express their anxieties, not interested in exploring their pasts, and often refused to use free

association (Landreth, 2002). Thus, a new format for a developmentally appropriate therapeutic intervention with children was born.

Melanie Klein (1982) was a pioneer in the development of play therapy. Her training and theoretical rationale were based in psychoanalysis, and in 1919, Klein reported her first case of psychoanalysis with a five year old boy. Klein conducted the sessions at the child's home with his own toys. The symbolic language of play was foundational to Klein's theory. "Play analysis had shown that the capacity to use symbols enables the child to transfer not only interests but also fantasies, anxieties and guilt to objects other than people" (Klein, 1982, p. 88).

Coinciding with Klein, Anna Freud began her use of play in analysis with children. However, Freud disagreed with Klein's use of interpretation and believed a child's play may not be symbolic of anything (Schaefer, 1985). Instead, Freud used play to facilitate an emotional attachment with her child patients. This emotional relationship was used to gain access to the child's inner world (Freud, 1946).

In 1939, David Levy described the development of release play therapy as a structured approach to therapy for children who have experienced anxiety related to specific stressful events. Levy dedicated play sessions to structured activities designed to release destructive behavior and anxiety. For change to occur, Levy (1982) believed that release play therapy should only be applied to something that occurred in the past and not a difficult or traumatic situation occurring at the time of therapy.

In 1955, Gove Hambidge developed structured play therapy as an extension of Levy's release play therapy. Hambidge (1982) believed structured play therapy was particularly useful for the "release and mastery of repressed or developmentally by-

passed and insufficiently lived-out affect” (p. 112). Hambidge further asserted that therapy with children had advanced beyond psychoanalysis leading to his focused, time efficient, and structured approach.

Garry Landreth (2002) popularized child-centered play therapy as an expansion of Axline’s (1969) non-directive play therapy. Both Landreth and Axline applied Carl Rogers’ (1961) principles of non-directive therapy including empathy, genuineness, and unconditional positive regard to therapy with children (Landreth, 2002). Child-centered play therapy follows Rogers’ (1961) philosophical model: therapy is a process where individuals are capable of self-realization and naturally strive towards growth (Axline, 1969; Landreth, 2002). The process of Child-centered play therapy provides children with the permissiveness to (a) be themselves, (b) accept themselves, (c) recognize and clarify their emotional experiences, (d) learn about themselves, and (e) freely choose their own course (Axline, 1969).

Axline (1969) outlined eight basic principles to guide the therapist in developing a safe therapeutic environment for children. These eight basic principles include: (a) developing a warm, friendly relationship with the child; (b) accepting the child exactly as he/she is; (c) establishing a feeling of permissiveness so that a sense of freedom of expression is developed in the child; (d) recognizing and reflecting a child’s feelings back to him/her to assist the child in gaining insight into his/her behavior; (e) respect for the child’s ability to make choices and solve his/her own problems; (f) the child leads and the therapist follows; (g) recognition that therapy is a gradual process and is not to be hurried; and (h) the therapist sets only the limits that are necessary.

An assumption of child-centered play therapy is that individuals are naturally forward moving and growth oriented. Children possess an inherent tendency, which is not externally motivated or taught, to move towards adjustment, mental health, independence, autonomy, and self actualization (Landreth, 2002). “This inherent push toward discovery, development, and growth is readily observable in the developmental stages of infants and young children” (Landreth, 2002, p. 66).

Both Axline (1969) and Landreth (2002) emphasized the uniqueness of the process of play therapy for each child. Child-centered play therapy focuses on the child’s phenomenal world. “The child’s behavior must always be understood by looking through the child’s eyes” (Landreth, 2002, p. 62). This is especially important because how children feel about themselves makes a significant difference in their behavior.

The relationship with the therapist is an essential feature of the change process in child-centered play therapy. The child-centered play therapist provides security and opportunity for children to explore the playroom and themselves in relation to the play therapist (Axline, 1969). Landreth (2002) further emphasized the importance of the therapeutic relationship by asserting that genuine change is only possible when the child feels free not to change. This freedom can only be established through the therapist’s communication of unconditional acceptance of the child back to the child (Landreth, 2002). Landreth (2002) outlined the role of the therapist, stating:

Whatever is important or necessary for children’s growth already exists in children. The therapist’s role or responsibility is not to reshape children’s lives or make them change in some way, but rather to respond in ways that facilitate release of the curative potential that already exists in them. (p. 109)

### *Rationale for Using Child-Centered Play Therapy*

Play is an intrinsically complete, spontaneous, enjoyable, and non-goal-directed central activity of childhood occurring at all times and in all places (Landreth, 2002). Developmentally, children are more comfortable with play than with words as their natural form of communication; therefore, children utilize play to communicate their emotions and experiences. Children naturally operate in a concrete world, and play provides children a concrete mode of expression (Landreth, 2002).

McMahon (1992) asserted that regressive play is an essential aspect of play therapy and provides children an opportunity to “restore missed sensory experiences” (p. 9). Ginot (1961) stated that through the use of toys, children can express without words how they feel about themselves and the people in their lives. As a result, toys provide an “important therapeutic variable” (p. 51) and should be carefully and deliberately selected.

Bratton and Ray (2001) compiled a comprehensive literature review of 82 experimental research studies on play therapy conducted from 1942-2000. The studies documented the efficacy of play therapy with a variety of emotional and behavioral concerns. The following literature review includes studies focusing on children between the ages of three and thirteen who experienced individual Child-centered play therapy. The studies will be divided into preoperational and concrete operations stages.

Bratton, Ray, Rhine, and Jones' (2005) meta-analysis of play therapy analyzed 93 treatment control comparison research studies conducted over the past 60 years. Results revealed that after receiving play therapy, children experiencing the intervention were functioning .80 standard deviations better than children not treated. The authors



further reported that play therapy is effective across modalities, settings, age, gender, clinical and non-clinical populations, and theoretical orientation of the therapist. Results further indicated that the length of treatment and parental involvement may impact the effectiveness of play therapy.

Bratton et al. (2005) reported that age was not a significant predictor of play therapy treatment outcome. Broad age ranges and the inclusion of children described as cognitively delayed were cited as possible factors that may have obscured the analysis of the relationship between age and play therapy treatment effect. Bratton et al. further identified that the mean age of children in previous play therapy literature ranged from 7.9 to 10.5 years of age.

### *Play Therapy and Preoperational Development*

A review of the play therapy literature revealed research conducted on the effectiveness of play therapy with a variety of presenting problems. The following studies focus on the efficacy of play therapy with children in the preoperational stage of development, specifically children between the ages of three and six. Some of the following research studies include children with a wider range of ages, but the mean age falls within the preoperational development.

Cox (1953) assessed the efficacy of play therapy on the sociometric status and individual adjustment of 52 children between the ages of 3 and 13. A time-sequence experimental design was devised to measure children's adjustment after 10 weeks of individual play therapy and again after an additional 13 week follow-up period. Results

demonstrated a statistically significant improvement in the social adjustment of 3 year old children as measured by the Thematic Apperceptions Test.

Pelham (1972) conducted a study evaluating the efficacy of self-directive play therapy in increasing the social maturity of kindergarten students previously identified with socially immature classroom behavior. The study included 35 children; 17 children were in the experimental group and, 18 were in the control group. The experimental group was divided into 9 children receiving group play therapy and 8 children receiving individual play therapy. The mean age of children was 5 years and 8 months. Results indicated that children receiving 6-8 45 minutes play therapy sessions demonstrated an increase in social maturity compared to children in the control group. Further, Pelham (1972) found no significant difference in the increase in social maturity between children receiving individual play therapy or children receiving group play therapy. Finally, children in the experimental group demonstrated an improvement in their in classroom behavior.

Oualline (1975) explored the results of 10 weeks of individual play therapy sessions on deaf preschool children between the ages of four and six who exhibited behavioral concerns. Results indicated that children receiving the individual nondirective play therapy sessions demonstrated a statistically significant increase in mature behavior patterns compared to control group children who received 10 sessions of individual free play.

Hannah (1986) utilized a single subject time-series experimental design to assess behavioral changes in children. The study included children between the ages of four and six who received individual play therapy over the course of 11 weeks.

Hannah's utilization of observations and standardized interviews at the conclusion of the intervention revealed a positive change in children's verbal social interactions, off-task behavior, and aggressive acts.

Kot's (1995) study examined the effectiveness of intensive play therapy for child witnesses of domestic violence. The study consisted of 11 control group children and 11 experimental group children. Children in the control group ranged in age from 4 to 10 years with a mean age of 6 years and 9 months and children in the experimental group also ranged in age from 4 to 10 with a mean age of 5 years and 9 months. Kot's analysis revealed that after 12 nondirective play therapy sessions over 2 weeks, children in the experimental group demonstrated significant improvement in their self-concept measured by the Joseph Pre-School and Primary Self Concept Screening Test. Children in the experimental group also demonstrated significant reduction in the externalizing and total behavior problems as measured by the Child Behavior Checklist. Further, children demonstrated significant improvement in play behaviors specifically physical proximity and play themes as measured by the Children's Play Session Behavior Rating Scale.

Brandt (1999) conducted a study of 29 children between the ages of four and six who were experiencing various emotional and behavioral problems as identified by the Child Behavior Checklist (CBCL) and Parenting Stress Index (PSI). An experimental group of 15 children received weekly individual child-centered play therapy for seven to ten weeks. A second group consisting of 14 children comprised a control group. Results of an ANOVA indicated a statistically significant decrease in children's internalizing

behaviors as measured by the CBCL. However, the results of an additional ANOVA analysis indicated no statistically significant decreases in the PSI.

### *Play Therapy and Concrete Operational Development*

Perez's (1987) study compared the effects of different treatment modalities for child victims of sexual assault. 55 children between the ages of four and nine participated in the study. Children were divided into three groups: individual play therapy treatment group, group play therapy treatment group, and a control group. Results indicated that children in the treatment groups demonstrated a significant increase in self-concept as measured by the Primary Self Concept Inventory. Children in the control group actually scored lower on the assessment at post-test. The study found no significant differences between individual and group play therapy.

Quayle (1991) conducted a study evaluating the impact of child-centered play therapy on the behavior, adjustment, and self concept of children. Participants were boys and girls in kindergarten through third grade (ages 5 through 9) in the Lake Placid Elementary School. A total of 54 children participated in the study; the mean age of children was 7 years and one month. More specifically, 19 of the children were 5 and 6 years old and 35 of the children were between 7 and 9 years of age. Results indicated that children receiving play therapy improved their learning skills, assertive social skills, task orientation, and peer social skills.

Crow (1989) assessed the efficacy of nondirective play therapy on the self esteem of first graders who were retained one year due to low reading achievement. The study included an experimental group of 12 children who received 10 nondirective

individual play therapy sessions and a control group of another 12 children who did not receive treatment. Results indicated that the children in the experimental group demonstrated statistically significant improvement in their self-concept as measured by the Piers-Harris Children's Self Concept Scale.

### *Parent-Child Relationship Stress*

Researchers have identified the circular nature of the relationship between child behaviors and parenting stress (Crnic & Greenburg, 1990; Hadadian & Merbler, 1996). While researchers assert that child behavior problems including aggressiveness and Attention Deficit Hyperactivity Disorder (ADHD) increase parental stress, scholars also assert that parental stress may limit the ability of parents to respond to their child's needs thus impacting the child's developmental processes (Anastopoulos, Guevremont, Shelton, & DuPaul, 1992; Baker, 1994; Cornelius, 1987; Hadadian & Merbler, 1996). Therefore, a reduction in parent-child relationship stress is often used as an index of effective treatment with young children.

### *Child Behavior Problems Increase Parenting Stress*

Anastopoulos et al. (1992) investigated the relationships between parenting stress and several parent, child, and family-environmental variables. The study consisted of 104 mother-child dyads. All children meet the DSM-III-R criteria for ADHD and were under 12 years of age. Abidin's (1995) Parenting Stress Index (PSI) provided the measure of overall stress within the parent-child relationship. In addition, the mothers completed the SCL-90-R (1983). Through the use of a stepwise multiple

regression analysis, the researchers found that child characteristics including the severity of Attention Deficit Hyperactivity Disorder (ADHD), aggressiveness, and health accounted for 43% of the variance predicting parenting stress. Anastopoulos et al. (1992) interpreted these results to indicate that an increase in children's behavioral problems, including aggressiveness and severity of ADHD, and a decrease in the child's overall health significantly increased the stress experienced by parents.

The majority of studies evaluating parenting stress are actually studies of maternal stress. Baker (1994) noted this limitation to previous research and conducted a study of 20 sets of parents, including both mothers and fathers, of children with Attention Deficit Hyperactivity Disorder (ADHD). The respondents each completed a Child Behavior Checklist (CBCL) and the Parenting Stress Index (PSI). A series of stepwise multiple regression analyses were conducted to determine how various child and family variables predict parenting stress. Baker's (1994) analysis indicated that child behavior problems, defined by the Total Problem Behavior scores on the CBCL, were significantly related to increased parenting stress. Further, Baker found no significant differences between mothers' and fathers' reports of child behavior or parenting stress. Thus, both mothers and fathers reported experiencing increased stress when they perceived that their children's behavioral problems had escalated.

### *Parenting Stress Affects Children's Development*

McKay (1996) conducted a study of 46 parent-child dyads to assess the relationship between parenting stress and parent-child interactions. The Marschack Interaction Method (MIM) was utilized to assess parent-child interactions and the

Parenting Stress Index (PSI) assessed parenting stress. Results of the study indicated that parenting stress predicted the quality of parent-child interactions, and less optimal parent-child interactions negatively influenced children's emotional and behavioral development (McKay, 1996).

Abidin, Jenkins, and McGaughey (1992) conducted a longitudinal study of the relationship between family variables and children's behavioral adjustment. The study consisted of 85 white, middle class mothers who were recruited from a pediatric practice in central Virginia. The mothers initially completed a PSI during the first year of their child's life, and the posttest of the PSI was administered 4 ½ years later. Through the use of a hierarchical regression analysis, family variables including child gender, life stress, maternal characteristics, and spousal supportiveness predicted 39% of the variance in child behavioral problems. Abidin et al. (1992) interpreted these findings to indicate that as parents experienced additional stress resulting from factors including mothers' mood and spousal support, children's behavioral problems increased.

Cornelius (1987) stated, "the number of stressors facing young families are multiple and in turn relate to the child's development" (p. 2). Cornelius conducted a study of 40 children between the ages of four and six and their mothers. This study compared the amount of children's imaginative and social play to the amount of maternal stress. The researcher utilized both observational instruments of the child's play and assessments measuring maternal stress and attitudes about play. The observational instruments included the Peer Play Scale, measuring social play, and the Play Observational Scale, measuring imaginative play. Cornelius (1987) reported that children exhibited different play behaviors in response to varying levels of maternal

stress. As the mother's stress level increased, the child's play behaviors were more likely to regress from higher forms of reciprocal and social play into fantasy play, which required little use of language and social interaction between children. Cornelius (1987) interpreted these results to indicate that a regression in children's play behavior was a coping strategy for children whose mothers experienced higher levels of stress (Cornelius, 1987). Thus, high maternal stress levels were found to negatively impact the developmental behaviors of children.

### *Recursive Relationship between Child Behavior Problems and Parenting Stress*

The above studies indicate a positive relationship between child behavioral problems and parenting stress. As children's behavioral problems increased, so did the amount of stress reported by parents. A further review of the literature illuminates the recursive relationship between children's behavioral problems and parenting stress. As parents report more stress, children exhibit increased behavioral problems (Abidin, Jenkins, & McGaughey, 1992; Cornelius, 1987; Crnic & Greenbug, 1990; Hadadian & Merbler, 1996).

Hadadian and Merbler (1996) conducted a study of 33 mothers of children between the ages of 36 and 54 months. Assessments including the Attachment Q-Set (A Q-Set) and the Parenting Stress Index (PSI) were utilized to measure maternal stress and attachment. Results from a correlational analysis indicated a significant negative relationship between the Child Domain subscales of the PSI and attachment as measured on the A Q-Set. Results further indicated a statistically significant correlation between Acceptability and Mood on the Child Domain of the PSI. Hadadian



and Merbler (1996) interpreted these results to indicate that the more stress the mother experiences related to the child's behavior problems, the less likely she is to accept and respond to the needs of her child. This leads to a less secure and attached parent-child relationship. Based on the results of this study, the researchers hypothesized that increased stress resulted in decreased maternal responsiveness and attachment and has significant long-term effects on child development (Haladian & Merbler, 1996).

Crnic and Greenberg (1990) conducted a five year longitudinal study of 74 mother child pairs beginning when children were one month of age. Data collected for analysis included observed interactions of free-play and structured activities for the mother-child pairs. Mothers also completed a set of questionnaires assessing (a) parenting and life satisfaction; (b) life stress; (c) family status; and (d) and mother's and child's psychological status. A series of hierarchical regression analyses were performed to evaluate the relationship between life stress and daily hassles, child behavior, parenting stress, and family functioning. Crnic and Greenburg (1990) interpreted the results to indicate that the stress reported by mothers significantly predicted more child behavior problems which, in turn, resulted in greater maternal distress.

Another longitudinal study further supported the recursive relationship between parenting stress and children's emotional and behavioral problems. Heller, Baker, Henker, and Henshaw (1996) conducted a study of 77 children and their families focusing on five specific areas: (a) severity of child externalizing behavior, (b) child's cognitive functioning, (c) child's expressive language ability, (d) parenting practices and attitudes, and (e) parenting stress. Children were assessed during preschool and again

two-years later in first grade. A series of regression analyses were conducted and revealed several statistically significant predictor variables of children's externalizing behavior problems. Such variables included parenting style, maternal expectations, and parenting stress (Heller et al., 1996). Heller et al.'s results indicated that as parents reported increased levels of stress, children's externalizing behavioral problems also increased.

### Summary

In summary, a solid foundation in child development is essential for selecting the appropriate treatment modality for treating children's emotional and behavioral problems. Piaget's, Vygotsky's, and Erikson's theories provide a theoretical foundation regarding the significant role of play in children's cognitive, affective, and social development. Each recognized the symbolic nature of play. These theorists provide a foundation for play as a therapeutic intervention with children. Landreth (2002) asserted that play provides a developmentally appropriate form of expression for children "Children must be approached and understood from a developmental perspective. They must not be viewed as miniature adults" (Landreth, 2002, p. 9).

Empirical research has established play therapy as an effective treatment modality for children. However, previous research evaluating the efficacy of individual child-centered play therapy has not addressed the developmental shifts in children's play behavior. Previous play therapy researchers have identified the need to account for the impact of child's age and developmental stage on the efficacy of play therapy. Limitations in previous play therapy research include small sample sizes which limited

the ability to detect statistically significant results. Also, researchers have recognized a need to evaluate the impact of several variables, including the experience of play therapists, number of sessions, child's age, and parental involvement on the outcome of play therapy (Ray et al., 2001).

## CHAPTER II

### METHODS AND PROCEDURES

This study utilized a repeated measures ANOVA design to analyze the effects of child-centered play therapy on children assigned to two distinct age defined treatment groups. Archival data from the Child and Family Resource Clinic (CFRC) at the University of North Texas was examined. Children between the ages of three and eight who received 19-23 individual child-centered play therapy sessions were assigned to treatment groups based on age. This chapter outlines the methods and procedures utilized in this study. Included are the hypotheses, definition of terms, instrumentation, selection of participants, data collection, treatment, and data analysis.

#### Hypotheses

This study addressed the impact of child-centered play therapy on children of different developmental levels.

#### *Null Research Hypotheses*

To achieve the stated purpose of this study, the following hypotheses were formulated:

- 1a. Following 19-23 sessions of child-centered play therapy, children assigned to the preoperational development treatment group will experience no statistically significant change in the mean scores across time from the pretest (prior to treatment), to approximate midpoint (after 8-12 sessions) to the posttest (19-23 sessions) on the Child Domain of the Parenting Stress Index.

- 1b. Following 19-23 sessions of child-centered play therapy, children assigned to the concrete operations development treatment group will experience no statistically significant change in the mean scores across time from the pretest (prior to treatment), to approximate midpoint (after 8-12 sessions) to the posttest (19-23 sessions) on the Child Domain of the Parenting Stress Index.
- 1c. Following 19-23 sessions of child-centered play therapy, children assigned to the preoperational development treatment group will experience no statistically significant difference in the change in the mean scores across time from the pretest (prior to treatment), to approximate midpoint (after 8-12 sessions) to the posttest (19-23 sessions) on the Child Domain of the Parenting Stress Index than will children assigned to the concrete operations development treatment group.
- 2a. Following 19-23 sessions of child-centered play therapy, children assigned to the preoperational development treatment group will experience no statistically significant change in the mean scores across time from the pretest (prior to treatment), to approximate midpoint (after 8-12 sessions) to the posttest (19-23 sessions) on the Parent Domain of the Parenting Stress Index.
- 2b. Following 19-23 sessions of child-centered play therapy, children assigned to the concrete operations development treatment group will experience no statistically significant change in the mean scores across time from the pretest (prior to treatment), to approximate midpoint (after 8-12 sessions) to the posttest (19-23 sessions) on the Parent Domain of the Parenting Stress Index.
- 2c. Following 19-23 sessions of child-centered play therapy, children assigned to the preoperational development treatment group will experience no statistically

significant differences in the change in the mean scores across time from the pretest (prior to treatment), to approximate midpoint (after 8-12 sessions) to the posttest (19-23 sessions) on the Parent Domain of the Parenting Stress Index than will children assigned to the concrete operations development treatment group.

- 3a. Following 19-23 sessions of child-centered play therapy, children assigned to the preoperational development treatment group will experience no statistically significant change in the mean scores across time from the pretest (prior to treatment), to approximate midpoint (after 8-12 sessions) to the posttest (19-23 sessions) on the Total Stress Score of the Parenting Stress Index.
- 3b. Following 19-23 sessions of child-centered play therapy, children assigned to the concrete operations development treatment group will experience no statistically significant change in the mean scores across time from the pretest (prior to treatment), to approximate midpoint (after 8-12 sessions) to the posttest (19-23 sessions) on the Total Stress Score of the Parenting Stress Index.
- 3c. Following 19-23 sessions of child-centered play therapy, children assigned to the preoperational development treatment group will experience no statistically significant difference in the change in the mean scores across time from the pretest (prior to treatment), to approximate midpoint (after 8-12 sessions) to the posttest (19-23 sessions) on the Total Stress Score of the Parenting Stress Index than will children assigned to the concrete operations treatment group.

## Definition of Terms

*Child-centered play therapy:* For the purposes of this study, Landreth's (2002) definition was used:

Play therapy is defined as a dynamic interpersonal relationship between a child and a therapist trained in play therapy procedures who provides selected play materials and facilitates the development of a safe relationship for the child. To fully express and explore self (feelings, thoughts, experiences, and behaviors) through play, the child's natural medium of communication, for optimal growth and development (p. 16).

*Child emotional and behavioral problems:* For the purposes of this study, negative child behaviors are operationally defined by parent or guardian's report of emotional and behavioral problems on the Child and Adolescent Background Form provided by the CFRC during the initial clinical intake. An example of this form is provided in the Appendix at the conclusion of this study.

*Parent-child relationship stress:* Defined by High scores on the Child and Parent Domains of the Parenting Stress Index. Abidin (1995) defines High scores on the PSI as scores at or above the 85<sup>th</sup> percentile.

*Child's developmental stage:* Piaget's cognitive developmental stages of Preoperational and Concrete operational thought will be examined in this study and delineated by age assignment.

*Preoperational stage of development:* Piaget and Inhelder (1969) defined the preoperational stage as occurring in children between the ages of three and six. Key characteristics of this stage include the cognitive abilities of imagined patterns and relationships and the play behaviors of egocentric symbolic play.

*Concrete operations stage of development:* Piaget and Inhelder (1969) defined the concrete operations stage as occurring in children between the ages of seven and

eleven. Key characteristics of this stage include the cognitive abilities of grouping and reversibility and the play behaviors of socialized games with rules.

### Instrumentation

The Parenting Stress Index (PSI) is a 120-item instrument designed to “identify parent-child systems that were under stress and at risk for the development of dysfunctional parenting behaviors or behavior problems in the child involved” (Abidin, 1995, p. 6). The PSI was standardized for use with parents of children between the ages of one month to 12 years. The instrument consists of Child Domain, Parent Domain, Life Stress, and Total Stress Score. Scores at or above the 85<sup>th</sup> percentile are interpreted as falling in the High range on this assessment.

Abidin (1995) stated, “high scores on the Child Domain may be associated with children who display qualities that make it difficult for parents to fulfill their parenting role” (p. 8). High scores on the Child Domain further indicate that intervention may need to focus on the behaviors of the child rather than parent concerns that affect the parent-child relationship. The Child Domain consists of 47 items. Internal consistency for the overall Child Domain is .90 and for ranges from .70-.83 for the Child Domain subscales. Abidin (1995) defined the six subscales of the Child Domain as:

*Distractibility/ Hyperactivity:* High scores on this subscale appear to be associated with (1) children who display behaviors associated with ADHD; (2) parent lacks the energy to keep up with a normal child; (3) older parents with a formerly stable life pattern are having difficulty adjusting to the child; or (4) unreasonable parental expectations for mature, adult-like behavior.



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

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

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

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

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

High scores on the Parent Domain indicate that the sources of stress in the parent-child relationship are related issues in the parent's functioning (Abidin, 1995). The Parent Domain consists of 54 items. The internal consistency is .93 for the overall Parent Domain and ranges from .70-.84 for Parent Domain subscales. Abidin (1995) included seven subscales in the Parent Domain:

*Competence:* High scores on this subscale may be produced by a number of factors (e.g., young parents of an only child, parents who are lacking practical child development knowledge, and parents who do not find the role of parent as reinforcing

as expected). High scores are also associated with a lack of acceptance and criticism from the child's other parent.

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

*Attachment:* The presence of high scores on this subscale suggests two possible sources of dysfunction: (1) the parent does not feel a sense of emotional closeness to the child and/or (2) the parent's real or perceived inability to observe and understand the child's feelings and/or needs accurately.

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

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

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

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

The Life Stress scale includes 19 items and provides information on the amount of stress the parent is experiencing outside of the parent-child relationship. High Life

Stress scores are indicative of parents who find themselves in stressful circumstances frequently beyond their control (e.g., death of a relative or loss of a job). The total stress the parent reports may be intensified by the Life Stress scores (Abidin, 1995).

The Total Stress Score reflects the underlying assumption of this instrument, “sources of stress are additive” (Abidin, 1995, p. 1). The Total Stress Score is calculated by adding the Parent and Child Domains. Abidin (1995) asserted that parents who earn high scores should be referred for professional intervention.

A Defense Responding score provides further information regarding interpretation of the results of the PSI. A Defensive Responding score of 24 or less indicates caution should be taken in interpreting the results due to possible defensive responding. Very low Defensive Responding scores may also be found in situations where it is “obvious that the parent is very competent and that the parent-child relationship exists within a supportive social situation that is economically advantaged” (Abidin, 1995, p. 6).

Abidin (1995) summarized test-retest studies analyzing the reliability of the PSI. The correlation coefficients indicated stability of scores during a one to three month interval. The correlation coefficients were .63 for the Child Domain, .91 for the Parent-Domain, and .96 for the Total Stress Score. After one year, test-retest reliability coefficients were retained at .55 for the Child Domain, .70 for the Parent Domain, and .65 for the Total Stress Score. The results of the studies cited by Abidin support the stability of scores across time particularly for the Parent Domain.

The manual contains sixteen pages of abstracts of research studies supporting the validity of the PSI for various populations including children with developmental

delays, behavioral problems, asthma; various cross cultural studies including the Spanish translation of the PSI; and marital adjustment problems. For example, Abidin (1995) reported that mothers with high scores on the PSI reported more behavioral problems in their children when compared to mothers with scores in the normal range. Another study by Abidin, Jenkins, and McGaughey (1992) evaluated the relationship of the PSI scores to children's behavioral adjustment. Mothers completed the PSI when their children were between six and twelve months of age and again four and a half years later. The Life Stress, Child and Parent Domains were significant predictors of child functioning in areas such as social aggression, behavior problems, attention problems, and anxiety withdrawal. Further, Bigras, LaFreniere, and Dumas (1996) reported that the both the Child and Parent Domains independently contributed significantly to the prediction of marital adjustment (29%), depression (45%), and child difficulties (12%). Heinze and Grisso (1996) reviewed the PSI and found that the instrument is sensitive to treatment interventions for problems such as ADHD.

The Child and Adolescent Background Information Form (CABIF) was designed and approved by the Counseling Program Clinical Services Committee at the University of North Texas. Parents are provided the CABIF during the initial clinical intake at the Child and Family Resource Clinic. The CABIF consists of questions related to the child and parent's biological and environmental histories and current physical and psychological stressors. A complete CABIF is included in the Appendix at the end of this study.

## Participant Selection

Community child clients between the ages of three and eight who received clinical services at the Child and Family Resource Clinic (CFRC) on the campus of the University of North Texas between January 2002 and December 2005 were assigned to two age groups based on their age at the time of treatment. Piaget's (1962) research on the role of play on children's development provided the rationale for the treatment groups in this study. The researcher assigned children between the ages of three and six to the preoperational comparison group. Symbolic play reaches its apogee during the preoperational stage in children between three and six years of age. The researcher assigned children between the ages of seven and eight to the concrete operations comparison group. While Piaget (Piaget & Inhelder, 1969) asserted that the concrete operations developmental stages extends from the age of seven to eleven, children ages nine and above receiving services at the CFRC may participate in more structured activities as part of their therapy rather than Child-centered play therapy.

The CFRC provides short-term and long-term counseling services for residents of the city of Denton and the greater Dallas/Ft. Worth Metroplex. As a sliding scale fee clinic, clients are typically low income, with an average household income at or near the poverty level. Children were referred by their parents or guardians for a variety of behavioral concerns and/or problems in the parent-child relationship. Short-term therapy has been defined as 8-12 counseling sessions (Peterson-Johnson, 2001). Bratton et al.'s (2005) meta analysis revealed that optimal treatment effects occur between 35-40 sessions. However, Bratton et al. reported that the mean number of sessions across the 67 studies included in the meta-analysis was 16.9. Therefore the 19-23 sessions

included in this study exceeds the average number of sessions cited in previous research, and the 8-12 sessions at approximate midpoint corresponds with the average number of sessions granted by managed care (Bratton et al., 2005).

The researcher submitted this study to the University of North Texas Internal Review Board and received approval to use human subjects. Children meeting the following criteria were included in the study:

1. The child received 19-23 individual child-centered play therapy sessions from masters or doctoral counseling interns at the Child and Family Resource Clinic at the University of North Texas.

2. The parent/guardian must have completed a pretest of the Parenting Stress Index (PSI) prior to the child receiving treatment, a approximate midpoint administration the PSI after 8-12 individual child-centered play therapy sessions, and a posttest of the PSI after 19-23 individual child-centered play therapy sessions.

3. Parents and or guardians must have received a copy of the Notice of Privacy Practice and Informed Consent informing them of the use of mental health information in research and training and signed a Confirmation of Receipt of Privacy Notice and Informed Consent during their initial counseling intake appointment.

4. Due to the description of chronological age corresponding to developmental stage, children diagnosed with developmental disabilities such as autism or identified as having low cognitive or intellectual functioning were excluded from this study.

Participants were assigned by age to two different treatment groups, the preoperational treatment group ( $n=15$ ), or the concrete operations treatment group ( $n=12$ ) each receiving individual child-centered play therapy sessions. Due to problems

with normal distribution, three children from the preoperational treatment group were excluded from the study. Demographic variables examined included age, gender, and ethnic breakdown of all children and are reported in Table 1. Table 2 describes the number of sessions at approximate midpoint and posttest, the number of sessions between pretest and approximate midpoint, and the number of sessions between approximate midpoint and posttest for children in the preoperational and concrete operations treatment groups.

Table 1

*Demographic Information for the Children Participating in the Study*

	<b>Preoperational Treatment Group <i>n</i>=12</b>	<b>Concrete Operations Treatment Group <i>n</i>=12</b>	<b>Total Children <i>n</i>=24</b>
<b>Age in Years</b>			
3	3	N/A	N/A
4	4	N/A	N/A
5	1	N/A	N/A
6	4	N/A	N/A
7	N/A	5	N/A
8	N/A	7	N/A
<b>Average Age in Years</b>	4.5	7.5	6.0
<b>Gender</b>			
Male	5	9	14
Female	7	3	10
<b>Ethnicity</b>			
Caucasian	11	11	22
African American	1	0	1
Native American	0	1	1

Table 2

*Average Number of Sessions and Length between Sessions for Children in the Preoperational and Concrete Operations Treatment Groups*

	<b>Preoperational Treatment Group <i>n</i>=12</b>	<b>Concrete Operations Treatment Group <i>n</i>=12</b>
<b>Number of Sessions at Approximate Midpoint</b>		
8	1	1
9	1	3
10	4	4
11	3	1
12	3	3
<b>Average Number of Sessions at Approximate Midpoint</b>	10.5	10.17
<b>Number of Sessions at Posttest</b>		
19	2	2
20	3	2
21	4	2
22	3	4
23	0	2
<b>Average Number of Sessions at Posttest</b>	20.67	21.17
<b>Number of Session Between Approximate Midpoint and Posttest</b>		
9	5	0
10	3	4
11	2	4
12	3	4
<b>Average Number of Sessions Between Approximate Midpoint and Posttest</b>	10.08	11

Data Collection

Archived clinical files at the Child and Family Resource Clinic were used to determine the participants for this study. Children selected for this study were brought to



the CFRC by their parents or guardians due to concerns related to the child's behavioral and emotional problems. Upon arriving at the CFRC, parents or guardians completed a Child and Adolescent Background Information Form (CABIF) and a Parenting Stress Index (PSI) prior to a clinical intake with a Master's or Doctoral counseling intern. The researcher collected the participants' demographic information including age, gender, and ethnicity from the CABIF. The researcher also collected the (PSI) scores completed by parents prior to children receiving clinical services, PSI scores after the initial 8-12 sessions, and PSI scores after 19-23 sessions of individual child-centered play therapy sessions. To ensure the confidentiality of the information provided, the researcher assigned codes to each participant with only the researcher having the master list with participants' names. All confidential client files remained locked in the Child and Family Resource Clinic during the course of the study. In accordance with state law (Subtitle A. Texas Department of Mental Health and Mental Retardation, Sec. 577.013.b), child files remained locked at the CFRC until the file destruction date, the later of the client's 20<sup>th</sup> birthday or the 10<sup>th</sup> anniversary of the date on which the client last received services (Texas Department of State Health Services, 2005).

### Treatment

Subjects who met all specified criteria: clients between the ages of 3 and 8 years who received 19-23 individual child-centered play therapy sessions facilitated by masters and doctoral counseling interns at the Child and Family Resource Clinic operated by the Counseling program at the University of North Texas were included in this research. All counseling student interns have completed at least two courses in play

therapy, including an introduction to play therapy course and a clinical practicum. In addition, each counselor received individual or triadic supervision on a weekly basis from an experienced play therapist and 1.5 hours of group supervision from a counselor education faculty member. All children selected for this study received treatment consisting of individual child-centered play therapy sessions. Assignment to the treatment groups was based on the child's age at time of treatment.

Child-centered play therapy incorporates play as the child's natural and developmentally appropriate form of self expression. Child-centered play therapy is a dynamic interpersonal relationship between child and therapist. Child-centered play therapists select specific toys and utilize specific interventions and reflections (Landreth, 2002). The child-centered play therapists participating in this study incorporated both nonverbal and verbal skills identified by Ray (2004). The nonverbal skills include: (1) maintaining an open posture and leaning forward; (2) appearing interested in the child; (3) appearing comfortable and relaxed; (4) matching the child's affect through tone and rate of speech; and (5) conveying a sense of genuineness by matching words and affect. The child-centered play therapists' reflective verbal responses include: (1) utilizing short, interactive and personalized responses at an appropriate rate of responses matching the energy level of the child; (2) tracking child's play behavior; (3) reflecting content; (4) reflecting feeling; (5) facilitating decision making and returning responsibility; (6) using esteem-building responses; and (7) incorporating relationship facilitating responses (Landreth, 2002; Ray, 2004). All sessions were conducted in play therapy rooms at the Child and Family Resource Clinic on the campus of the

University of North Texas. The rooms were equipped with the following toys in accordance with Landreth's (2002) recommendations:

Sand	Puppets	Telephone
Scoops/shovel/bucket	Puppet theatre	Plastic domestic animals
Dramatic play clothes	Vehicles/planes	Plastic zoo animals
Masks and hats	Riding car	Medical kit
Plastic dinosaurs	Baby dolls/clothes	Adhesive bandages
Knife/sword	Pacifiers	Cash register
Dart gun	Nursing bottles	Play kitchen/food
Handcuffs	Pillow/blanket	Pots/pans/dishes
Rope	Wood blocks	Dollhouse/bendable family
Paints and easel	Broom/dust pan/mop	Toy soldiers
Craft table	Musical instruments	Bop bag
Crayons and paper	Camera/binoculars	Egg cartons
Play dough	Chalkboard and chalk	Transparent tape/glue/blunt scissors

### Data Analysis

After the data was collected from the archived clinical files at the clinic, data was analyzed through a repeated measures ANOVA design. The preoperational and concrete operations treatment groups create the between, or comparison, factors. The within factor refers to assessment occasion: the pretest, approximate midpoint test, and posttest.

A repeated measures design provides researchers the ability to measure change over time. Repeated measures analysis requires subjects to be measured on more than

two occasions (Girden, 1992). This study meets this assumption because the subjects were measured on three occasions: (a) pretest prior to beginning treatment, (b) approximate midpoint test after 8-12 child-centered play therapy sessions, and (c) posttest after 19-23 child-centered play therapy sessions.

Repeated measures analysis provides several benefits over a simple pretest-posttest design or ANOVA. First, Kraemer and Thiemann (1989) identified repeated measures design as the most appropriate measurement for working with psychotherapeutic research characterized as soft data. Soft data refers to measures that exhibit both intersubject and intrasubject variability. Further, soft data has poor test-retest reliability thus additional measurement occasions utilized in a repeated measures ANOVA design increase the likelihood of finding statistical significance (Kramer and Theimann, 1989). Further, a repeated measures design provides the benefit of needing a much smaller sample size than does an ANOVA or simple pretest-posttest design. Repeated measures analysis can yield significant results with as few as 6 participants (Girden, 1992). Maxwell (1998) recommended that a minimum of three time points be collected for estimating change utilizing repeated measures ANOVA. Kramer and Theimann (1989) report that the repeated measures ANOVA does not require equally spaced observations or measurement occasions. Thus the design of this study involving ranges of sessions does not violate any assumptions of the repeated measures ANOVA.

A repeated measures analysis provides researchers the ability to decrease error in the analysis by partitioning out the variation due to individual differences. Decreasing this error may improve a researcher's chances of obtaining statistical significance.

Through repeated measures analysis, a researcher can gain information on both within-individual change and between individual differences in change (Willett, 1994).

Assumptions of normality were not met for the preoperational development treatment group based on the normality distribution. Three outlying cases from the preoperational development treatment group were identified by SPSS. These outlying cases were removed resulting in the normality assumption being met. After removing the three outlying cases, the preoperational development treatment group consisted of a sample size of 12 ( $n=12$ ). Assumptions for sphericity, kurtosis, and skewness were met for each hypothesis unless otherwise stated.

Each hypothesis was analyzed using Statistical Package for the Social Sciences for Windows (2001) to evaluate the effects of child-centered play therapy on children at different developmental levels as determined by a decrease in parent-child relationship stress. For hypothesis 1a, a one within, one between repeated measures analysis of variance was computed to determine whether children in the preoperational development treatment group experienced a statistically significant change in mean scores on the Child Domain of the Parenting Stress Index across 19-23 child-centered play therapy sessions. For hypothesis 1b, a one within, one between repeated measures analysis of variance was calculated to determine whether children in the concrete operations treatment group experienced a statistically significant change in mean scores on the Child Domain of the Parenting Stress Index across 19-23 child-centered play therapy sessions. For hypothesis 1c, a two between, one within repeated measures analysis of variance was computed to determine whether a statistically significant difference in the efficacy of child-centered play therapy exists between the

children assigned to the preoperational versus concrete operations developmental treatment groups as measured by a change in mean scores on the Child Domain of the PSI.

For hypothesis 2a, a one within, one between repeated measures analysis of variance was computed to determine whether children in the preoperational development treatment group experienced a statistically significant change in mean scores on the Parent Domain of the Parenting Stress Index across 19-23 child-centered play therapy sessions. For hypothesis 2b, a one within, one between repeated measures analysis of variance was calculated to determine whether children in the concrete operations treatment group experienced a statistically significant change in mean scores on the Parent Domain of the Parenting Stress Index across 19-23 child-centered play therapy sessions. For hypothesis 2c, a two between, one within repeated measures analysis of variance was computed to determine whether a statistically significant difference in the efficacy of child-centered play therapy exists between the children assigned to the preoperational versus concrete operations development treatment group as measured by a change in mean scores on the Parent Domain of the Parenting Stress Index.

For hypothesis 3a, a one within, one between repeated measures analysis of variance was computed to determine whether children in the preoperational development treatment group experienced a statistically significant change in mean scores on the Total Stress Score of the Parenting Stress Index across 19-23 child-centered play therapy sessions. For hypothesis 3b, a one within, one between repeated measures analysis of variance was calculated to determine whether children in the

concrete operations treatment group experienced a statistically significant change in mean scores on the Total Stress Score of the Parenting Stress Index across 19-23 child-centered play therapy sessions. For hypothesis 3c, a two between, one within repeated measures analysis of variance was computed to determine whether a statistically significant difference in the efficacy of child-centered play therapy exists between the children assigned to the preoperational versus concrete operations developmental treatment groups as measured by a change in mean scores on the Total Stress Score of the PSI.

Further analysis of the repeated measures ANOVA for each hypothesis revealed whether differences existed in mean score across time for all children participating in the study ( $n= 27$ ) on the Child Domain, Parent Domain, and Total Stress Score of the Parenting Stress Index. Additionally, further analysis revealed any differences in mean score of the preoperational and concrete operations treatment groups on the Child Domain, Parent Domain, and Total Stress Scores of the Parenting Stress Index at each measurement occasion.

## CHAPTER III

### RESULTS AND DISCUSSION

This chapter presents the results of the analysis of data for each hypothesis analyzed in this study. The hypotheses specifically investigated the impact of child-centered play therapy with children of different developmental levels in reducing parent-child relationship stress. The impact of child-centered play therapy was assessed by a decrease in parent-child relationship stress, as measured by results on the Child Domain, Parent Domain, and Total Stress Scores of the Parenting Stress Index. This section includes tables and statistical information detailing the results of repeated measures ANOVA for each hypothesis, a discussion of the results of this study, limitations of the study, implications, and recommendations for future research.

#### Results

The results of this study are presented in the order in which the hypotheses were tested. The alpha .05 level of statistical significance was used as a criterion for either retaining or rejected in the null hypothesis. For hypotheses 1a, 1b, 2a, 2b, 3a, and 3b, a one between one within ANOVA was computed to determine whether a difference in the efficacy of child-centered play therapy exists for children of different developmental levels as determined by a reduction in parent-child relationship stress across time. A reduction in parent-child relationship stress was measured by a decrease in scores on the Parenting Stress Index (Abidin, 1995). For hypotheses 1c, 2c, and 3c, a two between (preoperational and concrete operations developmental level), one within (measurement occasions measuring change across time) repeated measures ANOVA



was computed to determine whether a difference in the decrease in parent-child relationship stress across time existed between the preoperational and concrete operations development treatment groups. Unless otherwise stated sphericity assumptions were met for each hypothesis.

Additionally, effect sizes were calculated to determine the strength of the relationship between treatment and outcome. Trusty, Thompson, and Petrocelli (2004) addressed the need for clinical researchers to describe the significance of their findings in relation to counseling practice in terminology readily understood by practitioners. Reporting effect size provides information regarding the practical significance of results by highlighting the magnitude of change experienced by the participants that is caused by the intervention.

For the purposes of this research study, an eta squared will be utilized to report effect size. SPSS provides estimates of effect size for repeated measures ANOVA in the form of eta squared ( $\eta^2$ ). "Eta squared is an estimate of the proportion of variability in the dependent variable explained, or accounted for, by membership in the groups defining the independent variable. Eta squared estimates are referred to as variance-accounted-for statistics" (Trusty et al., 2004, p.108). For example, the interpretation of eta squared value of .08 for an independent variable would mean that 8% of the difference in the dependent variable scores was explained by the independent variable.

Cohen's (1988) guidelines for interpreting eta *squared* calculations of effect size were used to explore practical significance of findings. Cohen proposed the following values: .01=small, .06=medium, .14= large effect. However, researchers (Thompson, 2002; Trusty et al., 2004) have cautioned against rigidly applying these standards. In

fact, Cohen (1988) addressed the difference in interpreting effect sizes for sociologists and clinicians. He proposed that one effect size may be defined as a small for a sociologist, but be defined as medium by a clinical psychologist. Consider the following example of the implications of the results of a treatment intervention with a client diagnosed with Major Depressive Disorder. Results from the statistical analysis of a treatment method may not provide statistical or practical significance, but if the treatment intervention results in a decrease in symptoms and inpatient hospitalizations, then the client and counselor may view this as a clinically significant change. For the purposes of this research, the researcher utilized an eta squared calculation of effect size to determine practical significance of these results.

#### *Hypothesis 1a*

Following 19-23 sessions of child-centered play therapy, children assigned to the preoperational development treatment group will experience no statistically significant change in the mean scores across time from the pretest (prior to treatment), to approximate midpoint (after 8-12 sessions) to the posttest (19-23 sessions) on the Child Domain of the Parenting Stress Index. Table 3 presents the pretest, approximate midpoint test, and posttest means and standard deviations for the preoperational development comparison group ( $n=12$ ) on the Child Domain of the PSI. Table 4 presents the results of the repeated measures ANOVA, showing the levels of statistical significance of the difference of the mean scores across time and an eta squared effect size of practical significance.

Table 3

*Mean Scores of the Preoperational Development Treatment Group on the Child Domain of the Parenting Stress Index (PSI)*

	<i>M</i>	<i>SD</i>	<i>n</i>
Pretest	80.83	23.47	12
Midpoint test	79.58	18.16	12
Posttest	76.33	17.79	12

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

Table 4

*Repeated Measures ANOVA Summary Table on the Child Domain of the Parenting Stress Index (PSI) for the Preoperational Development Treatment Group*

Source of Variation	Sum of Square	<i>df</i>	<i>MS</i>	<i>F</i>	* <i>p</i>	$\eta^2$
Individuals	11819.42	11	1074.49			
Time	129.50	2	64.750	1.05	.37	.37
Error	1351.83	22	61.45			
Total	13300.74	35				

\*Computed using alpha=.05.

Table 4 shows that there was no statistically significant effect for time. The *F* ratio was not statistically significant at the .05 level ( $F=1.05$ ,  $p=.37$ ), indicating that there was not a statistically significant change across time in the preoperational developmental treatment group's Child Domain scores as measured by the PSI. Therefore, the Null Hypothesis for Hypothesis 1a was retained. Additionally, an eta squared was calculated to assess the practical significance of Child-centered play therapy on the change in parent-child relationship stress as measured by the Child Domain of the PSI and determined to be very large ( $\eta^2=.37$ ). Although results revealed no statistically significant difference over time for the Child Domain of the PSI for children in the

preoperational development treatment group based on the child-centered play therapy intervention, results revealed very large practical significance.

*Hypothesis 1b*

Following 19-23 sessions of child-centered play therapy, children assigned to the concrete operations development treatment group will experience no statistically significant change in the mean scores across time from the pretest (prior to treatment), to approximate midpoint (after 8-12 sessions) to the posttest (19-23 sessions) on the Child Domain of the Parenting Stress Index. The sphericity assumption was not met; therefore, the Greenhouse-Geisser correction was utilized resulting in a decrease in the likelihood of finding statistical significance. Table 5 presents the pretest, approximate midpoint test, and posttest means and *standard deviations* for the concrete operations comparison group ( $n=12$ ) on the Child Domain of the PSI. Table 6 presents the results of repeated measures ANOVA, showing the levels of statistical significance of the difference of the mean scores across time and an eta squared effect size of practical significance.

Table 5

*Mean Scores of the Concrete Operations Development Treatment Group on the Child Domain of the Parenting Stress Index (PSI)*

	<i>X</i>	<i>SD</i>	<i>n</i>
Pretest	75.17	28.83	12
Midpoint test	71.08	31.31	12
Posttest	57.08	29.44	12

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

Table 6

*Repeated Measures ANOVA Summary Table on the Child Domain of the Parenting Stress Index (PSI) for the Concrete Operations Treatment Group*

Source of Variation	Sum of Square	df	MS	F	*p	$\eta^2$
Individuals	2319.56	11	2392.69			
Time	2158.72	1.37	1575	7.57	.01	.41
Error	3137.94	15.08	27.45			
Total	7616.22	27.45				

Computed using alpha=.05.

Table 6 shows that there was a statistically significant effect for time across the measurement occasions. The *F* ratio for the time was statistically significant at the .05 level ( $F=7.57, p=.01$ ). Analysis of these results indicates a statistically significant change across time in the concrete operations development treatment group's Child Domain scores as measured by the PSI. Therefore, the Null Hypothesis for Hypothesis 1b was rejected. Additionally, an eta squared was calculated to assess the practical significance of child-centered play therapy on the change in parent-child relationship stress as measured by the Child Domain on the PSI and determined to be very large ( $\eta^2=.41$ ). Results revealed statistically significant and very large practically significant difference over time for the Child Domain of the PSI for children in the concrete operations development treatment group based on the child-centered play therapy intervention.

#### *Hypothesis 1c*

Following 19-23 sessions of child-centered play therapy, children assigned to the preoperational development treatment group will experience no statistically significant

difference in the change in mean scores across time from the pretest (prior to treatment), to approximate midpoint (after 8-12 sessions) to the posttest (19-23 sessions) on the Child Domain of the Parenting Stress Index than will children assigned to the concrete operations development treatment group. The sphericity assumption was not met; therefore, the Greenhouse-Geisser correction was utilized thus decreasing the likelihood of finding statistical significance. Table 7 presents the pretest, approximate midpoint test, and posttest means and standard deviations for the preoperational ( $n=12$ ) and concrete operations ( $n=12$ ) comparison groups and for the total children included in the study ( $n=24$ ) on the child Domain of the PSI. Table 8 presents the results of repeated measures ANOVA, showing the levels of statistical significance of the difference of the mean scores of the interaction effect of time and developmental level and presents an eta squared effect size of practical significance.

Table 7

*Mean Scores for the Preoperational and Concrete Operations Development Treatment Groups and Total Children on the Child Domain of the Parenting Stress Index (PSI)*

Occasion	Developmental Stage	$X$	$SD$	$n$
Pretest	Preoperational	80.83	23.47	12
	Concrete Operations	75.17	28.83	12
	Total	78.00	25.87	24
Midpoint	Preoperational	79.58	18.16	12
	Concrete Operations	71.08	31.31	12
	Total	75.33	25.41	24
Posttest	Preoperational	76.33	17.79	12
	Concrete Operations	57.08	29.44	12
	Total	66.71	25.74	24

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

Table 8

*Repeated Measures ANOVA Summary Table on the Child Domain of the Parenting Stress Index (PSI) for the Preoperational and Concrete Operations Development Treatment Groups*

Source of Variation	Sum of Square	df	MS	F	*p	$\eta^2$
Individuals	38138.97	22	1733.59			
Time	1672.03	1.55	1079.13	8.19	.00	.19
Development	2233.35	1	2233.35	1.29	.27	.25
Time X Dev	616.19	1.55	397.69	3.02	.07	.68
Error	4489.78	34.09	131.71			
Total	47150.32	60.185				

\*Computed using  $\alpha=.05$ .

Table 8 illustrates no statistically significant differences in the change in mean scores across time when comparing children in the preoperational and concrete operations development treatment group's Child Domain of the Parenting Stress Index. The *F* ratio for the development was not statistically significant at the .05 level ( $F=3.02$ ,  $p=.07$ ). Therefore, the Null Hypothesis for Hypothesis 1c was retained. Additionally, an *eta squared* was calculated to assess the practical significance of the difference in the change in mean scores across time when comparing children in the preoperational and concrete operations development treatment was determined to be very large ( $\eta^2=.68$ ). Although results revealed no statistically significant difference over time for the Child Domain of the PSI for children in the preoperational versus concrete operations development treatment groups based on the child-centered play therapy intervention, results revealed very large practical significance.

### *Hypothesis 2a*

Following 19-23 sessions of child-centered play therapy, children assigned to the preoperational treatment group will experience no statistically significant change in the mean scores across time from the pretest (prior to treatment), to approximate midpoint (after 8-12 sessions) to the posttest (19-23 sessions) on the Parent Domain of the Parenting Stress Index. Table 9 presents the pretest, approximate midpoint test, and posttest means and standard deviations for the preoperational development comparison group ( $n=12$ ) on the Parent Domain of the PSI. Table 10 presents the results of the repeated measures ANOVA, showing the levels of statistical significance of the difference of the mean scores across time and an eta squared effect size of practical significance.

Table 9

*Mean Scores of the Preoperational Development Treatment Group on the Parent Domain of the Parenting Stress Index (PSI)*

	X	SD	n
Pretest	71.17	18.84	12
Midpoint test	79.50	13.50	12
Posttest	71.33	14.18	12

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

Table 10

*Repeated Measures ANOVA Summary Table on the Parent Domain of the Parenting Stress Index (PSI) for the Preoperational Development Treatment Group*

Source of Variation	Sum of Square	df	MS	F	*p	$\eta^2$
Individuals	5146.67	11	467.90			
Time	544.67	2	272.33	2.01	.16	.59
Error	2976.67	22	135.30			
Total	8668.00	35				

\*Computed using  $\alpha=.05$ .



Table 9 shows that there was no statistically significant effect for time. The  $F$  ratio for was statistically significant at the .05 level ( $F=2.01$ ,  $p=.16$ ), indicating no statistically significant change in the preoperational development treatment group's Parent Domain, as measured by the PSI, across time from the pretest, through the approximate midpoint test, to the posttest. Therefore, the Null Hypothesis for Hypothesis 2a was retained. Additionally, an eta squared was calculated to assess the practical significance of child-centered play therapy on the change in parent-child relationship stress as measured by the Parent Domain of the PSI and determined to be very large ( $\eta^2=.59$ ). Although results revealed no statistically significant difference over time for the Parent Domain of the PSI for children in the preoperational development treatment group based on the child-centered play therapy intervention, results revealed very large practical significance.

#### *Hypothesis 2b*

Following 19-23 sessions of child-centered play therapy, children assigned to the concrete operations development treatment group will experience no statistically significant change in the mean scores across measurement occasion from the pretest (prior to treatment), to approximate midpoint (after 8-12 sessions) to the posttest (19-23 sessions) on the Parent Domain of the Parenting Stress Index. Table 11 presents the pretest, approximate midpoint test, and posttest means and standard deviations for the concrete operations development treatment group ( $n=12$ ) on the Child Domain of the PSI. Table 12 presents the results of repeated measures ANOVA, showing the levels of

statistical significance of the difference of the mean scores across time and an eta squared effect size of practical significance.

Table 11

*Mean Scores of the Concrete Operations Development Treatment Group on the Parent Domain of the Parenting Stress Index (PSI)*

	<i>X</i>	<i>SD</i>	<i>n</i>
Pretest	34.00	24.32	12
Midpoint test	33.00	27.87	12
Posttest	27.50	26.18	12

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

Table 12

*Repeated Measures ANOVA Summary Table on the Parent Domain of the Parenting Stress Index (PSI) for the Concrete Operations Development Treatment Group*

Source of Variation	Sum of Square	<i>df</i>	<i>MS</i>	<i>F</i>	* <i>p</i>	$\eta^2$
Individuals	19205.67	11	1745.97			
Time	294	2	147	.96	.40	.09
Error	3385.33	22	153.88			
Total	22885	35				

Computed using alpha=.05.

Table 12 shows that no statistically significant effect for time. The *F* ratio for was not statistically significant at the .05 level ( $F=.96, p=.40$ ). Analysis of these results indicates no statistically significant change in the concrete operations development treatment group's Parent Domain scores as measured by the PSI. Therefore, the Null Hypothesis for Hypothesis 2b was retained. Additionally, an eta squared was calculated to assess the practical significance of child-centered play therapy on the change in parent-child relationship stress as measured by the Parent Domain on the PSI and

determined to be moderate ( $\eta^2=.09$ ). Although results revealed no statistically significant difference over time difference for the Parent Domain of the PSI for children in the concrete operations development treatment group based on the child-centered play therapy intervention, results revealed moderate practical significance.

### *Hypothesis 2c*

Following 19-23 sessions of child-centered play therapy, children assigned to the preoperational development treatment group will experience no statistically significant differences in the change in the mean scores across time from the pretest (prior to treatment), to approximate midpoint (after 8-12 sessions) to the posttest (19-23 sessions) on the Parent Domain of the Parenting Stress Index than will children assigned to the concrete operations treatment group. Table 13 presents the pretest, approximate midpoint test, and posttest means and standard deviations for the preoperational ( $n=15$ ) and concrete operations ( $n=12$ ) comparison groups and for the total children included in the study ( $n=27$ ) on the Parent Domain of the PSI. Table 14 presents the results of repeated measures ANOVA, showing the levels of statistical significance of the difference of the mean scores of the interaction effect of time and developmental stage and presents an eta squared effect size of practical significance.

Table 13

*Mean Scores for the Preoperational and Concrete Operations Development Treatment Groups and Total Children on the Parent Domain of the Parenting Stress Index (PSI)*

Occasion	Developmental Stage	$\bar{X}$	$SD$	$n$
Pretest	Preoperational	71.17	18.84	12
	Concrete Operations	34.00	24.32	12
	Total	52.58	28.51	24
Midpoint	Preoperational	79.50	13.50	12
	Concrete Operations	33.00	27.87	12
	Total	56.25	31.98	24
Posttest	Preoperational	71.33	14.18	12
	Concrete Operations	27.50	26.18	12
	Total	49.42	30.42	24

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

Table 14

*Repeated Measures ANOVA Summary Table on the Parent Domain of the Parenting Stress Index (PSI) for the Preoperational and Concrete Operations Development Treatment Group*

Source of Variation	Sum of Square	$df$	$MS$	$F$	$*p$	$\eta^2$
Individuals	24352.33	22	1106.92			
Time	561.33	2	280.67	1.94	.16	.01
Development	32512.50	1	32512.50	29.37	.00	.82
Time X Dev	277.33	2	138.67	.96	.39	.01
Error	8670.09	50	173.402			
Total	64065.50	71				

\*Computed using  $\alpha=.05$ .

Table 14 illustrates no statistically significant differences in the change in mean scores across time when comparing children in the preoperational and concrete operations development treatment group's Parent Domain of the Parenting Stress

Index. The  $F$  ratio for the time and development was not statistically significant at the .05 level ( $F=.96, p=.39$ ). Therefore, the Null Hypothesis for Hypothesis 2c was retained. Additionally, an eta squared was calculated to assess the practical significance of the difference in the change in mean scores across time when comparing children in the preoperational and concrete operations development treatment was determined to be small ( $\eta^2=.01$ ). Results revealed no statistically significant difference and only a small practically significant difference over time for the Parent Domain of the PSI for children in the preoperational versus concrete operations development treatment groups based on the child-centered play therapy intervention.

### *Hypothesis 3a*

Following 19-23 sessions of child-centered play therapy, children assigned to the preoperational development treatment group will experience no statistically significant change in the mean scores across time from the pretest (prior to treatment), to approximate midpoint (after 8-12 sessions) to the posttest (19-23 sessions) on the Total Stress score of the Parenting Stress Index. Table 15 presents the pretest, approximate midpoint test, and posttest means and standard deviations for the preoperational development comparison group ( $n=12$ ) on the Total Stress score of the PSI. Table 16 presents the results of the repeated measures ANOVA, showing the levels of statistical significance of the difference of the mean scores across time and an eta squared effect size of practical significance.

Table 15

*Mean Scores of the Preoperational Development Treatment Group on the Total Stress Score of the Parenting Stress Index (PSI)*

	<i>X</i>	<i>SD</i>	<i>n</i>
Pretest	82.00	8.77	12
Midpoint test	85.42	9.69	12
Posttest	76.42	14.30	12

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

Table 16

*Repeated Measures ANOVA Summary Table on the Total Stress Score of the Parenting Stress Index (PSI) for the Preoperational Development Treatment Group*

Source of Variation	Sum of Square	<i>df</i>	<i>MS</i>	<i>F</i>	<i>*p</i>	$\eta^2$
Individuals	2183.22	11	198.46			
Time	495.39	2	247.69	2.80	.08	.47
Error	1944.61	22	88.39			
Total	4623.22	35				

\*Computed using alpha=.05.

Table 16 shows that there was no statistically significant effect for time. The *F* ratio was not statistically significant at the .05 level ( $F=2.80$ ,  $p=.08$ ), indicating that there was not a statistically significant change across time in the preoperational development treatment group's Total Stress Score as measured by the PSI. Therefore, the Null Hypothesis for Hypothesis 3a was retained. Additionally, an eta squared was calculated to assess the practical significance of child-centered play therapy on the change in parent-child relationship stress for the preoperational development treatment group as measured by the Total Stress Score of the Parenting Stress Index and determined to be very large ( $\eta^2=.47$ ). Although results revealed no statistically significant difference over

time for the Total Stress Score on the PSI for children in the preoperational development treatment group based on the child-centered play therapy intervention, results revealed very large practical significance.

*Hypothesis 3b*

Following 19-23 sessions of child-centered play therapy, children assigned to the concrete operations development treatment group experienced no statistically significant change in the mean scores across time from the pretest (prior to treatment), to approximate midpoint (after 8-12 sessions) to the posttest (19-23 sessions) on the Total Stress Score of the Parenting Stress Index. Table 17 presents the pretest, approximate midpoint test, and posttest means and standard deviations for the concrete operations development treatment group ( $n=12$ ) on the Total Stress Score of the PSI. Table 18 presents the results of repeated measures ANOVA, showing the levels of statistical significance of the difference of the mean scores across time and an eta squared effect size of practical significance.

Table 17

*Mean Scores of the Concrete Operations Development Treatment Group on the Total Stress Score of the Parenting Stress Index (PSI)*

	<i>X</i>	<i>SD</i>	<i>n</i>
Pretest	60.50	27.97	12
Midpoint test	51.50	28.86	12
Posttest	35.33	26.01	12

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

Table 18

*Repeated Measures ANOVA Summary Table on the Total Stress Score of the Parenting Stress Index (PSI) for the Concrete Operations Development Treatment Group*

Source of Variation	Sum of Square	df	MS	F	*p	η <sup>2</sup>
Individuals	19162.22	11	1742.02			
Time	3902.89	2	1951.44	7.10	.004	.39
Error	6050.44	22	275.02			
Total	25251.95	35				

Computed using alpha=.05.

Table 18 shows that there was a significant effect for time across the measurement occasions. The *F* ratio for the time was statistically significant at the .05 level ( $F=7.10$ ,  $p=.004$ ). Analysis of these results indicates a statistically significant change in the concrete operations development treatment group's Total Stress Score as measured by the PSI. Therefore, the Null Hypothesis for Hypothesis 3b was rejected. Additionally, an eta squared was calculated to assess the practical significance of the difference across time and determined to be very large ( $\eta^2=.39$ ). Results revealed statistically significant and very large practically significant difference over time for the Total Stress Score of the PSI for children in the concrete operations development treatment group based on the child-centered play therapy intervention.

### *Hypothesis 3c*

Following 19-23 sessions of child-centered play therapy, children assigned to the preoperational development treatment group will experience no statistically significant differences in the change in the mean scores across time from the pretest (prior to



treatment), to approximate midpoint (after 8-12 sessions) to the posttest (19-23 sessions) on the Total Stress Score of the Parenting Stress Index than children assigned to the concrete operations development treatment group. Table 19 presents the pretest, approximate midpoint test, and posttest means and standard deviations for the preoperational ( $n=12$ ) and concrete operations ( $n=12$ ) comparison groups and for the total children included in the study ( $n=24$ ) on the Total Stress Score of the PSI. Table 20 presents the results of repeated measures ANOVA, showing the levels of statistical significance of the difference of the mean scores across time and presents an eta squared effect size of practical significance.

Table 19

*Mean Scores for the Preoperational and Concrete Operations Development Treatment Groups and Total Children on the Total Stress Score of the Parenting Stress Index (PSI)*

Occasion	Developmental Stage	Mean	SD	<i>n</i>
Pretest	Preoperational	82.00	8.77	12
	Concrete Operations	60.50	27.97	12
	Total	71.25	23.06	24
Midpoint	Preoperational	85.42	9.69	12
	Concrete Operations	51.50	28.86	12
	Total	68.46	27.27	24
Posttest	Preoperational	76.42	14.30	12
	Concrete Operations	35.33	26.01	12
	Total	55.88	29.35	24

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

Table 20

*Repeated Measures ANOVA Summary Table on the Child Domain of the Parenting Stress Index (PSI) for the Preoperational and Concrete Operations Development Treatment Groups*

Source of Variation	Sum of Square	df	MS	F	*p	$\eta^2$
Individuals	21345.44	22	970.25			
Time	3220.19	2	1610.19	8.86	.00	.10
Development	18624.50	1	18624.50	19.20	.00	.60
Time X Dev	1178.08	2	589.04	3.24	.049	.04
Error	7995.06	44	181.71			
Total	52363.27	71				

\*Computed using alpha=.05.

Table 20 illustrates that the  $F$  ratio for the interaction effect between time and development was statistically significant. Children assigned to the preoperational treatment group experienced a statistically significant difference in the change in mean scores, at the .05 level ( $F=3.24$ ,  $p=.049$ ) across time on the Total Stress Score of the Parenting Stress Index compared to children assigned to the concrete operations treatment group. Therefore, the Null Hypothesis for Hypothesis 3c was rejected. Additionally, an eta squared was calculated to assess the practical significance of the difference between preoperational and concrete operations development treatment groups across time and determined to be moderate ( $\eta^2=.04$ ).

Results revealed statistically significant and a moderate practically significant difference over time for the Total Stress Score of the PSI for children in the preoperational versus concrete operations development treatment groups based on the child-centered play therapy intervention. Children in the concrete operations development treatment group experienced more change as a result of the intervention

than did children in the preoperational development treatment group. These results will be discussed in detail below.

### Post Hoc Clinical Significance Analysis

Due to the discrepancies between practical and statistical significance, post hoc analyses were conducted to address the clinical significance of the findings. Kazdin (2003) defined clinical significance as “the practical or applied value or importance of the effect of an intervention, that is, whether the intervention makes a real difference in everyday life to the clients or to others with whom the clients interact” (p.691). For the purposes of this study, the researcher utilized a comparison method for evaluating the clinical significance of change in the mean scores of the PSI after receiving child-centered play therapy.

Analysis of the Child Domain scores for children in the preoperational development treatment group revealed that 7 of the 12 (58%) children had scores in the Clinical range on the PSI for at the pretest prior to receiving child-centered play therapy. After receiving 19-23 sessions of child-centered play therapy, 4 of the 7 (57%) children were scored in the Normal range at the posttest administration of the PSI. These results could be interpreted as clinically significant for these children in the preoperational development treatment group.

The concrete operations development treatment group exhibited similar results. Analysis of the Child Domain scores for children in the concrete operations development treatment group revealed that 7 of the 12 (58%) children had scores in the Clinical range on the PSI for at the pretest prior to receiving child-centered play therapy.

After receiving 19-23 sessions of child-centered play therapy, 5 of the 7 (71%) children were scored in the Normal range at the posttest administration of the PSI. These results could be interpreted as clinically significant for these children in the concrete operations development treatment group.

Additionally, a similar analysis was conducted for the Parent Domain of the PSI. Analysis of the Parent Domain scores for children in the preoperational development treatment group revealed that 4 of the 12 (33%) children had scores in the Clinical range of the PSI for at the pretest prior to receiving child-centered play therapy. After receiving 19-23 sessions of child-centered play therapy, 3 of the 4 (75%) children were scored in the Normal range at the posttest administration of the PSI. These results could be interpreted as clinically significant for these children in the preoperational development treatment group. Post hoc analysis of children in the concrete operations development treatment group revealed no scores in the Clinical range on the Parent Domain of the PSI at pretest.

Finally, a post hoc analysis was conducted for children in the preoperational and concrete operations development treatment group on the Total Stress Score of the PSI. Analysis of the Total Stress Scores for children in the preoperational development treatment group revealed that 4 of the 12 (33%) children had scores in the Clinical range on the PSI at the pretest prior to receiving child-centered play therapy. After receiving 19-23 sessions of child-centered play therapy, 2 of the 4 (50%) children were scored in the Normal range at the posttest administration of the PSI. These results could be interpreted as clinically significant for these children in the preoperational development treatment group.

Post hoc analysis of children in the concrete operations development treatment group revealed 3 of the 12 (25%) children had scores in the Clinical range on the Parent Domain of the PSI at pretest. After receiving 19-23 sessions of child-centered play therapy, 2 of the 3 (66%) children were scored in the Normal range at the posttest administration of the PSI. These results could be interpreted as clinically significant for these children in the concrete operations development treatment group.

Finally, overall analysis of children in both groups revealed that 14 of the 24 (58%) of children in this study had scores in the Clinical range on the Child Domain of the PSI at the pretest prior to receiving treatment. After receiving 19-23 sessions of child-centered play therapy, 9 of the 14 (64%) children's scores had declined to the Normal range on the PSI. Results of this study reveal that child-centered play therapy works differently between the two groups in this study; however, it is noteworthy that child-centered play therapy did demonstrate statistical, practical, and clinical significance when all children in the study were analyzed together. Further interpretation of the study results are detailed below.

## Discussion

The majority of counseling researchers are doctoral level professionals. These professionals conduct empirical research into treatment effects of various counseling interventions. Statistical analyses are run on treatment effects, and findings are published based on results demonstrating statistical significance. However, the majority of practicing counselors are Master's degree level professionals who are seeking results that support the practical and clinical significance of a particular counseling intervention.

This is a primary reason why counseling researchers are required by some journal editors to report on effect sizes that measure the practical significance of treatment interventions.

Effect sizes provide research consumers the ability to better understand the magnitude of treatment effects and interpret practical significance of empirical research results (Trusty et al., 2004). The statistical, practical, and clinical results of this study provide information on the effects of child-centered play therapy with children of the preoperational and concrete operations developmental stages in reducing parent-child relationship stress. This study examined whether differences in the efficacy of child-centered play therapy existed for children in the preoperational versus concrete operations developmental stages.

Results of this study highlight the effects of child-centered play therapy with children in the preoperational ( $n=12$ ) and concrete operations ( $n=12$ ) developmental stages in decreasing parent-child relationship stress as measured by the Parenting Stress Index. All children receiving treatment were referred to the Child and Family Resource Clinic at the University of North Texas by their parent or guardian and received between 19-23 individual child-centered play therapy sessions. Master's or Doctoral counseling interns trained in child-centered play therapy provided all treatment. Treatment outcomes were measured utilizing a repeated measures design. A .05 level of significance was established for either retaining or rejecting the null hypotheses.

Some results of this study indicate a decrease in parent-child relationship stress resulting from children experiencing child-centered play therapy. Of the nine null hypotheses three were rejected at the .05 level of significance. Further, eight of the

hypotheses revealed moderate to very large treatment effect sizes, as measured by eta squared, for the children receiving individual child-centered play therapy. Caution should be exercised when interpreting the practical significance of the results for children in the preoperational development treatment group.

Further analysis of children in the preoperational development treatment group did reveal a clinically significant decrease in child behavioral problems impacting parent-child relationship stress as measured by the Child Domain of the PSI. Clinical significance for the effect of child-centered play therapy with children in the preoperational development treatment group was determined by the decrease in scores from the Clinical range on the Child Domain of the PSI to the Normal range after receiving 19-23 sessions of child-centered play therapy.

A thorough evaluation of the statistical, practical and clinical significance of the results indicates that there are differences in the impact of child-centered play therapy for children in the preoperational versus concrete operations developmental stages. The concrete operations development treatment group exhibited statistical, practical and clinical significance for the Child Domain and Total Stress Score of the Parenting Stress Index. The preoperational development treatment group did not exhibit statistical significance for the Child Domain, Parent Domain, or Total Stress Score of the Parenting Stress Index. Additionally, results revealed statistically and practically significant difference in the change in means scores for children in the preoperational versus concrete operations development treatment groups for the Total Stress Score of the Parenting Stress Index. These results are elaborated throughout the discussion below.

A discussion of the effects of child-centered play therapy in decreasing parent-child relationship stress as measured by the Child Domain, Parent Domain, and Total Stress Score of the Parenting Stress Index are organized as follows: (a) children in the preoperational developmental stage, (b) children in the concrete operations developmental stage, and (c) differences between the effects of child-centered play therapy on children of preoperational versus concrete operations developmental stages.

### *Children in the Preoperational Developmental Stage*

#### *Child Domain*

Children in the preoperational developmental stage experienced decreases in parent-child relationship stress triggered by child behavior problems, as measured by mean scores on the Child Domain of the Parenting Stress Index, after receiving 19-23 sessions of child-centered play therapy. There were no statistically significant decreases in child behavioral problems for children in this treatment group. Results of an eta squared analysis did reveal practical significance; however, this practical significance should be interpreted with caution. Readers should consider this clinical significance of the results of this study. Mean scores revealed only a 4 point change in the Child Domain scores from the pretest to the posttest administration of the PSI. Additionally, 58 percent of the children initially scoring in the Clinical range at the pretest administration of the Child Domain of the PSI, scored in the Normal range at the posttest administration.

The Child Domain is associated with qualities displayed by children that may make it difficult for parents to fulfill their parenting role. The Child Domain measures



parents' experience of their child's behavioral problems including hyperactivity, adaptability, demandingness, and mood. When high scores appear on the Child Domain of the PSI, Abidin (1995) encouraged interventions that focus on child behaviors versus other domains of the parent-child system. Further, Abidin noted that the Child Domain score is typically elevated above the Parent Domain score for parents of children with emotional disturbances, hyperactivity, and behavioral problems. Results of this study indicated scores on the Child Domain of the Parenting Stress Index were elevated above scores on the Parent Domain of the Parenting Stress Index for children in the preoperational developmental stage. Results of the repeated measures ANOVA revealed that the elevation in mean scores on the Parent Domain of the PSI at the midpoint measurement were not statistically significant. Information provided by parents on the Child and Adolescent Background Information Form further supported that the children included in this study were experiencing a range of emotional and behavioral problems. Child-centered play therapy did not demonstrate statistical significance for child behaviors for children in the preoperational developmental stage, but did demonstrate practical significance.

### *Parent Domain*

Children in the preoperational developmental stage did not experience decreases in the parent-child relationship stress triggered by the parent's functioning, as measured by mean scores on the Parent Domain of the Parenting Stress Index, after receiving 19-23 sessions of child-centered play therapy. Instead, results revealed scores on the Parent Domain of the PSI were elevated after 8-12 weeks of child-centered play

therapy. At the conclusion of 19-23 sessions, Parent Domain Scores returned to the pretest level. Additional Post hoc analysis did reveal that of the 33 percent of children who initially received scores in the Clinical range on the Parent Domain of the PSI, received scores in the Normal range at the posttest administration of the PSI. The Parent Domain is associated with sources of stress in the parent-child relationship that are related to issues in the parent's functioning including the parent's sense of competence, feelings of isolation and depression, and lack of emotional and active support from their spouse or partner (Abidin, 1995). Individuals earning high scores on the Parent Domain feel overwhelmed by the role of parenting.

Child-centered play therapy provides a therapeutic intervention for working with children and is not an intervention designed for treating parents. Therefore, results indicating no decrease in the Parent Domain of the PSI are not surprising as this domain is associated with sources of stress related to the parent's functioning. The lack of decrease in scores on the Parent Domain scores could necessitate a referral for parents to receive counseling services to specifically address their reported stress. However, previous researchers reported a recursive relationship between child behavioral problems and parent stress (Abidin, Jenkins, & McGaughey, 1992; Cornelius, 1987; Crnic & Greenbug, 1990; Hadadian & Merbler, 1996). After conducting research on parenting stress, this researcher was surprised to find that the Parent Domain score did not show statistically or practically significant decreases while the Child Domain scores did demonstrate practically significant decreases.

Further analysis of these results led the researcher to postulate explanations based on previous literature and research into the process of play therapy. First, child-

centered play therapy encourages children to express themselves freely and openly (Landreth, 2002). This form of self expression may not be expected by parents and may result in parents initially experiencing increased stress as they adapt to changes in their child's behavior.

Moustakas' (1955, 1997) observations and analysis of children in play therapy offer an additional explanation of results. Moustakas identified stages in the therapeutic process of play therapy: (1) diffuse and undifferentiated negative feelings expressed everywhere in their play; (2) unfocused feelings of anger and hostility; (3) direct negative feelings directed toward specific people including parents and siblings; (4) continued negative feelings of anger mixed with positive feelings directed towards others; and (5) realistic positive and negative feelings are separated and consistent with positive feelings predominant in children's play. Moustakas (1997) asserted that as children begin to feel safe and accepted by their play therapist "a sense of power and confidence awakens that facilitate expressions of anger, pain or sorrow" (p. 25).

Results of the Parent Domain for children in the preoperational developmental stage indicated an increase in stress prior to a return to pre-intervention stress levels for children receiving child-centered play therapy. This correlates to Moustakas' (1997) research indicating that as the relationship between children and their play therapist intensifies; children's feelings become sharper and more specifically directed toward particular persons such as parents and siblings. Thus, parents in this study may have experienced an increase in stress as their children began directing their intense negative feelings of anger and hostility towards their parents.

### *Total Stress Score*

Children in the preoperational developmental stage experienced decreases in parent-child relationship stress, as measured by mean scores on the Total Stress Score of the Parenting Stress Index, after receiving 19-23 sessions of child-centered play therapy. While these decreases were not statistically significant, results did reveal practical significance. Further evaluation of the results across time indicated an initial increase in the Total Stress Score of the PSI after 8-12 sessions. This increase in the Total Stress Score was a result of the initial increase in the Parent Domain score. After completing 19-23 sessions, the results indicated a practically significant decrease from the pretest scores. Additionally, results revealed that of the 33% of children receiving scores in the Clinical range of the Total Stress Score of the PSI at pretest, 50% of those children score in the Normal range at the posttest administration.

The results of child-centered play therapy with children in the preoperational developmental stage revealed practically significant changes in parent-child relationship stress, as measured by mean scores on the Child Domain and Total Stress Score of the PSI. Further, the effects of child-centered play therapy with children in the preoperational developmental stage did not exhibit statistically or practically significant changes in mean scores on the Parent Domain of the PSI. Further, analysis revealed that scores on the Child Domain were higher on each measurement occasion than were scores on the Parent Domain. These results indicate the primary source of parent-child relationship stress for children in the preoperational developmental stage were related to child behavioral and emotional problems rather than problems specifically associated with the parent's functioning.

Abidin (1995) asserted that when the Child Domain is elevated above the Parent Domain children are typically experiencing emotional disturbances, hyperactivity, and behavioral problems. Bratton et al.'s (2005) meta-analysis of treatment outcomes of play therapy indicated that the benefits of play therapy increase up to 35 sessions. Given the results of Bratton et al.'s and Abidin's research, it is reasonable to assert that the children in the preoperational developmental stage did not receive enough play therapy to lead to statistically significant decreases in mean scores on the Parenting Stress Index. In response to the results revealing no decrease in the Parent Domain scores, future therapeutic recommendations involving both parents and children may be warranted.

### *Children in the Concrete Operations Developmental Stage*

#### *Child Domain*

Children in the concrete operations developmental stage experienced statistically and practically significant decreases in parent-child relationship stress triggered by child behavioral problems, as measured by mean scores on the Child Domain of the Parenting Stress Index, after receiving 19-23 sessions of child-centered play therapy. Additionally, 71% of the children initially scoring in the Clinical range at the pretest administration of the Child Domain of the PSI, scored in the Normal range at the posttest administration after receiving child-centered play therapy.

Similar to the children in the preoperational developmental stage, children in the concrete operations developmental stage demonstrated scores on the Child Domain of the Parenting Stress Index that were elevated above scores on the Parent Domain of

the Parenting Stress Index. Abidin (1995) reported that this result is typical for parents of children with emotional disturbances, hyperactivity, and behavioral problems. Results of this study indicated that child-centered play therapy is an effective intervention for decreasing qualities displayed by children including hyperactivity, emotional disturbances and behavioral problems that may make it difficult for parents to fulfill their parenting role.

### *Parent Domain*

Children in the concrete operations developmental stage experienced decreases in parent-child relationship stress triggered by the parent's functioning, as measured by mean scores on the Parent Domain of the Parenting Stress Index, after receiving 19-23 sessions of child-centered play therapy. While these decreases were not statistically significant, results did reveal practical significance. A post hoc analysis of these results revealed that none of the children in the concrete operations development treatment group scored in the Clinical range at the pretest administration of the Parent Domain of the PSI. Further, results trend toward a decrease in scores on the Parent Domain across time and after additional sessions these decreases may have become statistically significant.

### *Total Stress Score*

Children in the concrete operations developmental stage experienced statistically and practically significant decreases in mean scores on the Total Stress Score of the Parenting Stress Index after receiving 19-23 sessions of child-centered

play therapy. Additionally, a post hoc analysis of these results revealed that 66 percent of the children in the concrete operations development treatment group who received scores in the Clinical range at the pretest administration of Total Stress Score of the PSI were in the Normal range at the posttest administration. These results suggest that child-centered play therapy may be an effective therapeutic intervention for decreasing parent-child relationship stress for parents of children in the concrete operations developmental stage.

The results of child-centered play therapy with children in the concrete operations developmental stage revealed statistically and practically significant changes in parent-child relationship stress. Additional analysis revealed that scores on the Child Domain were higher on each measurement occasion than were scores on the Parent Domain. Similar to the results with children in the preoperational developmental stage, these results indicated the primary source of parent-child relationship stress for children in the concrete operations developmental stage was related to child behavioral and emotional problems rather than problems specifically associated with the parent's functioning.

*Effects of Child-Centered Play Therapy on Children of Preoperational versus Concrete Operations Developmental Stages*

*Child Domain*

Children in the preoperational and concrete operations developmental stages experienced differences in the effects of child-centered play therapy in decreasing parent-child relationship stress triggered by child behavioral problems, as measured by changes in mean scores on the Child Domain of the Parenting Stress Index. While these differences were not statistically significant, results revealed practically significant

differences in the decrease in parent-child relationship stress for children in the preoperational and concrete operations developmental stages after receiving 19-23 sessions of child-centered play therapy.

Ironically, the researcher did not expect these results based on the literature review conducted prior to beginning this study. Piaget's (1962) theory of development and observations of children's play behaviors concluded that symbolic play reaches its pinnacle during the preoperational developmental stage. Although the hypotheses for this study were stated in the null form, the researcher initially posited that any differences in the effects of child-centered play therapy would have indicated the intervention was more effective for decreasing parent-child relationship stress for children in the preoperational developmental stage based on the significance of symbolic play for children in the preoperational developmental stage.

Abidin (1995) indicated that when scores on the Child Domain are elevated above scores on the Parent Domain of the PSI, interventions should focus on child behaviors versus other domains of the parent-child system because high scores on the Child Domain are associated with child behavioral and emotional problems. Child-centered play therapy is an intervention focusing on the child rather than other domains of the parent-child system. However, previous research into parent-child relationship stress revealed a recursive relationship between child behavioral and emotional problems and parent stress. When scores on the Child Domain decrease, a decrease in the Parent Domain might also be anticipated. As a result, the researcher believed scores on both Domains would demonstrate decreases.



Figure 1 provides a visual depiction of the differences in the Child Domain scores of the PSI for children in the preoperational versus concrete operations developmental stages. This graph illustrates a downward trend in child behavioral problems for children in both the preoperational and concrete operations developmental stages after receiving 19-23 sessions of CCPT. Additionally, this graph demonstrates that parents of children in the preoperational developmental stage reported higher levels of stress resulting from child behavioral problems as measured by the Child Domain of the PSI on each measurement occasion than parents of children in the concrete operations developmental stage.

### Child Domain Scores

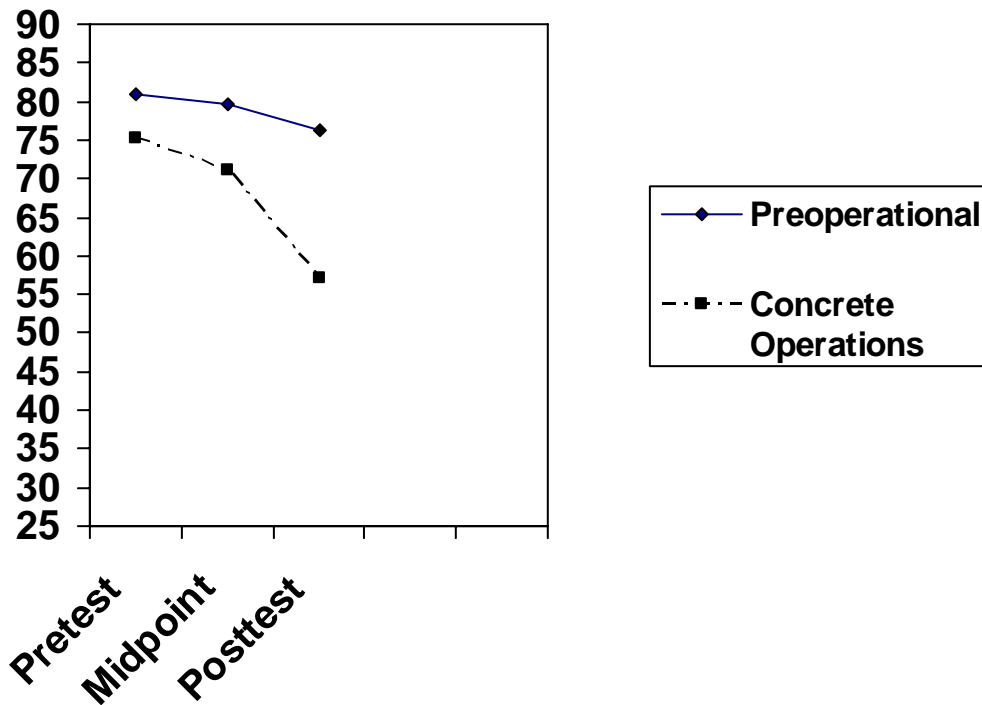


Figure 1. Impact of child-centered play therapy on children of preoperational versus concrete operations developmental stages as measured by the Child Domain of the Parenting Stress Index (PSI).

Child development theory again provides a possible explanation for the difference in the parent's perception of their child's behavioral problems. Piaget's (1962) recognized that as children move from preoperational to concrete operations development their play behavior shifts away from egocentric, symbolic play to socialized play. Piaget referred to the new play behavior that corresponds to concrete operations development as games with rules. Children's social play behavior parallels changes in their social development. Children in the concrete operations developmental stage experience increased social interest and their play behaviors begin to center around social activities and connecting with others.

Gesell's (1945) maturational development theory provides further assistance in the interpretations of these results. As children move into the concrete operations developmental stage, their ability to form and maintain relationships shifts. Gesell asserted that as children reach 7 or 8 years of age, the concrete operations developmental stage, they develop an increasingly good understanding of relationships (Ilg, 2005). At this stage children begin to develop a need for relationships and recognize that behaving in ways that please others increasingly strengthens their relationships. In the context of the parent-child relationship, children in the concrete operations developmental stage begin to understand that certain behaviors please their parents. Thus, parents may experience a decrease in feelings of stress associated with the parent-child relationship once their children reach the concrete operations developmental stage. Further, parents may begin to feel an increased sense of understanding their children's needs and emotions once they reach the concrete

operations developmental stage. This increased understanding is measured by subscales within the Parent Domain of the Parenting Stress Index.

The ability to develop and understand relationships is a developmental milestone that may be enhanced through the child-centered play therapy process. As children develop a relationship with their play therapist, this relationship may be transferable to other relationships in the child's life. During the concrete operations developmental stage, children have an increased ability to express themselves verbally (Piaget, 1962). This new verbal ability is more readily understood and accepted by adults than a child's nonverbal communication. Child-centered play therapy assists children in developing their verbal expression of feelings and sensitivity to relationships. Thus child-centered play therapy may seem more effective on a parent report outcome measure because the change may be more readily noticed by parents of children in the concrete operations development stage than children in the preoperational developmental stage

An additional explanation of these results rests in the research and principles of child-centered play therapy. Child-centered play therapy provides children a safe environment to freely express both positive and negative emotions (Landreth, 2002). Moustakas (1997) asserted that as children are able to freely express themselves positive emotions and more pleasing behaviors will follow. Child-centered play therapy provides children the opportunity to gain insight into their behaviors through the therapist's recognition and reflection of the child's feelings (Axline, 1969).

### *Parent Domain*

Children in the preoperational and concrete operations developmental stages

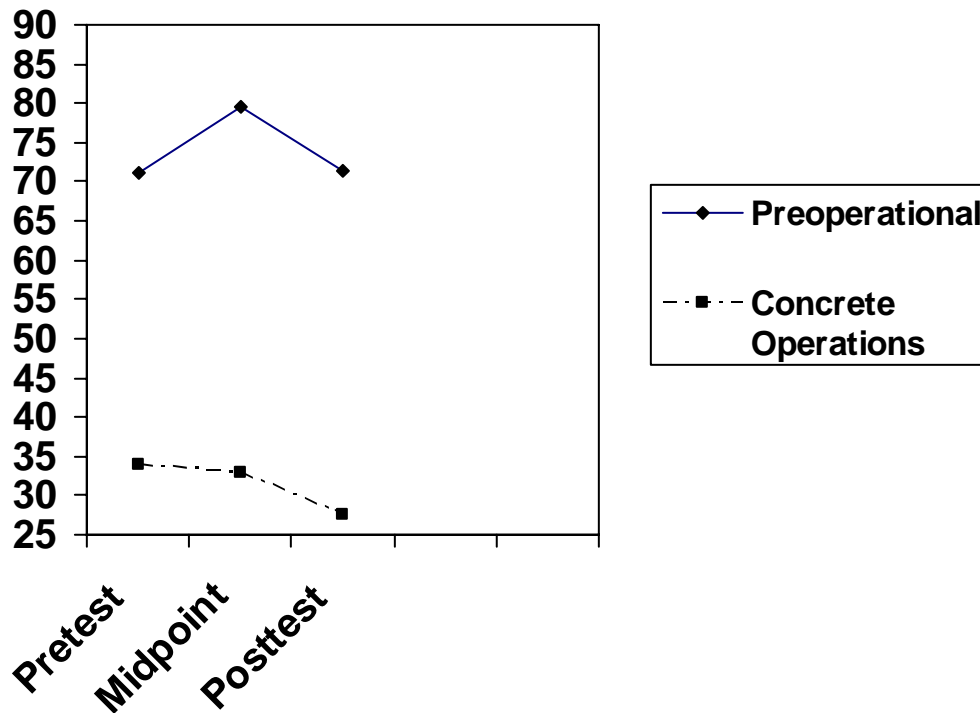
experienced differences in the effects of child-centered play therapy in decreasing parent-child relationship stress triggered by the parent's functioning, as measured by changes in mean scores on the Parent Domain of the Parenting Stress Index. While these differences were not statistically significant, results revealed practically significant differences in the decrease in parent-child relationship stress as measured by the Parent Domain of the PSI for children in the preoperational and concrete operations developmental stages after receiving 19-23 sessions of child-centered play therapy.

It is certainly noteworthy that parents of children in the concrete operations developmental stage experienced a practically significant decrease in scores on the Parent Domain while parents of children in the preoperational developmental stage did not experience any decrease in the Parent Domain scores. Previous research and an understanding of child development provide a solid basis for interpreting these results. Literature revealing a recursive relationship between child behavioral and emotional problems and parent stress suggests that as the Child Domain, associated with stress related to the child's behavior, decreases so will the Parent Domain, associated with stress resulting from parental functioning. Children in the concrete operations stage demonstrated significant decreases in stress related to the child's behavioral and emotional problems and also stress related to the parent's functioning. These results support the finding that there is a recursive relationship between child behavioral and emotional problems and parent stress. This has also been reported in previous research (Abidin, Jenkins, & McGaughey, 1992; Cornelius, 1987; Crnic & Greenbug, 1990; Hadadian & Merbler, 1996).

Figure 2 provides a visual depiction of the differences in the Parent Domain scores of the PSI for children in the preoperational versus concrete operations developmental stages. This graph illustrates a downward trend for children in both the preoperational and concrete operations developmental stages. Additionally, this graph shows that parents of children in the preoperational developmental stage reported higher levels of stress as measured by the Parent Domain of the PSI on each measurement occasion than did parents of children in the concrete operations developmental stage.

It is necessary to acknowledge that child-centered play therapy is an intervention for children and does not specifically address areas of parent's functioning as measured by the Parent Domain of the PSI. It may be necessary to refer the parent to counseling to achieve statistically significant decreases in stress resulting from the parent's functioning. It is noteworthy that while child-centered play therapy is an intervention aimed at addressing child behavioral and emotional problems, results of this study demonstrate a trend towards a decrease in parent-child relationship stress resulting from parent's functioning. Again, these results support previous literature identifying a recursive relationship between child behavioral and emotional problems and parent stress.

## Parent Domain Scores



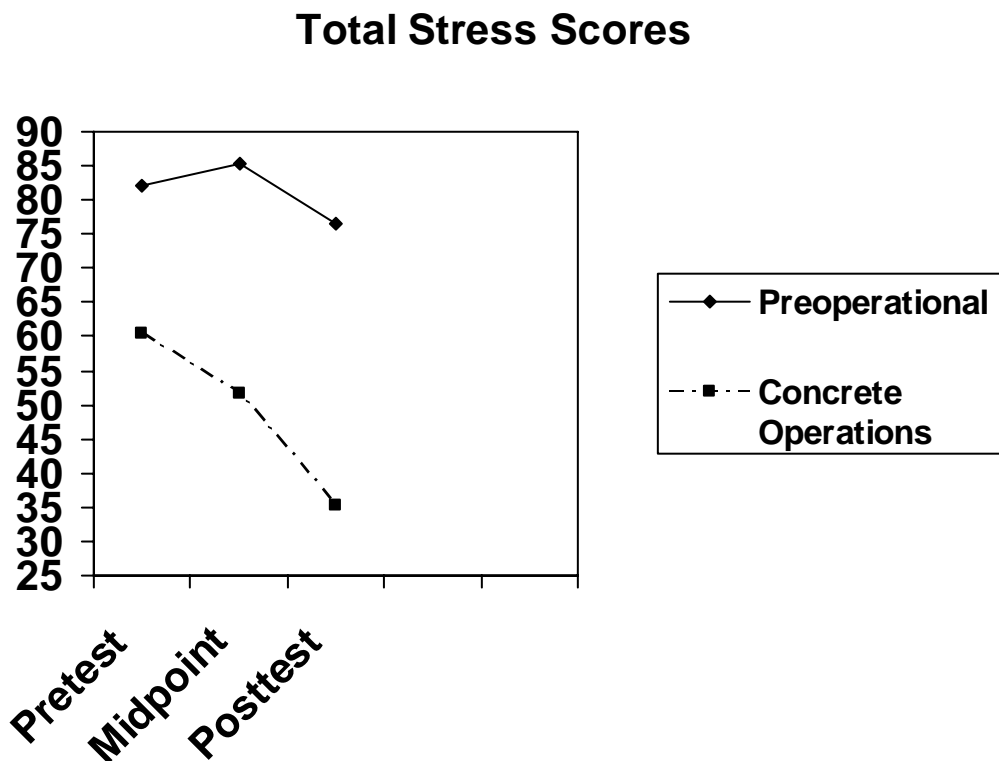
*Figure 2.* Impact of child-centered play therapy on children of preoperational versus concrete operations developmental stages as measured by the Parent Domain of the Parenting Stress Index (PSI).

### *Total Stress Score*

Children in the preoperational and concrete operations developmental stages experienced statistically and practically significant differences in the effects of child-centered play therapy in decreasing parent-child relationship stress, as measured by changes in mean scores on the Total Stress Score of the Parenting Stress Index. The Total Stress Score represents the underlying assumption of the Parenting Stress Index: “sources of stress are additive” (Abidin, 1995, p. 1). The Total Stress Score represents

stress in the parent-child relationship resulting from both the child's behavioral and emotional problems and the parent's functioning.

Figure 3 provides a visual depiction of the differences in the Total Stress Score of the PSI for children in the preoperational versus concrete operations developmental stages. This graph illustrates a downward trend for children in both the preoperational and concrete operations developmental stages. Consistent with the previously stated results of the Child and Parent Domains this graph shows that parents of children in the preoperational developmental stage reported higher levels of stress as measured by the Total Stress Score of the PSI on each measurement occasion than did parents of children in the concrete operations developmental stage.



*Figure 3.* Impact of child-centered play therapy on children of preoperational versus concrete operations developmental stages as measured by the Total Stress Score on the Parenting Stress Index (PSI).

## Implications

Previous research into play therapy indicates a stronger treatment effect for play therapy provided by a parent, filial therapy (ES 1.15), than play therapy provided by a mental health professional, (ES .72) (Bratton, et al., 2005). Child development literature again provides a rationale for this finding. The rationale is that children in the preoperational developmental stage have an interdependent relationship with their parents and this fact may necessitate an intervention with both parents and children. Perhaps this need for an intervention simultaneously engaging both parent and child provides a rationale for the lack of statistically significant decreases in parent-child relationship stress across the Child Domain, Parent Domain, and Total Stress Score of the Parenting Stress Index for children in the preoperational developmental stage. Abidin (1995) recommended that interventions focusing on children should be the primary treatment modality when high scores are reported on the Child Domain. Additionally, parents should be referred for professional intervention when high scores are reported on the Parent Domain. Several therapeutic interventions allow the opportunity for parents and children to be simultaneously engaged.

Child-centered play therapists can serve children while also engaging parents. McGuire and McGuire (2001) offer several recommendations for linking parents to play therapy. The play therapist's first goal is to listen to parents. During the initial therapeutic intake, play therapists are instructed to reflect parents' feelings, gather information, clarify parents' expressions by asking for examples of "aggressive behavior," and explain the process and goals of play therapy. While the child is the



child-centered play therapist's client, the therapist also has the role of parent supporter and educator (McGuire & McGuire, 2001).

It is suggested that play therapists maintain a relationship with parents throughout their therapeutic relationship with the child in the form of parent consultations. Parent consultations, in conjunction with the child's play therapy, afford the therapist the opportunity to offer homework assignments and provide additional parent education and support. McGuire and McGuire (2001) offered various homework assignments for parents including arranging a specific date with the child, a 30-second attention burst, and providing children notes, cards or phone calls indicating their parents are thinking of them. These homework assignments emphasize the importance of parents and children making a connection with one another.

Filial therapy is another therapeutic intervention that simultaneously engages both parents and children. Filial therapy is a parent education model designed to affect change in the parent-child relationship through play. Filial therapy was designed by Guerney (1964) to train parents and paraprofessionals in the principles of child-centered play therapy. Filial therapists train parents in the application of child-centered play therapy with their children and supervise parents 30 minute weekly play sessions with their children. This intervention is designed to strengthen the parent-child relationship through play. Filial therapists believe that parents are the most significant adults in their children's lives and as such parents can learn to conduct child-centered play therapy sessions with their child thus becoming the primary therapeutic agent with their child (VanFleet, 2005). Van Fleet (2005) identified three aims of Filial therapy: "(a) to eliminate the presenting problem, (b) develop positive interactions between parents and

their children, and (c) increase families' communication, coping, and problem-solving skills so they are better able to handle future problems independently and successfully" (p. 4).

While filial therapy may have led to statistically significant results for the children in the preoperational developmental stage, it should not be overlooked that this study revealed practically significant results for child-centered play therapy conducted by Master's and Doctoral counseling interns for children in the preoperational developmental stage. Further, results of 19-23 child-centered play therapy sessions with children in the concrete operations developmental stage led to statistically and practically significant decreases in child behavioral and emotional problems, stress in parents' functioning and overall parent-child relationship stress.

Further, results of this study indicate that when all children were analyzed together there were statistically significant decreases, at the .05 level of significance ( $F=8.19$ ,  $p= .00$ ), on the Child Domain of the PSI for all children in the study ( $n=24$ ) after receiving 19-23 sessions of child-centered play therapy. Additionally, an eta squared calculation of effect size revealed a very large practical significance ( $\eta^2=.19$ ).

Additionally, results reveal statistically significant decreases, at the .05 level of significance ( $F=8.86$ ,  $p= .00$ ), on the Total Stress Score of the PSI for all children in the study after receiving 19-23 child-centered play therapy sessions. Further, an eta squared calculation of effect size revealed a large practical significance ( $\eta^2=.10$ ).

Bratton et al's (2005) meta-analysis indicated that age was not a significant predictor of the outcome of play therapy, but suggested that the mean age of children benefiting from play therapy warranted further research. This study specifically

compared the results of play therapy for children of different ages and revealed differences in the effects of child-centered play therapy for children of different developmental stages. Had this design simply analyzed all children together (n=24) results would have revealed a statistically significant effect for child-centered play therapy in reducing parent-child relationship stress, but the developmentally differences would have gone unnoticed. Without comparing the children in this study according to developmental stage, the analysis would only have revealed statistically and practically significant results of play therapy for children with a mean age of 6.5 years. This study provided an analysis of the treatment effects of play therapy for children with a mean age of 4.5 years, the preoperational development treatment group, and children with a mean age of 7.5 years. Bratton et al.'s (2005) meta analysis reported that the average age of children in previous play therapy research was 7.0 years. This study provided analysis specifically addressing play therapy with young children.

### Limitations of the Study

Due to the use of archival data and other data collection factors, several limitations were presented. The following limitations are addressed for the reader's consideration when interpreting the data analysis.

1. The children participating in this study experienced a range in the number of sessions received at approximate midpoint, 8-12 sessions, and at posttest, 19-23 sessions. While these ranges are small, and Kramer and Theimann (1989) reported that the repeated measures design does not require equally spaced observations or

measurement occasions to meet the assumptions of the repeated measures design, a range of four sessions could have impacted the outcome of the analysis.

2. This study excluded children who received fewer than 19 Child-centered play therapy sessions. Thus, the children in this study may have only included children with more severe and persistent problems, thus requiring additional treatment beyond 19 sessions.

3. Secondly, the amount of play therapy training and experience of the counselors may differ as both Master's and Doctoral level counseling interns were included in this research.

4. No objective controls were available to ensure the treatment protocols of child-centered play therapy.

5. The difference in presenting problems reported by parents on the Child and Adolescent Background Information Form presents potential limitations to this research. While the repeated measures design controls for this limitation because each participant serves as their own control, this study did not evaluate the amount of variance in the results based on the child's presenting problem.

6. While repeated measures analysis provides the benefit of enabling researchers to find statistical significance with a small sample size, the sample size utilized in this study may initially lead readers to doubt the results.

7. The preoperational development treatment group encompassed a larger age range than the concrete operations development treatment group.

8. This study relied on age as a proxy for developmental stage.

9. This study did not include a diverse cultural or ethnic representation of the area in which the study was conducted.

### Recommendations for Future Research

The researcher has several recommendations for future research based on the results of this study. First, a replication of the study extending the length of sessions to 36 and an elimination of session ranges is recommended. Future researchers should conduct a pretest, approximate midpoint at 12 sessions, approximate midpoint at 24 sessions, and posttest at 36 sessions. This would allow for an additional measurement occasion providing 4 data points and would increase the statistical power of the repeated measures ANOVA (Kramer and Theimann, 1989). Additionally, the impetus for extending the study to include 36 sessions relates specifically to Bratton et al.'s (2005) meta-analysis, which stated that the effect of play therapy reaches its apogee at 35 sessions.

Additionally, a replication study including additional measurement instruments, specifically the Child Behavior Checklist, and incorporating a qualitative element in the form of a standardized parent interview at each administration of a standardized instrument is recommended. A future replication study would also be strengthened by utilizing additional measurement instruments to measure variables from the child's perspective thereby reducing the reliance on outside observation and the effects of rater bias. The addition of a parent interview would allow parents to provide a narrative explanation of their perception of changes in the parent-child relationship. This additional information could provide specific information addressing the clinical

significance of results. Any replication study should include treatment protocols to ensure consistency in the application of child-centered play therapy and should address the type and severity of presenting problems.

A follow-up study is recommended to determine whether treatment effects were maintained after termination for children in the concrete operations development treatment group. Further, a follow-up study for the preoperational group could provide information regarding whether additional time allowed for treatment effects to surface.

Finally, the researcher suggests conducting a study focusing on specific treatment interventions for the preoperational developmental stage. For example, future researchers may compare child-centered play therapy and Filial Therapy for this age group. A repeated measures design where the same children receive both interventions would allow for a direct comparison of the effects of these therapeutic interventions and would address the specific developmentally needs of children in this age group.

### Conclusion

Despite a growing awareness of the gap between the emotional, behavioral, and developmental needs young children and the availability of mental health services for young children, little empirical research exists citing effective therapeutic interventions specifically designed to serve them. Developmental theorists including Piaget (1962) have recognized that there are different developmental needs for children at different ages. This study highlighted differences in the cognitive, affective, and social development and corresponding play behaviors of children in the preoperational and concrete operations developmental stages. Piaget's assertions about the contributions

of play to cognitive, affective, and social development have provided a basis for the theoretical rationale for the use of play as a therapeutic intervention. Play therapy provides children an opportunity to work through emotional and behavioral issues using their natural form of self expression, play.

Previous research on play therapy has not specifically addressed the developmental nuances of children. For example, previous play therapy studies have combined children from ages ranging from 3 to 10 years of age without recognizing the distinct developmental stages spanning these 7 years of childhood. Literature addressing child development theory highlights the inherent problems in this design. Children's cognitive, affective and social development, corresponding play behaviors, and understanding of relationships is significantly varied at different ages and developmental stages.

This study investigated the impact of child-centered play therapy with children of the preoperational and concrete operations developmental stages. Results of the treatment effects were measured by a decrease in parent-child relationship stress as measured by the Child Domain, Parent Domain, and Total Stress Score on the Parenting Stress Index. A total of 24 children were included: 12 in the preoperational developmental stage, ages 3 to 6 years, and 12 in the concrete operations developmental stage, ages 7 and 8 years. Parents completed the Parenting Stress Index prior to children receiving treatment, after 8-12 sessions, and after 19-23 sessions of individual child-centered play therapy. These assessments provided the researcher three points of measurement.

A repeated measures ANOVA was utilized to determine whether the null hypotheses should be rejected. Results revealed a decrease in parent-child relationship stress resulting from children experiencing child-centered play therapy. Of the nine null hypotheses three were rejected at the .05 level of significance. Further, eight of the hypotheses revealed moderate to very large treatment effects for the children receiving individual child-centered play therapy.

An analysis of the results indicated that children in the preoperational and concrete operations developmental stages experienced differences in the impact of child-centered play therapy in decreasing parent-child relationship stress as measured by changes in mean scores on the Parenting Stress Index. Parents of children in the preoperational developmental stage reported more stress at each measurement occasion than did parents of children in the concrete operations developmental stage. Child development theory provides a possible explanation for the difference in the parent's perception of their child's behavioral problems.

Piaget (1962) recognized that as children move from preoperational to concrete operations development their play behavior shifts from egocentric, symbolic to a socialized form of play. Children in the concrete operations developmental stage experience increased social interest and their play behaviors begin to center around social activities and connecting with others. Gesell's (1945) maturational development theory further supports the ability of 7 and 8 year old children's ability to form and maintain relationships. The Parenting Stress Index is an instrument designed to assess levels of stress in the parent-child relationship. As a result, it is reasonable to assert that



parents of children who have an ability to form and maintain relationships would experience less stress.

While there were developmental differences in the impact of child-centered play therapy for children in the preoperational and concrete operations developmental stages, it is noteworthy that there were decreases in parent-child relationship stress for children in both developmental stages. Although not all of these decreases were statistically significant, results revealed moderate to very large practical significance. Further, when all children ( $n=24$ ) were analyzed together there were statistically and practically significant differences in parent-child relationship stress.

This study highlights the importance of a strong understanding of child development when identifying appropriate therapeutic interventions. In order to meet Landreth's (2002) charge that children should be understood from a developmental perspective, therapists need a practical understanding of development including children's cognitive, affective, and social development, and corresponding play behaviors. This study met its stated goal to examine the impact of child-centered play therapy with children at different developmental levels and found statistically and practically significant differences.

APPENDIX A

NOTICE OF PRIVACY PRACTICE AND INFORMED CONSENT

# NOTICE OF PRIVACY PRACTICE AND INFORMED CONSENT

**THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY.**

Welcome to the UNT Counseling Program Clinical Services (CPCS). The following notice is an introduction to your rights and responsibilities as a client at the clinic. The UNT CPCS serve dual functions: to provide counseling for the community and to aid in the professional development of counselors and supervisors. All counseling is facilitated by graduate students at the masters or doctoral level who are supervised by a counseling professor. Counseling sessions at the UNT CPCS are supervised and recorded.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. This notice also serves to obtain your consent for clinical policies and procedures. Please review it carefully.

The UNT CPCS is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about the privacy practices at a UNT Counseling Clinic, please contact Dr. Dee Ray, (940) 565-2066.

Effective April 14, 2003:

## **I. How We Protect Your Health Information**

We protect your health information by:

- ❖ Treating all of your health information that we collect as confidential.
- ❖ Stating confidentiality policies and practices in our clinic staff handbooks, as well as disciplinary measures for privacy violations.
- ❖ Restricting access to your health information only to those clinical staff that need to know your health information in order to provide our services to you.
- ❖ Maintaining physical, electronic, and procedural safeguards to comply with federal and state regulations guarding your health information.

## **II. Conditions That Require Release of Health Information**

The UNT CPCS maintains records of client health information in a confidential file system. The client files remain the property of the UNT CPCS but the information belongs to you. The UNT CPCS protects the privacy of your health information.

## **Uses and Disclosures Requiring Authorization**

The UNT CPCS may use or disclose mental health information outside treatment or healthcare operations when your appropriate authorization is obtained. An authorization is written permission above and beyond the general consent that permits only specific disclosures. In those instances when the UNT CPCS are asked for your private information, we will obtain a written authorization from you before releasing this information. You may revoke such authorizations at any time provided each revocation is in writing.

### **Uses And Disclosures With Neither Consent Nor Authorization**

The UNT CPCS may use or disclose your mental health information without your consent or authorization in the following circumstances:

- ❖ Abuse – If we have reason to believe that a minor child, elderly person, or person with a disability has been abused, abandoned, or neglected, the UNT CPCS must report this concern or observations related to these conditions or circumstances to the appropriate authorities.
- ❖ Health Oversight Activities – If the Texas State Board of Examiners of Professional Counselors is investigating a clinician that you have filed a formal complaint against, the clinic may be required to disclose protected health information regarding your case.
- ❖ Judicial and Administrative Proceedings as Required – If you are involved in a court proceeding and a court subpoenas information about the professional services provided you and/or the records thereof, we may be compelled to provide the information. Although courts have recognized a clinician-client privilege, there may be circumstances in which a court would order the clinic to disclose personal health or treatment information. The UNT CPCS will not release your information without attempting to notify you or your legally appointed representative.
- ❖ Professional Harm – If you disclose sexual contact with another mental health professional with whom you have had a professional relationship, we are required to report this violation to the licensing board. You have the right to anonymity in the filing of the report.
- ❖ Serious Threat To Health or Safety – If you communicate to clinic personnel an explicit threat of imminent serious physical harm to yourself or others and we believe you may act on that threat, we have a legal duty to take the appropriate measures, including disclosing information to the police. In both cases, we will disclose only what we feel is the minimal amount of information necessary.
- ❖ National Security – We may be required to disclose to military authorities the health information of armed forces personnel under certain circumstances. We may be required to disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may be required to disclose mental health information to a correctional institution or law enforcement official having lawful custody of protected mental health information of an inmate or client under certain circumstances.
- ❖ Research and Training: Because the UNT CPCS serves to train counselors, client mental health information is used for research and training purposes. Recorded sessions may be used for the education of counseling students. In this case, personal identifying information is protected. Any research conducted at the UNT CPCS is subject to an institutional review board that serves to safeguard your privacy and health.

### **III. Client's Rights and Counselor's Duties**

- ❖ Rights to Request Restrictions - You have the right to request additional restrictions on certain uses and disclosures of protected health information. The clinic may not be able to accept your request, but if we do, we will uphold the restriction unless it is an emergency.
- ❖ Right to Receive Confidential Communications by Alternative Means and at Alternative Locations – You have the right to request and receive confidential communications of mental health information by alternative means and at alternative locations. (For example, you may not want a family member to know you are being seen at the clinic. On your request, the clinic will send your information to another address.)
- ❖ Right to Inspect and Copy – You have the right to inspect or obtain a copy of your clinical records. A reasonable fee may be charged for copying. Access to your records may be limited or denied under certain circumstances, but in most cases, you have a right to request a review of that decision. On your request, we will discuss with you the details of the request and denial process.
- ❖ Right to Amend – You have the right to request in writing an amendment of your health information for as long as the mental health information records are maintained. The request must identify which information is incorrect and include an explanation of why you think it should be amended. If the request is denied, a written explanation stating why will be provided to you. You may also make a statement disagreeing with the denial, which will be added to the information of the original request. If your original request is approved, we will make a reasonable effort to include the amended information in future disclosures. Amending a record does not mean that any portion of your health information will be deleted.
- ❖ Right to an Accounting – You generally have the right to receive an accounting of disclosures of mental health information. If your mental health information is disclosed for any reason other than treatment or health operations, you have the right to an accounting for each disclosure of the previous six (6) years, but

the request cannot include dates before April 14, 2003. The accounting will include the date, name of person, or entity, description of the information disclosed the reason for disclosure, and other applicable information. If more than one (1) accounting is requested in a twelve (12) month period, a reasonable fee may be charged.

- ❖ Electronic Information – The UNT CPCS does not allow the distribution of client information through electronic means. Requests for client mental health information are honored through phone and postal mail communication only.

#### **IV. UNT CPCS Duties:**

- ❖ The UNT CPCS is required by law to maintain the privacy of mental health information and to provide you with a notice of legal duties and privacy practices.
- ❖ The clinic and university reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, the clinic is required to abide by the terms currently in effect.

#### **V. UNT CPCS Procedures:**

- ❖ The clinic operates only during limited hours that do not include overnights, weekends, or university holidays and breaks. Counseling sessions are limited to pre-arranged times set between the counselor and client.
- ❖ The benefits you receive from counseling depend upon your attendance. Therefore, if you are absent two weeks in a row, your name will be placed at the end of the clinic's waiting list.
- ❖ If you wish to reach your counselor between sessions, you may leave messages with the clinic secretary who will contact the counselor. If you experience mental health crisis, you will need to obtain clinical services from the list provided to you of crisis telephone numbers or by going to a nearby hospital emergency room.
- ❖ The clinic operates according to a fee schedule. You will be assigned a fee based on your financial situation and will be expected to pay for services at the end of each counseling session. If your fee represents a hardship for you, please notify your counselor who will work with you to possibly modify your fee. The counseling UNT CPCS do not file for reimbursement from health insurance companies.
- ❖ In case of secrets revealed during family or couple counseling, information will be kept confidential without another family member's knowledge (unless it involves one or more of the exceptions mentioned under the *Uses and Disclosure With Neither Consent Nor Authorization*). However, open communication is encouraged among family members and couples, and counseling will be terminated if secrets are judged to be detrimental to therapeutic progress. By signing this Informed Consent, clients involved in couple and family counseling consent for one file to be maintained for all joint sessions which any family/couple member may access or obtain copies of at any time.
- ❖ The clinic reserves the right to postpone or terminate counseling with you in any of the following circumstances: a) if you come to session under the influence of drugs or alcohol; b) if you do not comply with the medication recommendations of your psychiatrist or physician; c) if your counselor believes that you are not benefiting from counseling; d) if your counselor is impaired in providing competent counseling to you; e) if in couple counseling, your counselor learns that you are abusing your partner. In the case of group counseling, group entry may be denied to anyone considered inappropriate for the group or termination may be enacted for anyone whose behavior is considered detrimental to the group.

#### **Other Restrictions:**

- ❖ The UNT CPCS must also conform to Federal Regulations (42CFR,Part 2) regarding the release of alcohol/drug treatment records and confidentiality standards related to such treatment.

#### **VI. Changes to this Notice**

The UNT CPCS and the university reserve the right to change our privacy practices and terms of this notice at any time, as permitted by applicable law. We reserve the right to make the changes in our privacy practices and new terms of our notice effective for all mental health information that we maintain, including mental health information we created or received before we made the changes. Before we make such changes, we will update this notice and post the changes in the waiting room of the facility. You may request a copy of the notice at any time.

#### **VII. Questions and Complaints**

For questions regarding this notice or our privacy practices, please contact the UNT CPCS Privacy Officer, Dr. Dee Ray.

If you are concerned that your privacy rights may have been violated, you may contact the person listed below to make a complaint. You may also make a written complaint to the U.S. Department of Health and Human Services whose address can be provided upon request.

If you choose to make a complaint with us or the Texas Department of Health and Human Services, we will not retaliate in any way.

Dee Ray, Ph.D., LPC, NCC, RPT-S  
Director, Child and Family Resource Clinic  
University of North Texas  
P.O. Box 310829  
Denton, TX 76203  
(940) 565-2066

APPENDIX B  
CONFIRMATION OF RECEIPT OF NOTICE OF PRIVACY  
AND INFORMED CONSENT

### Confirmation of Receipt of Privacy Notice and Informed Consent

By your signature below, you are indicating 1) that you have received a copy of the *Notice of Privacy and Informed Consent*; 2) that you voluntarily agree to receive mental health assessment and medical health care, treatment, or services, and that you authorize the clinic to provide such services as considered necessary and advisable; 3) that you understand and agree that you will participate in the planning of your care, treatment, or services, and that you may at any time stop such services received through the clinic; 4) that you have read and understand this statement and have had ample opportunity to ask questions about, and seek clarification of, anything unclear to you.

**Release for Liability and Hold Harmless Provisions:** By signing this document, you are releasing the clinic and holding the clinic harmless from any personal liability that arises from departure from your right of confidentiality.

By my signature, I verify the accuracy of *Notice of Privacy and Informed Consent* and acknowledge my commitment to conform to its specifications.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Counselor Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

If the client is a minor, the legal guardian (managing conservator) must sign the statement below:

The UNT Counseling Program Clinical Services requires documentation of conservatorship/guardianship. If your conservatorship/guardianship is established by a divorce decree or custody document, you are required to furnish the clinic with a photocopy of the cause page (first page calling out the case), the page specifying conservator(s), and the signature page from the decree or document, before clinical services can begin.

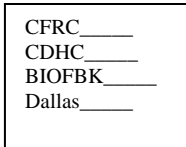
With your signature below, you affirm that you are the legal guardian (managing conservator) of \_\_\_\_\_ (minor's name). With an understanding of the above requirements, you grant permission for your child to participate in counseling and release the counselor and the UNT Counseling Program Clinical Services from liability for same, as stated in the *Release from Liability and Hold Harmless* provisions above.

\_\_\_\_\_  
Managing Conservator's Signature

\_\_\_\_\_  
Date



APPENDIX C  
CHILD/ADOLESCENT BACKGROUND INFORMATION FORM



University of North Texas
Department of Counseling, Development & Higher Education
Counseling Program Clinical Services

Child/Adolescent Background Information Form (use for all minors)

Welcome to the Child and Family Resource Clinic. Please answer all information as completely as possible. If applicable, both mother and father should complete together. Information given is strictly confidential and beneficial in providing the best possible service. Feel free to ask for assistance, if needed. Your child's counselor will discuss your responses with you after he/she has reviewed the form.

Child's Name: Last First MI Date of First Visit

Completed by: Relationship to Child:

Home Phone: (May call: Yes No May Leave Message: Yes No )

Work Phone: (May call: Yes No May Leave Message: Yes No )

Best Time and Place to call:

Child's Address:

Street City State Zip

Child's Gender: Male Female Date of Birth Age SS#

Child's Ethnicity:

Africa American Bi-racial Hispanic/Latin Asian Caucasian Native American Other

Child's primary language: English Spanish Other

Language spoken at home (parent's language)

Child's Legal Guardian (Managing Conservator):

(If the child is not living with both natural parents, both adoptive parents, or only living parent, the clinic requires a photocopy of the legal document stating custody arrangements, consisting of the cover page, page specifying conservator(s), and signature page). (The photocopy should be stapled to this form.)

In case of emergency, contact:

Name: Last, First Relationship Phone

Is your child presently receiving counseling elsewhere? Yes No (If yes, do not complete this form until you have talked with your counselor)

Family members receiving services at this clinic Yes No (Name/Dates of service)

Is your child currently on probation? Yes No

School Child attends:

Current School Address & Phone

Grade Level (now): \_\_\_\_\_  
Has your child ever been retained? Yes No  
If yes, what grade \_\_\_\_\_  
Current Teacher(s): 1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_

Current School Counselor: \_\_\_\_\_

Is your child receiving special education or other services? Yes No  
(explain) \_\_\_\_\_

Has your child ever seen a mental health professional (psychiatrist, psychologist, or a counselor)? Yes No (If so, we will need your permission in order to communicate with that individual or agency)

Previous Mental Health Professional/Agency \_\_\_\_\_ Name \_\_\_\_\_ Address \_\_\_\_\_  
Phone \_\_\_\_\_ Dates of Service \_\_\_\_\_ (beginning - ending)

Has your child been hospitalized for mental health concerns? Yes No  
If yes: When \_\_\_\_\_  
Where \_\_\_\_\_

How were you referred to our clinic? (Check those that apply):  
Counselor/Psychologist/Psychiatrist\_\_ School personnel\_\_  
Court\_\_ Minister\_\_ Self\_\_  
DPRS\_\_ Newspaper Ad\_\_ UNT Community\_\_  
Flyer\_\_ Physician\_\_ Yellow Pages\_\_  
Friend or Co-Worker\_\_ Relative\_\_ Other\_\_

Are you seeking services because your child is a victim of a crime? Yes No

Did it result in legal action? Yes No (If Yes, explain) \_\_\_\_\_

Person responsible for financial arrangements with our clinic:

\_\_\_\_\_  
Name: Last, First

Are you applying for sliding scale payments? Yes No

Gross Household Annual Income and Child Support Received  
\_\_\_ Less than \$15,000 \_\_\_ 20,001 - 22,000 \_\_\_ 26,001 - 28,000 \_\_\_ 34,001 - 39,000  
\_\_\_ 15,001 - 18,000 \_\_\_ 22,001 - 24,000 \_\_\_ 28,001 - 31,000 \_\_\_ 39,001 - 40,000  
\_\_\_ 18,001 - 20,000 \_\_\_ 24,001 - 26,000 \_\_\_ 31,001 - 34,000

How many family members currently reside in your home? \_\_\_\_\_





Mother only \_\_\_\_

Other \_\_\_\_\_

List by Household your child's current family, beginning with the oldest member and include the child:

**Primary Household** (anyone who currently lives with child)

**How long in this current living situation:** \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_ Relationship to you (include step, half, etc.)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Child lives in:** House \_\_\_\_\_ Apartment \_\_\_\_\_ Duplex \_\_\_\_\_  
Other \_\_\_\_\_

**Second Household** (non-custodial or extended family - if applicable)

Name \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_ Relationship to you (include step, half, etc.)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Currently involved in a custody dispute: No Yes (If yes, explain)

\_\_\_\_\_

If divorced, circle the number which best describes your relationship with your ex-spouse.

Hostile Frustrating Friendly  
1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_ 4 \_\_\_\_\_ 5

How often does client see non-custodial parent? \_\_\_\_\_

**\* CHILD'S HEALTH \***

*Child's Primary Care Physician:*

Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

*Has your child ever seen a psychiatrist? Yes No*

Is child currently seeing a psychiatrist? Yes No (If yes, list name, address and phone):

\_\_\_\_\_  
Name Phone

\_\_\_\_\_  
Address

Date of LAST complete physical \_\_\_\_\_

Physical Disability: Yes No (If yes, explain)

\_\_\_\_\_

Chronic Illness: Yes No (If yes, explain)

\_\_\_\_\_

Terminal Illness: Yes No (If yes, explain)

\_\_\_\_\_

Check the following items for a diagnosis or medication that your child is now receiving or has received:

Diagnosis Current Dosage	Past	Date of Diagnosis	Name of medication
Depression _____	_____	_____	_____
ADHD _____	_____	_____	_____
ADD _____	_____	_____	_____
Conduct Disorder _____	_____	_____	_____
Learning Disability _____	_____	_____	_____
Anxiety/ Nervousness _____	_____	_____	_____
Panic Attack _____	_____	_____	_____
Manic-Depression (Bipolar) _____	_____	_____	_____
Schizophrenia _____	_____	_____	_____
Oppositional Defiant Disorder _____	_____	_____	_____
Mood/Anger _____	_____	_____	_____
Tics _____	_____	_____	_____
Insomnia/ Sleeplessness _____	_____	_____	_____
Obsessive/ Compulsive _____	_____	_____	_____
Addictions _____	_____	_____	_____
Convulsions _____	_____	_____	_____

Post-Traumatic \_\_\_\_\_  
Stress Disorder \_\_\_\_\_

Other \_\_\_\_\_

(If you do not know the name and dosage of current medication, please bring the medication to your next session)

*If your child has been diagnosed, who gave the diagnosis?*

Counselor/Psychologist\_\_\_ Family Physician\_\_\_ Psychiatrist\_\_\_ School\_\_\_ Other\_\_\_\_\_

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

*What other medication is your child currently taking?*

Medication \_\_\_\_\_ Dosage \_\_\_\_\_ Taken for what reason? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**\* CURRENT CONCERNS \***

**Indicate severity of up to 10 items that currently apply to your child. (1-mild; 2-moderate; 3-severe) Circle the item that you see as the most significant issue**

- \_\_\_ Abuse (physical, emotional, sexual)
- \_\_\_ Adjustment to life changes (changing schools, parents divorcing, moving, getting married or divorced, etc.)
- \_\_\_ Bed wetting daytime wetting, soiling or related problems
- \_\_\_ Career Decisions
- \_\_\_ Disturbing memories (past abuse, neglect or other traumatic experience)
- \_\_\_ Drug or alcohol use (both legal and illegal drugs)
- \_\_\_ Eating problem (purging, bingeing, overeating, hoarding, severely restricting diet)
- \_\_\_ Family or Stepfamily relationship problems
- \_\_\_ Feeling angry or irritable
- \_\_\_ Feeling anxious (nervous, clingy, fearful, worried, panicky, obsessive-compulsive, lacking trust, etc.)
- \_\_\_ Feeling guilty or shameful
- \_\_\_ Feeling sadness or depression NOT related to grief
- \_\_\_ Feeling sadness or depression related to grief
- \_\_\_ Gang related concerns (explain) \_\_\_\_\_
- \_\_\_ Health concerns (physical complaints and/or medical problems)
- \_\_\_ Illegal behaviors (runaway, stealing, fire setting, truancy, etc.)
- \_\_\_ Learning/Academic difficulties
- \_\_\_ Non-family relationship problems (teachers, peers, etc.)
- \_\_\_ Parent-Child relationship (discipline, adoption, single parent, etc.)
- \_\_\_ Personal Growth (no specific problem)
- \_\_\_ Religious or Spiritual concerns
- \_\_\_ Sexual concerns (excessive masturbation, inappropriate acting out)
- \_\_\_ Sexual identity concern
- \_\_\_ Sleep problem (nightmares, sleeping too much or too little, etc.)
- \_\_\_ Speech problem (not talking, stuttering, etc.)
- \_\_\_ Suicidal Ideation (thoughts of death, wanting to die)
- \_\_\_ Unusual behavior (bizarre actions, speech, compulsive behavior, tics, motor behavior problems, etc.)
- \_\_\_ Unusual experiences (loss of periods of time, sensing unreal things, etc.)
- \_\_\_ Other (explain) \_\_\_\_\_

**\*Remember to circle the most significant issue.**

**When did you first become concerned about this issue?**

\_\_\_\_\_

*How have you attempted before now to deal with this issue?*

\_\_\_\_\_



Other treatment your child has received to address any of the concerns indicated above:

None\_\_\_\_  
Couples Counseling\_\_\_\_ Group counseling\_\_\_\_ Individual counseling\_\_\_\_  
Family counseling\_\_\_\_ Hospitalization\_\_\_\_ Other \_\_\_\_\_

What do you enjoy most about this child?

\_\_\_\_\_

What do you find most difficult about this child?

\_\_\_\_\_

Anything else you think we need to know?

\_\_\_\_\_

What is the one thing I need to know to help your child today?

\_\_\_\_\_

**\* FAMILY HISTORY/EXPERIENCES \***

(For each of the following items that apply, write in your child's approximate age at the time it occurred):

*Raised by:*

Adoptive parent(s)\_\_\_\_ Institution\_\_\_\_ Relatives\_\_\_\_  
Foster parents\_\_\_\_ Natural parents\_\_\_\_ Single natural parent\_\_\_\_  
Grandparents\_\_\_\_ Natural and step-parent\_\_\_\_ Other \_\_\_\_\_

*Stressors in the Family:*

Chronic illness of family member\_\_\_\_ Death of significant person\_\_\_\_ Domestic  
Violence\_\_\_\_

Family member absent

(explain)\_\_\_\_\_

Family member's disability/major accident/illness\_\_\_\_

Family member emotional problems (explain)\_\_\_\_\_

Family member suicide (explain)\_\_\_\_\_

Financial problems\_\_\_\_ Moved a lot\_\_\_\_ Parents arguing frequently\_\_\_\_

Parents divorced\_\_\_\_ Other \_\_\_\_\_

*History of your child having learning, emotional, behavioral problems:* Yes No  
(If yes, please explain)

\_\_\_\_\_

*History of your child having alcohol/drug/substance abuse:* Yes No  
(If yes, please explain)

\_\_\_\_\_

*History of family violence:* Yes No  
(If yes, please explain)

\_\_\_\_\_

*History of criminal activity in the family:* Yes No  
(If yes, please explain)

\_\_\_\_\_

*Has your child been abused* (check all that apply): Physically\_\_\_\_ Emotionally\_\_\_\_  
Sexually\_\_\_\_

*Has your child been neglected* (check all that apply): Physically\_\_\_\_ Emotionally\_\_\_\_

**School Problems** (check all that apply):  
 Academic problems \_\_\_ Discipline problems \_\_\_ Severely teased \_\_\_ Unpopular \_\_\_  
 Other \_\_\_\_\_

**Early Language/Speech Problems** (explain) \_\_\_\_\_

**History of emotional concerns include:**

Appetite change \_\_\_ Heard voices \_\_\_ Suicidal thoughts \_\_\_  
 Emotional problems \_\_\_ Loss of energy or fatigue \_\_\_ Suicide attempts \_\_\_  
 Gained weight \_\_\_ Lost weight \_\_\_ Other \_\_\_\_\_

\_\_\_\_\_

**History of behavior problems includes:** (check all that apply):

Accident-prone \_\_\_ Aggressive Behavior (explain) \_\_\_\_\_  
 Alcohol/drug use \_\_\_ Attention problems \_\_\_ Frequent arguments \_\_\_  
 Hyperactive \_\_\_ Impulsive \_\_\_ Loner \_\_\_  
 Misbehaved a lot \_\_\_ Ran away \_\_\_ Taken advantage of \_\_\_  
 Temper outbursts \_\_\_ Trouble with the law \_\_\_ Other \_\_\_\_\_

**History of anxiety symptoms includes:** (indicate all that apply):

Irritable \_\_\_ Obsessive worrying \_\_\_ Physical symptoms \_\_\_\_\_  
 Keyed up, on edge \_\_\_ Phobias \_\_\_ Other \_\_\_\_\_

**History of health/physical problems includes:** (check all that apply):

Asthma \_\_\_ Disability \_\_\_ Nervous stomach \_\_\_  
 Bedwetting \_\_\_ Dizziness \_\_\_ Neurological problems/exam \_\_\_  
 Bone/joint/muscle \_\_\_ Headache (kind) \_\_\_ PMS \_\_\_  
 Chest pain \_\_\_ Heart Palpitations \_\_\_ Serious overeating/undereating \_\_\_  
 Chronic illness \_\_\_ Hospitalization \_\_\_ Shortness of breath w/o exertion \_\_\_  
 Developmental delay(s) \_\_\_ Major accident \_\_\_ Sleep problem \_\_\_  
 Diarrhea \_\_\_ Major illness \_\_\_ Surgeries \_\_\_  
 Other \_\_\_\_\_

**History of trauma/stressor includes:** (check all that apply):

Child separated from parent (how long and when) \_\_\_\_\_  
 Death of a pet \_\_\_ Death of a significant person \_\_\_  
 Incarcerated family member \_\_\_ Medical \_\_\_ Natural Disaster \_\_\_ Sexual Assault \_\_\_  
 Victim of trauma (unusual, terrifying experience) \_\_\_ Other \_\_\_\_\_

**History of interpersonal problems includes:** (check all that apply):

Aggressive behavior (explain) \_\_\_\_\_  
 Bullied \_\_\_ Taken advantage of \_\_\_  
 Frequent arguments \_\_\_ Temper outbursts \_\_\_  
 Loner \_\_\_ Other \_\_\_\_\_

**Family Atmosphere** (circle the number that best describes how you view your child's current family atmosphere)

Very lenient	1	2	3	4	5	Very strict
Very non-religious	1	2	3	4	5	Very religious
Chaotic	1	2	3	4	5	Highly structured
Few expectations	1	2	3	4	5	High expectations
Inconsistent	1	2	3	4	5	Consistent

**Family Support System** (such as church, friends, relatives, school)

Hardly any support      1    2    3    4    5      Considerable support

*Your child's current use of Computer, VCR, and Television* (circle the number of hours that best describes use):

Computer (circle approximate hours spent each week)

0-2    3-5    6-8    9-11    12+

TV/VCR (circle approximate hours spent each week)

0-2    3-5    6-8    9-11    12+

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