International Journal of Play Therapy
2017, Vol. 26, No. 1, 33–46

1555-6824/17/$12.00 http://dx.doi.org/10.1037/pla0000035

Intensive Short-Term Child-Centered Play Therapy and Externalizing Behaviors in Children

Rochelle M. Ritzi and Dee C. Ray
University of North Texas

Brandy R. Schumann
Southern Methodist University

This study examined the effectiveness of intensive child-centered play therapy with children identified as having disruptive behaviors. Participants were recruited from public schools in the urban area of Darwin, Northern Territory, Australia area. A total of 24 participants completed the study: 18 boys and 6 girls aged 6 to 9 years old ($M = 7$); 17 Australian Caucasians, 1 English (U.K.) Caucasian, 1 Asian, 3 Hispanic/Latino, and 2 Biracial. Participants were randomly assigned: 12 to the experimental group and 12 to the waitlist control group. Children in the experimental group received 20 intensive Child-centered play therapy (CCPT) sessions: twice daily for 10 days. For each child participant, a parent completed the Child Behavior Checklist (CBCL) and a teacher completed the CBCL Teacher's Report Form (TRF) 3 times: at pretest, posttest, and 1-week follow-up. Results of factorial ANOVAs indicated a statistically significant interaction effect on CBCL Externalizing score, $F(2, 44) = 14.747$, $p < .001$, with a large effect size of $\eta^2 = .277$. Results also indicated a statistically significant interaction effect on the TRF Externalizing score, $F(2, 44) = 4.042$, $p = .024$, with a large effect size of $\eta^2 = .135$. Therefore, both parents and teachers indicated that children with externalizing behaviors who received intensive CCPT showed a significant decrease in those behaviors.

Keywords: Australia, child-centered play therapy, child therapy, externalizing problems, play therapy

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

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

This article was published Online First October 27, 2016.
Rochelle M. Ritzi and Dee C. Ray, Department of Counseling and Higher Education, University of North Texas; Brandy R. Schumann, Department of Dispute Resolution and Counseling, Southern Methodist University.

Correspondence concerning this article should be addressed to Rochelle M. Ritzi, 114 East Louisiana Street, Suite 201, McKinney, TX 75069. E-mail: rochelle@tots.pro

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

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

Child-Centered Play Therapy

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

CCPT originated from the philosophy of Carl Rogers' person-centered therapy (1951). According to Rogers (1980), individuals innately have the internal resources they need for growth and to reach their potential. He viewed individuals as the best authority on their experiences and fully capable of fulfilling their own potential for growth when presented with a facilitative environment (Rogers, 1951). Moreover, he stated that under adverse conditions, individuals will not grow and develop in healthy ways (Rogers, 1951, 1980).

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

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

Externalizing Behaviors and CCPT

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

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

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

CCPT Session Structure

Historically, CCPT is delivered in a once-per-week structure (Landreth, 2012). Yet, several studies over the decades have modified the once-per-week format to adjust to specific settings. Kot, Landreth, and Giordano (1998) examined the effectiveness of intensive CCPT provided in the setting of a domestic violence shelter with children who witnessed domestic violence. Because of the nature of the setting and mobility of residents, Kot et al. provided CCPT daily sessions for two weeks. The results indicated that children in the experimental group experienced significant improvement. When Jones and Landreth (2002) examined the effectiveness of CCPT in an intensive format at a summer camp for children diagnosed with diabetes, they provided 12 sessions of play therapy within three weeks as compared with children who did not receive CCPT at the camp. Jones and Landreth found significant effectiveness of the treatment on anxiety and depression; however, there was no statistical difference between the experimental and control group concerning behavior problems. Still, the results indicated an intensive format was effective in diabetes treatment compliance. Recent research conducted in school settings has utilized a twice-per-week format to address the limitations of the setting (e.g., Bratton et al., 2013; Stulmaker & Ray, 2015), finding that the more intensive twice-per-week format has led to statistically significant improvement.

Nordling and Guerney (1999) were the first to compare a twice-weekly session structure with a once-weekly session structure to examine the typical stages in CCPT. They concluded that the twice-weekly session frequency, as opposed to the more common once per week model, replicated the progress made in the same number of sessions delivered weekly, demonstrating that intense levels of therapeutic relational support facilitate children to respond with intense levels of change. Alternately, Muro, Ray, Schottelkorb, Smith, and Blanco (2006) explored long-term CCPT intervention in which they utilized a twice-per-week format for eight weeks followed by a once-per-week format for 16 weeks. Using child problem behaviors and teacher child relationship stress as outcomes, Muro et al. found that participants made steady increases to a statistically significant degree over the whole course of therapy with little difference noticed between the two formats. However, the focus of Muro et al.'s study was on overall impact of play therapy and no detailed analysis was conducted to compare the different formats.

Building on their previous research, Ray, Henson, Schottelkorb, Brown, and Muro (2008) explored the effect of both short- and long-term CCPT on teacher–student relationship stress. Children in the short-term intensive play therapy group participated in twice-weekly play therapy over eight weeks, and the children in the long-term play therapy group participated in 16 sessions over 16 weeks. The results demonstrated that both groups showed significant improvement in teacher–student relationship stress from pre to posttest, leading authors to conclude

that the two different formats were equally effective. Because of mixed results of studies using intensive formats, there is a lack of evidence regarding their effectiveness.

Purpose

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

Method

Participants

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

To participate in this study, children had to meet the following criteria: (a) were between the ages of 6 and 9 years old; (b) described as demonstrating high levels of problematic externalizing behaviors by one or more caregivers; (c) identified as having borderline or clinical levels of externalizing behaviors according to the Child Behavior Checklist–Parent Report (CBCL) or the Teacher Report Form (TRF) assessment measure; (d) spoke English; (e) had parental or guardian consent; (f) parent or guardian agreed to complete pre, post, and follow-up assessments; (g) child's teacher agreed to complete pre, post, and follow assessments; (h) child assented to participate; and (i) did not receive play therapy or other counseling services anywhere else during the duration on the study.

Instrumentation

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

According to the manual (Achenbach & Rescorla, 2001), the normative population for the CBCL was based on a diverse sample, which included children referred for clinical and special education services, as well as children attending diverse childcare and school settings. The children of the normative sample were residents of the United States, Canada, Australia, and Jamaica (2001). The test–retest reliability of the CBCL is strong ($r = .85$). The test–retest reliability coefficients for the syndrome subscales of the CBCL are: (a) Anxious/Depressed, $r = .68$; (b) Withdrawn, $r = .80$; (c) Somatic Complaints, $r = .84$; (d) Attention Problems, $r = .78$; (e) Rule Breaking Behavior, $r = .85$; (f) Aggressive Behavior, $r = .87$; (g) Internal-

izing Problems, $r = .90$; (h) Externalizing, $r = .87$; and (i) Total Problems, $r = .85$ (Achenbach & Rescorla, 2001). The content validity of the problems scales is strong and supported by research. Achenbach and Rescorla reported that the criterion-related validity of the problem scales has been supported by the instrument's capability to differentiate between referred and nonreferred children.

Teacher Report Form. The TRF was used to measure Externalizing Problems and was administered to the study participants' teachers at pre, post, and follow-up data collection points. The TRF is a teacher report instrument used to assess children's academic performance, adaptive functioning, and behavioral and emotional functioning (Achenbach & Rescorla, 2001). The TRF form is for use with children between the ages 6 and 18 years. It is a self-administered instrument and takes approximately 20 min to complete. The instrument requires teachers to rate each student's academic performance and behavior compared with other children in the class on a 118-problem item form. The student's behavior is rated on a 3-point scale of 0 to 2 indicating: *not true* = 0, *sometimes true* = 1, or *very true* = 2.

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

Procedures

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

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

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

Parents/guardians and teachers were offered to remotely complete their respective assessments from their home, work, child's school using a school computer, or at a key research member's independent practice using her computer. The ASEBA Web-Link immediately scored the assessments and a key member of the research team informed the parent of their child's inclusion of the study if their scores

demonstrated a Borderline and Clinical score on the Externalizing Problems Domain on either or both the CBCL or TRF. Parents/guardians of children who did not qualify were also immediately notified and offered referrals to local play therapists. Participants who qualified were randomly assigned using a random table of numbers to either the play therapy treatment group or waitlist control group.

Local key members of the research team were available during the collection of pretest and follow-up data collection to answer any questions and assure integrity of procedures. We were accessible through e-mail and phone during the initial data collection phase (recruitment and pretest), and during the follow up assessment phase. We were present for the treatment and posttest phases to answer questions and ensure integrity of data collection. Also, demographic data reported on the CBCL were collected and examined using SPSS. The U.S. team of play therapists arrived in Australia to assist in delivering the CCPT protocol.

Upon completion of the CCPT protocol, the end of 10-day period, parents of children in the intervention and control groups completed a CBCL posttest. Teachers were also asked to complete a post-TRF at the end of the CCPT protocol. To assess posttherapy effectiveness, parents and teachers of all participating children completed a CBCL or TRF one week after the posttest.

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

The lead researcher organized a 1-day training for cultural sensitivity and to standardize the delivery of CCPT among the play therapists before the intervention began. The 1-day training consisted learning differences between American English and Australian English, such as "mom" in American English and "mum" in Australian English. The basic tenets of CCPT were also reviewed and then practiced with children to ensure the integrity of delivery of CCPT. During the treatment phase, all play therapists received one hour of triadic supervision, and two 30-min individual supervision sessions per week by a Registered Play Therapist or a Registered Play Therapist Supervisor, as certified by the Association for Play Therapy (APT) or Australasia Pacific Play Therapy Association (AAPTA).

Experimental Group

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

CCPT intensive structure included two sessions daily for 10 days. Adjustments were made to allot for varying school/class schedules, clean up between sessions, and number of children in the treatment group at each location. During the first week, sessions were scheduled to allow for three to three and one half hours between the twice-daily sessions. During the second week, because of unforeseen scheduling conflicts within the schools, sessions were modified to allow between 30 min and three hours between sessions.

Waitlist Control Group

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

Data Analysis

For each dependent variable (teacher and parent report on Externalizing Problem behaviors), a two by two factorial analysis of variance (ANOVA) was performed in SPSS to analyze group differences, changes in time, and possible interaction effect. The independent variable was type of group, intervention or control, and the dependent variable consisted of pre- and posttest Externalizing Problems behavior scores on the CBCL/TRF (see tables 1 and 2). In the analysis, the experimental group served as the between-subjects variable and time (pretest to posttest to follow up) served as the within-subjects variable (Pallant, 2013). Data met assumptions of normality. Following analysis, we interpreted the results to determine statistical significance and practical significance. Statistical significance was interpreted according to .05 alpha level. Eta squared (η^2) effect sizes were calculated to assess the magnitude of difference between the two groups over time due to treatment. In the interpretation of η^2, the guidelines used were .01 equals a small effect, .06 equals a moderate effect, and.14 equals a large effect (Cohen, 1988). We decided that if analyses of externalizing scores yielded significant effects with meaningful effect sizes, we would explore pre–post data for the subscales making up the Externalizing Problems score (i.e., Aggression and Rule-Breaking).

Results

A two-factor repeated measures factorial ANOVA was performed in SPSS for each dependent variable (Externalizing Problems score on parent and teacher report) to determine whether the intensive CCPT and the wait list control groups performed differently across three points of time (pretest, posttest, and follow

Table 1
Mean Scores on Externalizing Problems Scales and Subscales on the CBCL and TRF

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

Note. CBCl = Child Behavior Checklist; TRF = Teacher Report Form; CCPT = Child Centered Play Therapy. A decrease in mean scores indicates an improvement in behavior.

Table 2
ANOVAs for Externalizing, Aggressive, and Rule-Breaking on the CBCL and TRF

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

Note. CBCL = Child Behavior Checklist; TRF = Teacher Report Form.
* Statistically significant at $p < .05$.

up). The assumptions of random sampling, independence of observations, homogeneity of variance, normal distribution, homogeneity of intercorrelations, and sphericity were all analyzed and reasonably met.

The CBCL and TRF were administered prior to treatment, immediately after treatment, and one week after treatment to assess treatment effects on Externalizing Problems. A reduction in scores on the dependent variables indicated an improvement in the targeted behavior. To address potential effects of cultural differences regarding the delivery of play therapy by both Australian and U.S. therapists with children who were native to Australia, an analysis was conducted to determine if there was a difference between American play therapists and Australian play therapists on Externalizing Behaviors over time. Of the 12 children in the intervention group, American therapists saw six children, and Australian therapists saw six children. Results of the analysis revealed no statistically significant difference between American and Australian therapists, $F(2, 10) = 1.865$, $p = .18$, $\eta^2 \leq .001$, indicating a small effect size (see Table 3). These results indicate that according

Table 3
Mean Scores on Externalizing Behaviors by Therapist Country of Origin

	American (n = 6[a])		Australian (n = 6[a])	
Externalizing	*M*	*SD*	*M*	*SD*
Pretest	73.50	6.53	70.00	4.05
Posttest	68.83	8.51	58.17	8.93
Follow up	62.50	12.40	57.67	10.38

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

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

CBCL Results

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

Children in the treatment group demonstrated a statistically significant decrease in scores on the subscale Aggressive Behavior as compared with children in the waitlist control group over time, as reported by the parents/guardians on the CBCL. Results of the analysis of the dependent variable Aggressive Behavior on the CBCL revealed a statistically significant interaction effect between treatment group and time, $F(2, 44) = 18.396$, $p \leq .001$, with a large effect size of $\eta^2 = .322$. There was also a statistically significant effect for time, $F(2, 44) = 16.423$, $p \leq .001$, $\eta^2 = .287$. The main effect for group was not statistically significant, $F(1, 44) = .055$, $p = .816$, $\eta^2 = .006$.

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

TRF Results

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

Children in the treatment group demonstrated a statistically significant decrease in scores on the subscale Aggressive Behavior as compared with children in the waitlist control group over time, as reported by the teachers on the TRF. Results of the analysis of the dependent variable Aggressive Behavior on the TRF revealed a statistically significant interaction effect between treatment group and time, $F(2, 44) = 4.907$, $p = .012$, with a large effect size of $\eta^2 =$

.130. There was also a statistically significant effect for time, $F(2, 44) = 9.958$, $p \leq .001$, $\eta^2 = .264$. The main effect for group was not statistically significant, $F(1, 44) = .170$, $p = .685$, $\eta^2 = .022$.

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

Discussion

This current study sought to determine the effectiveness of intensive CCPT with children who have been identified as having disruptive behaviors. This study was the first collaborative study between the United States and Australia on CCPT. Results of this study indicated that intensive CCPT was an effective intervention in reducing problematic externalizing behaviors. Intensive CCPT appears to be an appropriate intervention to decrease problematic externalizing behaviors in young children aged 6 to 9 years old and demonstrated that intensive CCPT was an effective modality cross-culturally.

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

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

The results of this current study are consistent with other play therapy studies that demonstrated the effectiveness of CCPT as an effective treatment for children with externalizing problems (Bratton et al., 2005, 2013; Bratton & Ray, 2000). Both play therapists and parents in this study conveyed they perceived notable decreases in observed problematic externalizing behavior. For example, the mother of a 7-year-old boy initially reported that her son demonstrated aggressive behavior at home and at school, hitting his siblings and peers when frustrated, and using defiant behavior leading to being sent home from school on several occasions. However, after the seventh session, which was first session on the fourth day of the study, the mother reported a notable decrease in aggressive behavior and stated that her son appeared happier and less defiant.

Favorable outcomes of this current study appeared to demonstrate that the fundamental tenets of CCPT, rooted in the healing factor of the relationship between therapist and child, is effective in helping children with problematic externalizing behavior. Therapists who utilize the core CCPT tenets (empathy, unconditional positive regard, and genuineness), offer children materials that allow for expression of aggressive feelings and behaviors (Landreth, 2012). In this study, aggressive materials were offered in the playrooms to provide distance from difficult emotional problems for children to freely express their aggression (Ray, 2011). The intensive CCPT provided in this research offered

materials traditionally labeled as aggressive, such as knives, guns, bop bags, handcuffs, and aggressive animals, along with other materials such as nurturing and realistic toys. In addition to the materials, the play therapists facilitated the child's freedom of expression of aggression and other emotions. Limits were also set to protect the child, play therapist, and the room and to structure the session.

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

International Collaboration

This international collaborative study may help to increase awareness of the benefits of mental health counseling in Australia, especially for young children. Burgess et al. (2009) reported that after reviewing the findings for the National Survey of Mental Health and Wellbeing in relation to the number of mental health problems reported, Australians do not appear to typically utilize mental health support. According to the Australian Institute of Health and Welfare (2012), there were approximately 45,000 reported cases of behavioral and emotional problems among children ages birth to 14 years old. The AIHW also reported that about 2.5% of the total child population reported long-term conditions of psychological disabilities between 2007 and 2008. According to the Australian Bureau of Statistics (2006), in 2004 to 2005, 7% of people aged birth to 17 years reported mental or behavioral problems. In 2004 to 2005, problems of psychological development (2.8%) and emotional and behavioral problems with usual onset in childhood/adolescence (3.0%) were most prevalent among those aged birth to 17 years.

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

Limitations

A major limitation of the current study was the small sample size recruited from a single geographical area; therefore, the results may not be generalizable to children living in other settings. A larger sample size selected from multiple regions would broaden the generalization of the results. Also, a small sample size leads to tentative conclusions regarding the overall data analysis. Another limitation is the lack of standardization of delivery regarding time between sessions. However, the outcome demonstrated

that as long as the children were able to receive the conditions of CCPT, the time periods between sessions did not affect the outcome. Another limitation is that the repeated completion of the CBCL over short intervals can lead to test–retest attenuation effect (Achenbach & Rescorla, 2001). However, according to the Achenbach and Rescorla, the instrument used in this study remains sensitive to short intervals when using control groups that will receive the same or different assessment schedules but no intervention to control for such effects. Ideally, random assignment to experimental groups also controlled for test-retest attenuation effect by having the waitlist control group on the same assessment schedule as the intervention group.

Implication for Practice and Future Research

The results of this study demonstrated that intensive CCPT is effective and therefore presents important implications for practice of CCPT. Practitioners should consider using intensive CCPT when working with children with externalizing behaviors and when time and financial resources permit. However, there may be times when intensive CCPT is not practical. Some settings may not lend to such an intensive format. Some clinics or practices may not have the available space or therapists for twice-daily sessions. It also may not be practical for parents regarding the time commitment and finances. In this current study, some parents initially committed to the intensive format; however, after several days the schedule became problematic due to other obligations.

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

Conclusion

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

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

References

Achenbach, T. M., & Rescorla, L. A. (2001). *Manual for the ASEBA school-age forms & profiles*. Burlington, VT: University of Vermont, Research Center for Children, Youth, & Families.

Achenbach, T. M., & Rescorla, L. A. (2010). *HIPAA & web-link*. Retrieved from http://www.web-link.org/hippa.asp?back=index.asp

Anticich, S., Barrett, P., Gillies, R., & Silverman, W. (2012). Recent advances in intervention for early childhood anxiety. *Australian Journal of Guidance*

and Counselling, 22, 157–172. http://dx.doi.org/10.1017/jgc.2012.24

Australian Bureau of Statistics 2004. (2006). *Mental health in Australia: A snapshot, 2004–5* (Cat. no. 4430.0). Canberra, Australia: Author.

Australian Bureau of Statistics. (2011). *Census of population and housing*. Canberra, Australia: Author. Retrieved from http://profile.id.com.au/darwin/population

Australian Institute of Health and Welfare 2012. *A picture of Australia's children 2012* (Cat. no. PHE 167). Canberra, Australia: Author.

Axline, V. (1969). *Play therapy*. New York, NY: Ballantine Books.

Badenoch, B. (2008). *Being a brain-wise therapist: A practical guide to interpersonal neurobiology*. New York, NY: Norton & Co.

Badenoch, B. (2011). *The brain-savvy therapist's workbook*. New York, NY: Norton & Co.

Badenoch, B., & Kestly, T. (2014). Exploring the neuroscience of healing play at every age. In D. Crenshaw & A. Stewert (Eds.), *Play therapy: A comprehensive guide to theory and practice*. New York, NY: Guilford Press.

Blanco, P. J., & Ray, D. C. (2011). Play therapy in elementary schools: A best practice for improving academic achievement. *Journal of Counseling & Development, 89,* 235–243. http://dx.doi.org/10.1002/j.1556-6678.2011.tb00083.x

Bratton, S. C., Ceballos, P. L., Sheely-Moore, A. I., Meany-Walen, K., Pronchenko, Y., & Jones, L. D. (2013). Head start early mental health intervention: Effects of child-centered play therapy on disruptive behaviors. *International Journal of Play Therapy, 22,* 28–42. http://dx.doi.org/10.1037/a0030318

Bratton, S., & Ray, D. (2000). What the research shows about play therapy. *International Journal of Play Therapy, 9,* 47–88. http://dx.doi.org/10.1037/h0089440

Bratton, S. D., Ray, D., Rhine, T., & Jones, L. (2005). The efficacy of play therapy with children: A meta-analytic review of treatment outcomes. *Professional Psychology: Research and Practice, 36,* 376–390. http://dx.doi.org/10.1037/0735-7028.36.4.376

Brown, J. (2013). Counseling and psychotherapy in Australia: Championing the egalitarian society? In R. Moodley, U. P. Gielen, & R. Wu (Eds.), *Handbook of counseling and psychotherapy in an international context* (pp. 171–181). New York, NY: Routledge/Taylor & Francis Group.

Burgess, P. M., Pirkis, J. E., Slade, T. N., Johnston, A. K., Meadows, G. N., & Gunn, J. M. (2009). Service use for mental health problems: Findings from the 2007 National Survey of Mental Health and Wellbeing. *The Australian and New Zealand Journal of Psychiatry, 43,* 615–623. http://dx.doi.org/10.1080/00048670902970858

Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2nd ed.). Hillsdale, NJ: Erlbaum.

Dahlitz, M. J., & Rossouw, P. J. (2014). The consistency-theoretical model of mental functioning: Towards a refined perspective. In P. J. Rossouw (Ed.), *Neuropsychotherapy: Theoretical underpinnings and clinical applications*. Brisbane, Queensland, Australia: Mediros.

Eickelkamp, U. (2008). (Re)presenting experience: A comparison of Australian Aboriginal children's sand play in two settings. *International Journal of Applied Psychoanalytic Studies, 5,* 23–50. http://dx.doi.org/10.1002/aps.136

Fiorentine, R. (2001). Counseling frequency and the effectiveness of outpatient drug treatment: Revisiting the conclusion that "more is better." *The American Journal of Drug and Alcohol Abuse, 27,* 617–631. http://dx.doi.org/10.1081/ADA-100107659

Fiorentine, R., & Anglin, M. D. (1996). More is better: Counseling participation and the effectiveness of outpatient drug treatment. *Journal of Substance Abuse Treatment, 13,* 341–348. http://dx.doi.org/10.1016/S0740-5472(96)00109-2

Garza, Y., & Bratton, S. (2005). School-based child centered play therapy with Hispanic children: Outcomes and cultural considerations. *International Journal of Play Therapy, 14,* 51–80. http://dx.doi.org/10.1037/h0088896

Grskovic, J. A., & Goetze, H. (2008). Short-term filial therapy with German mothers: Findings from a controlled study. *International Journal of Play Therapy, 17,* 39–51. http://dx.doi.org/10.1037/1555-6824.17.1.39

Hayes, L. (2007). Problem behaviours in early primary school children: Australian normative data using the Strengths and Difficulties Questionnaire. *Australian and New Zealand Journal of Psychiatry, 41,* 231–238. http://dx.doi.org/10.1080/00048670601172715

Jones, E., & Landreth, G. (2002). The efficacy of intensive individual play therapy for chronically ill children. *International Journal of Play Therapy, 11,* 117–140. http://dx.doi.org/10.1037/h0088860

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

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

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

Landreth, G. L. (2012). *Play therapy: The art of relationship* (3rd ed.). New York, NY: Routledge/Taylor & Francis Group.

Lin, Y., & Bratton, S. C. (2015). A meta-analytic review of child-centered play therapy approaches. *Journal of Counseling & Development, 93,* 45–58. http://dx.doi.org/10.1002/j.1556-6676.2015.00180.x

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

Muro, J., Ray, D., Schottelkorb, A., Smith, M., & Blanco, P. (2006). Quantitative analysis of long-term child-centered play therapy. *International Journal of Play Therapy, 15,* 35–58. http://dx.doi.org/10.1037/h0088914

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

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

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

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

Ray, D., Bratton, S., Rhine, T., & Jones, L. (2001). The effectiveness of play therapy: Responding to the critics. *International Journal of Play Therapy, 10,* 85–108. http://dx.doi.org/10.1037/h0089444

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

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

Ray, D. C., Blanco, P. J., Sullivan, J. M., & Holliman, R. (2009). An exploratory study of child centered play therapy with aggressive children. *International Journal of Play Therapy, 18,* 162–175. http://dx.doi.org/10.1037/a0014742

Ray, D. C., Henson, R. K., Schottelkorb, A. A., Brown, A., & Muro, J. (2008). Effect of short- and long-term play therapy services on teacher-child relationship stress. *Psychology in the Schools, 45,* 994–1009. http://dx.doi.org/10.1002/pits.20347

Rogers, C. R. (1951). *Client-centered therapy*. Boston, MA: Houghton Mifflin.

Rogers, C. R. (1980). *A way of being*. Boston, MA: Houghton Mifflin.

Rossouw, P. J. (2011). The triune brain: Implications for neuropsychotherapy. *Neuropsychotherapy, 5,* 2–3.

Rossouw, P. J. (2012). Effective client focused interventions: The top-down and bottom-up discourse. *Neuropsychotherapy News, 11,* 2–4. Retrieved from http://mediros.com.au/wp-content/uploads/2012/11/NPTIG-Newsletter-11.pdf

Schofield, M. J. (2013). Counseling in Australia: Past, present, and future. *Journal of Counseling & Development, 91,* 234–239. http://dx.doi.org/10.1002/j.1556-6676.2013.00090.x

Schumann, B. (2010). Effectiveness of child-centered play therapy for children referred for aggression. In J. N. Baggerly, D. C. Ray, & S. C. Bratton (Eds.), *Child-centered play therapy research: The evidence base for effective practice* (pp. 193–208). Hoboken, NJ: Wiley http://dx.doi.org/10.1002/9781118269626.ch11

Shen, Y. (2002). Short-term group play therapy with Chinese earthquake victims: Effects on anxiety, depression and adjustment. *International Journal of Play Therapy, 11,* 43–63. http://dx.doi.org/10.1037/h0088856

Siegel, D. J. (2010). *The mindful therapist: A clinician's guide to mindsight and neural integration*. New York, NY: Norton.

Stulmaker, H., & Ray, D. (2015). Child centered play therapy with young children who are anxious: A controlled trial. *Children and Youth Services Review, 57,* 127–133. http://dx.doi.org/10.1016/j.childyouth.2015.08.005

Tyndall-Lind, A., & Landreth, G. L. (2001). Intensive short-term group play therapy. In G. L. Landreth (Ed.), *Innovations in play therapy: Issues, process, and special populations* (pp. 203–215). New York, NY: Brunner-Routledge.

Received February 9, 2016
Revision received June 30, 2016
Accepted July 24, 2016 ■