

## Effects of Child-Centered Play Therapy for Students With High-Disruptive Behavior in High-Poverty Schools

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Authors examine effects of child-centered play therapy (CCPT) within a service-research project. Students were referred for highly disruptive behavior by principals, with teacher input, following guidance through referral definitions and indicators provided by the authors. CCPT services were provided in high-poverty schools by counseling interns or beginning play therapists in close supervision. Findings include significant differences for treatment versus control groups and moderate to large effects from 9-session hours across total problems, externalizing, attention problems, and learning related self-efficacy, with no change in internalizing behaviors. Findings support the importance of CCPT in schools and other real-world settings for high-need children.

**Keywords:** child-centered play therapy, disruptive behavior, high-poverty schools, controlled research study, child counseling

The assumptions of the school-to-prison pipeline have become far too well-accepted (Laura, 2014; Wald & Losen, 2007). The term, school-to-prison pipeline, depicts students who are underprivileged, often of minority groups, “having poor academic and behavioral experiences . . . being propelled away from educational opportunities toward criminalization and incarceration” (Houchins, Shippen, & Murphy, 2012, p. 271). The impacts are felt most severely by students in high-poverty schools (Archer, 2010). Reporting the devastation of poverty, as well as intersection with race, the Children’s Defense Fund (2007) described the problem beyond schools, as the *cradle-to-prison pipeline*, asserting:

So many poor babies in rich America enter the world with multiple strikes already against them [with

“strikes” including] lack of access to health and mental health care; child abuse and neglect; lack of quality early childhood education to get ready for school; educational disadvantages resulting from failing schools that do not expect or help them achieve or detect and correct early problems that impede learning [making] a successful transition to productive adulthood significantly less likely and involvement in the criminal justice system significantly more likely. (p. 3)

Children living in poverty achieve less and exhibit more problem behaviors (Duncan, Magnuson, Kalil, & Ziol-Guest, 2012), especially with regard to school success (Bradshaw, 2002; Strelitz & Lister, 2008). Further, researchers suggest that disparities in school readiness multiply over time (Cunha, Heckman, Lochner, & Masterov, 2005). Regarding the effects of poverty on the schools’ progress, low-poverty schools have been found to be 22 times more likely to reach high academic achievements than high-poverty schools (Harris, 2007).

Regarding the effects of poverty for students, researchers have evidenced connections of socioeconomic status to aspects of brain function (Farah et al., 2006; Kishiyama, Boyce, Jimenez, Perry, & Knight, 2009) with research suggesting the importance of early brain development for cognitive, social, and emotional functions (Knudsen, Heckman, Cameron, & Shonkoff, 2006). Evans and English (2002) found that poverty can create environments that undermine the development of self-regulation and other

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socioemotional development. [Duncan, Ziol-Guest, and Kalil \(2010\)](#) discovered effects within a nationally representative longitudinal sample in which adults who grew up in poverty complete fewer school years, earn less income, receive more food stamps, and among males are twice as likely to be arrested, compared with adults who grew up with moderate to higher income.

### Highly Disruptive Behavior Within Poverty

The futures for children in poverty, especially those with highly disruptive behavior evident in early elementary school years, are bleak. For the study, we termed highly disruptive behavior of elementary school years as: causing significant and persistent interference with one's own and peers' learning and instruction, through frequent aggression toward peers or teacher and/or noisiness and frequent refusal or failure to follow directions. Our term overlaps with the diagnostic categories of oppositional defiant disorder, childhood onset of conduct disorder, and attention-deficit/hyperactivity disorder (ADHD), which commonly co-occur and predict similar painful costs to the persons and environment ([American Psychiatric Association, 2013](#)).

Building on and within an ever-growing body of research on the problems following conduct difficulties in childhood ([Darke, Ross, & Lynskey, 2003](#); [Dodge & Pettit, 2003](#)), [Fergusson, Horwood, and Ridder \(2005\)](#) found from a 25-year longitudinal study, that even controlling for confounding variables (e.g., social disadvantages, family dysfunction), conduct problems present in ages 7–9 years were significantly associated with future higher rates of crime and substance dependence, as well as problems in mental health (depression and anxiety disorders, antisocial personality disorder, and suicide attempts) and sexual/partner relationships (teen pregnancy, domestic violence). In a separate longitudinal study, [Odgers et al. \(2008\)](#) identified “life course persistent” (p. 673) trajectories from childhood onset to serious violence, significant mental health problems and economic problems at age 32.

Similarly from their longitudinal study, [Fergusson, Lynskey, and Horwood \(1997\)](#) found that attentional difficulties in childhood, even when controlling for confounding variables (social disadvantage, conduct problems, and lower

IQ), significantly associated with academic failure. In [Barkley's \(2016\)](#) commentary of recent longitudinal studies of childhood ADHD, which includes emotional impulsivity and poor self-control, Barkley summarized that most cases persist from elementary school to adolescence, posing substantial risks for significantly ineffective functioning in education, peer relationships, and family life, with elevated risks of crime, intimate partner violence, teen pregnancy, lower occupational attainment, homelessness, and greater economic burdens to government and society. Further, cases involving aggressiveness or oppositional/conduct problems and/or featuring hyperactivity-impulsivity associate with worse outcomes, and that even “if [ADHD] symptoms decrease with age, impairments (both in number and global severity) may still increase or, at best, stabilize” ([Barkley, 2016](#), p. 252). When combined with the effects of growing up in high poverty, the existence of highly disruptive behavior in children would seem to predict devastating costs to the children and later adults, and to schools and society without effective intervention to turn around the growing cycle of misery and dysfunction.

### Opportunity for Early Intervention

Although the early years of a child's development are critical, there is opportunity during the school years for transformation ([Bratton, 2010](#)). As [Jensen \(2009\)](#) explained “because the brain is designed to adapt from experience, it can also change for the better [for children in poverty, with the] experience of emotional, social, and academic success” (p. 2).

### CCPT

CCPT ([Cochran, Nordling, & Cochran, 2010](#); [Guernsey, 2001](#); [Landreth, 2012](#)) is an age appropriate and culturally adaptive counseling intervention for children ages 3–12 that facilitates the child's path toward socially well-adjusted self-actualization, through the child's self-expression and processing of experience, in a therapeutic relationship featuring empathic attunement, unconditional positive regard, and genuineness ([Cochran, Nordling, et al., 2010](#)). CCPT is based on Virginia Axline's (1947) development of Carl Rogers' (1942, 1951) per-

son-centered approach with children. CCPT is well-researched for wide-ranging applications from normally occurring adjustment difficulties to significant trauma (Cochran, Nordling, et al., 2010; Lin & Bratton, 2015). While a multifaceted approach including parent involvement in treatment may be desirable (Bratton, Landreth, & Lin, 2010; Bratton, Ray, Rhine, & Jones, 2005; Guerney & Ryan, 2013), CCPT has also been successful in school settings with limited access to caregivers (Bratton, 2010).

### Purpose of the Study

This research took place in the context of a real-world setting, CCPT service project, which started as administrators of the primary site approached the authors asking for help. They found that some of their students whom they knew to have highly disruptive behavior (significantly worse than peers) were constantly cycling in and out of disciplinary pull-out programs that were meant to be temporary. The administrators worried over seeing even very young elementary schoolchildren from impoverished backgrounds fail to learn and frequently disrupt in the classroom, assumedly due to emotional regulation issues and chronic life stress. The authors obtained partial grant funding for this primary site from the Tennessee Commission on Children and Youth, whose goal was to serve and document progress for as many highly disruptive students as possible within the service period, in order to prevent juvenile delinquency.

CCPT was provided in the primary site, plus four additional high-poverty schools for students who were not showing a decrease in highly disruptive behavior in spite of multiple other intervention facets, including social work resource assistance, parent programs, teacher support, alternative disciplinary programs, extensive mentoring, and school counselor services. Our purpose in this research project is to test the effects of CCPT. Having checked that students who had the same teacher ratings around a waiting period, which was equal to the initial treatment period, were not significantly different at pretest, we aimed to determine if there was (a) a mean decrease within teacher ratings compared with the waiting period control group in total problem behaviors, externalizing behaviors, attention problems, and inter-

nalizing behaviors, and (b) a mean increase in learning-related self-efficacy.

## Method

### Participants

In the school settings of this study, students would normally be referred for counseling services from broad areas of concern, such as highly disruptive behavior determined by principals with teacher input. The broad term, highly disruptive behavior, can encompass the most common reasons for referral to school-based intervention teams—"inappropriate physical behavior, aggression, and social/relational problems" (p. 249), especially the externalizing and attentional problems found to generate significantly more referrals than internalizing at the elementary level, identified in a national survey of classroom teachers referrals (Briesch, Ferguson, Volpe, & Briesch, 2013).

In our written materials and meetings with school administrators guiding referrals, we defined *disruptive* as "interfering with student's own and peers' classroom learning and taking teacher time away from curricular instruction," with examples including "aggression toward peers or teacher, inattention, noisiness and frequent refusal or failure to follow directions." We defined *significant* as "behavior that has stood out as abnormally disruptive for most of the previous school year, in spite of normally effective interventions," or for students new to the school, "persisting for at least two months in spite of normally effective interventions." School administrator referrals provide no indication of causes of highly disruptive behavior, which could range from a variety of causes such as environmentally learned behaviors, reactions to stress or trauma, depression, or possible disability.

After school administrators selected highest priority students for referral, parents were contacted to request written consent for services, research, and video recording for supervision purposes (following procedures approved by the institutional review board for research with human subjects at the authors' university). Three parents declined permissions. Eighty students were referred through the five service years. Five students began the study, but moved away before completing enough sessions (9) for

follow-up ratings. Eight students had teacher changes which made follow-up ratings unusable, both because the teachers might not respond to the same items in the same way, and because the students might have had “honeymoon” periods with new teachers, producing false positives. Two students had other issues in teacher ratings disqualifying them from the study (see the Teacher Raters subsection, below). Sixty-five are included in the study. Referrals were accepted from a wide range of disruptive behavior, as long as school administrators saw the behavior as clearly fitting within the definition we provided for *significantly disruptive*.

Children were of elementary school years (K–5), with 52.4% from kindergarten to second grade and 47.6% from third–fifth. The average age of students in the study at time of referral was seven years. Percentages by age year were: 5 years, 10.8%; 6, 23.1%; 7, 18.5%; 8, 23.1%; 9, 13.8%; 10, 9.2%; 11, 1.5%. According to school records, 52.3% identified as Caucasian, 38.5% as African American, 7.7% as Hispanic, and 1.5% Native American; 76.9% were male.

### Setting Characteristics

Students were served from five schools with most (86%) served in three urban schools of a small city in the southeastern United States, with others served in two urban schools in a small city in the northeastern United States. All schools were considered high poverty, having free or reduced lunch rates above 90%. The largest school site (approx. 850 students) encompassed 62% of students served and was listed as a chronically underperforming school through its state’s No Child Left Behind mandated proficiency standards. It had a mobility rate of 40%.

Twenty-three percent received services at an afterschool program of one of the southeastern city’s schools. Though services were provided after school, the site’s referrals were made by the day school principals. Teacher ratings were completed by day school teachers for 13 of these 15 students. The other two student’s ratings were completed by the afterschool program director, whose ratings had been collected as backup in case day school teacher raters changed.

### Instrumentation

**Teacher’s Report Form for Ages 6–18 of the Child-Behavior Checklist (TRF).** The problem behaviors core of the TRF (Achenbach & Rescorla, 2001) is 120 items, yielding a Total Problems score, eight syndrome scores. Instructions for teacher raters are:

For each item that describes the pupil *now or within the past 2 months*, please circle **2** if the item is very true or often true . . . **1** if the item is *somewhat or sometimes true*. . . . If the item is *not true* of the pupil, circle the **0**. (p. 14)

The TRF has well-established validity and test-retest reliabilities established at: Total Problems, .95, Externalizing (consisting of rule-breaking and aggressive behavior syndromes), .89, Internalizing (consisting of anxious/depressed, withdrawn/depressed, and somatic complaints syndromes), .86, and Attention Problems, .95 (Achenbach & Rescorla, 2001).

**Self-Efficacy Scale for Children—Teacher Version (SES).** The nine SES items were developed to measure children’s self-efficacy as learners and problem solvers (Fall & McLeod, 2001). The validity of the SES Teacher Version has evidenced factorial validity and test–retest reliability established at .83 (Fall & McLeod, 2001). We included a measure of self-efficacy as a possible precursor to grade change and because the SES relates directly to the natural school goal of motivation to learn.

### Procedures

Upon receiving parental consent, primary teachers completed the TRF and SES for student(s) in the study from their class. As soon as initial teacher ratings were completed, students began treatment or began waiting period/comparison group procedures. Follow-up teacher ratings were completed in nine school weeks.

**Treatment assignment and waiting period/comparison group procedures.** Referrals were accepted throughout each school year as soon as parent permissions and initial teacher ratings were in-hand for the high need students who populate this study. Originally, school administrators agreed to pair referrals, with one of each pair having services delayed for comparison group purposes, and with intention to keep treatment and comparison period clients equal

in number. However, due to the high behavioral and emotional needs of all students served, as the study progressed, we received numerous “this one can’t wait!” requests for exceptions and unpaired referrals. Thus, the treatment and waiting period/comparison groups are not equal in size (46, 19). Yet, as playroom space and staff time reached maximum use, clients were then forced to waiting/comparison periods. Thus, those waiting/comparison group assignments were not related to severity.

**Checking for significant differences in waiting period versus initial treatment groups.** Because random assignment was not possible, we checked for differences in key areas. Using nonpaired *t* tests, we found no significant differences in initial ratings in dependent variables. Further, we found no significant differences on the TRF subscales of Social Problems and Academic Performance, which are not represented in dependent variables, but which are problem areas for which school administrators might have asserted for a student to be assigned to immediate treatment. Further, we found no significant differences in the potentially impactful demographics of age, gender, and ethnicity.

**Mental health related services of control period.** Due to the high-need nature of the communities and schools of the study, and due to the highly troubling (disruptive) behavior of the students, the schools provided regular food assistance and other social work interventions to connect families with needed resources, provided extensive parent training opportunities, extensive teacher support, alternative discipline programs, extensive mentoring from para-professionals, and school counseling services. The school counseling services usually featured solution-focused (de Shazer & Dolan, 2007; Ratner & George, 2012) or cognitive-behavioral (Beck, 2011; Riggensbach, 2012) guidance counseling approaches instead of longer-term and/or intensive individual counseling, focused on child self-expression and processing of experience. This focus of school counselor services in the study settings seemed to be due to time constraints for school counselors responsible for large numbers of students, as well as a lack of prior knowledge of CCPT, and its likely effectiveness for students with behavioral and emotional needs.

**Treatment.** Students received 30-min CCPT sessions (Cochran, Nordling, et al.,

2010) twice weekly. The reason for 30-min sessions was to more easily accommodate school schedules. However, it is important to note that sessions were a consistent full 30 min versus 30 min, minus possible delays in leaving class and travel time to and from playrooms in large schools. The 30-min, twice-weekly service delivery model is well supported through other CCPT studies (Bratton et al., 2013; Ray, Blanco, Sullivan, & Holliman, 2009), including in comparison with once weekly for twice as many weeks (Ray, Henson, Schottelkorb, Brown, & Muro, 2008).

We targeted second teacher ratings to follow students’ 18th 30-min session (9 session hours) and had some irregularities with numbers of sessions and timing. Fourteen students had fewer than 18 sessions at second rating because: (a) eight began treatment late in the school year, with enough time for minimum of nine sessions, but not enough time for 18 (the eight had 9–14 sessions, with average of 11), (b) three students moved before completing, with 14 or 15 sessions each, and (c) three teachers completed second rating a little too soon, following 16th or 17th session. Also, six students had more than 18 sessions at follow-up, having 19–22 sessions prior to second ratings, due to teachers being delayed in completing ratings. Services continued until each client was seen as ready to end based on consistently improved ratings, plus CCPT stage analysis of internal readiness to end (Cochran, Cochran, Nordling, McAdam, & Miller, 2010; Cochran, Nordling, et al., 2010). The mean number of sessions to follow-up rating was 17.

Sessions were conducted in specialized play therapy areas set up within the schools. The play therapy areas ranged from a section of an empty classroom to a short hallway that could be closed off for privacy to a space within a library in afterschool hours and sections of administrative offices in our high-poverty, often crowded school sites. At times our treatment providers were forced to shift therapy spaces during the treatment periods of some students, in order to enable construction, maintenance, and other site issues. Each play therapy area included developmentally, culturally, and symbolically representative toys that remained consistent and were specifically chosen to enable multiple modes of expression and the needs of

each typical stage of CCPT (Cochran, Cochran, et al., 2010; Cochran, Nordling, et al., 2010).

**Avoidance of nontreatment mental health services during treatment.** While other services were not required to end during treatment, any substantial direct-to-child school counseling services were dropped, due to time pressures for the school counselors to serve other children in need. Students in treatment did not receive nonschool-based counseling or therapy services. If students were receiving medication of any sort, including medications with mental health implications, the medical care was continued without regard to treatment.

**Teacher raters.** Each teacher rater had a multiple hours per school day of interaction with the student for at least two months prior to initial ratings. Thirteen (20%) of the student's teacher raters were blinded to the students' inclusion in treatment or control groups, due to the fact that raters were day school primary teachers, while those students were served in an afterschool program. TRFs for two students in the afterschool program were completed by the program director, based on his multiple hours per afterschool-day across multiple months or years, as teacher ratings were not available for those students.

**Qualifications of treatment providers.** Fifteen graduate students, counselors, or therapists provided services. Fourteen had completed the one-semester CCPT intensive, skill-based course based on Cochran, Nordling, et al. (2010), and were gaining her/his initial experience in providing CCPT with children under close supervision. The course features student partners engaging in mock sessions, with each playing roles of counselor and child, multiple practices of each skill area, with partners prompted to provide opportunities to practice each skill (e.g., responding to questions, commands; responding to structural challenges and setting limits; engaging in child-directed role play), plus coinstructor observations of and feedback on skills in mock sessions.

The other of the 15 treatment providers was the primary treatment coordinator (second author), who stepped in to serve older and very high-need students. She had over 20 years' experience providing, supervising, and teaching CCPT, and holds certifications as Child-Centered Play Therapist and CCPT Supervision from the

National Institute for Relationship Enhancement (Bethesda, MD).

Most clients, 78%, were served by student or beginning play therapists; 59%, by Master of Science in Counseling (MS) students. The breakdown by therapists' education level is: six MS interns served 24, one MS practicum student served three, two counselor education doctoral students served four, one clinical psychology doctoral student served two, the one experienced school counselor served two and the one experienced school social worker served one, and the one experienced and certified primary supervisor served 10 older or very high-need clients.

**Supervision and treatment fidelity.** Weekly individual/triadic, plus monthly small group supervision was provided by the authors, who had a combined 40+ years of experience providing, teaching, and supervising CCPT, as well as CCPT and CCPT-S certifications of the second author. Individual/triadic supervision was skill focused. Supervisees selected problematic segments of sessions for supervisor review in weekly supervision, as well as sought additional supervisor input as needed through the week. Co-led small group supervision focused on video segment review and shared experiences in reaction to clients, in relation to therapists' development of empathy, unconditional positive regard, and genuineness, and also included supervisees selecting segments to share for peer input.

All sessions were recorded for supervision. Students and/or beginner play therapists self-reviewed and brought segments of video for reviews that they found most challenging to weekly supervision for consultation, and supervisors checked for the central therapist qualities of empathy, unconditional positive regard, and genuineness (Cochran & Cochran, 2015; Cochran, Nordling, et al., 2010; Rogers, 1951) and for therapist behaviors in the four primary skill areas of CCPT: (a) structuring the playroom to facilitate therapeutic self-expression, including limit-setting for safety and therapist congruence, beginning and ending sessions (Guerney, 1994); (b) verbal and nonverbal tracking, or reflecting, the child's actions and experiences; (c) empathic attunement and expression of empathy in age appropriate modes; and (d) engaging in role play per child direction; as well as common problem areas of responding to ques-

tions, requests, and commands (Cochran et al., 2010; Nordling, 2016) to ensure activities are child-led and self-directed.

In addition to face-to-face supervision, supervisors reviewed 1–3 full sessions of each supervisee within that supervisee's first week of services. Supervisors noted central therapist quality or skill area weaknesses. Weaknesses identified were clarified for each supervisee and monitored for improvement in supervision meetings.

### Data Analysis

Dependent variables from within standardized measures were selected based on: best overall measure of behavior and well-being (TRF Total Problems), the subscales best fitting description of significant disruptive behavior provided to guide referrals (Externalizing and Attention Problems), and an early indicator of change in academic performance or learning readiness (SES). We also selected the TRF Internalizing score as a dependent variable as a check of nontargeted areas of behavior.

Testing for interactional differences across time for each dependent variable, after ensuring data met assumptions for repeated measures analysis including sphericity, we used the Wilk's lambda test of interaction of repeated measures analysis of variance (ANOVA) to check for significant differences in change from first to second teacher ratings in treatment and control groups. We calculated partial eta squared effect size as an indicator of the mag-

nitude of the difference between the two groups due to treatment. We used paired sample *t* tests of first to second teacher ratings for treatment and control groups to explore the significant interactions, calculating eta squared effect size as an indicator of magnitude of difference from first to second ratings. We checked the number of students whose teacher ratings moved from the clinical or borderline to the normal level for TRF scores in dependent variables from the TRF with significant interactions, as well as normally occurring school-based data that approximates the treatment period, as an indicator of the clinical significance of the intervention in the lives of participants (Kazdin, 2003).

### Results

Table 1 presents means and standard deviations of treatment and control groups across dependent variables. Results of repeated measures ANOVA for each dependent variable follow, plus results of paired-sample *t* tests exploring significant interactions.

#### Total Problems

Results of analysis of Total Problems ratings revealed a statistically significant interaction effect of Time (rating 1 to rating 2)  $\times$  Group Membership (treatment, control), Wilks'  $\lambda = .81$ ,  $F(1, 63) = 14.40$ ,  $p < .001$ ,  $\eta_p^2 = .19$ . The treatment group decreased significantly,  $p < .001$ ;  $\eta^2 = .27$ , while the control group increased signifi-

Table 1  
*Mean Scores of Dependent Variables*

Dependent variable	Rating 1	Rating 2
Total problems ( $n = 46$ , $n = 19$ )		
Treatment group	Mean 65.70, <i>SD</i> 24.16	Mean 52.72, <i>SD</i> 26.56
Control group	Mean 57.89, <i>SD</i> 28.26	Mean 65.00, <i>SD</i> 26.83
Externalizing ( $n = 46$ , $n = 19$ )		
Treatment group	Mean 20.78, <i>SD</i> 10.90	Mean 16.48, <i>SD</i> 11.93
Control group	Mean 19.21, <i>SD</i> 13.16	Mean 21.74, <i>SD</i> 12.52
Attention problems. ( $n = 46$ , $n = 19$ )		
Treatment group	Mean 28.07, <i>SD</i> 10.39	Mean 23.30, <i>SD</i> 10.83
Control group	Mean 24.32, <i>SD</i> 12.50	Mean 25.89, <i>SD</i> 11.21
Internalizing ( $n = 46$ , $n = 19$ )		
Treatment group	Mean 8.04, <i>SD</i> 6.85	Mean 7.26, <i>SD</i> 6.37
Control group	Mean 8.47, <i>SD</i> 6.49	Mean 9.26, <i>SD</i> 5.96
Self-efficacy ( $n = 40$ , $n = 19$ )		
Treatment group	Mean 20.28, <i>SD</i> 7.14	Mean 22.00, <i>SD</i> 6.50
Control group	Mean 20.32, <i>SD</i> 5.89	Mean 18.11, <i>SD</i> 6.12

cantly,  $p = .027$ ,  $\eta^2 = .24$ . These results indicate that the treatment group reduced overall problem behaviors significantly compared with the control group and reduced overall problem behaviors significantly pre-to-post, while the control group increased overall problem behavior significantly pre-to-post.

### Externalizing

Results of analysis of Externalizing behavior ratings revealed a statistically significant interaction effect of Time (rating 1 to rating 2)  $\times$  Group Membership (treatment, control), Wilks'  $\lambda = .87$ ,  $F(1, 63) = 9.74$ ,  $p = .003$ ,  $\eta_p^2 = .13$ . The treatment group decreased significantly,  $p = .002$ ,  $\eta^2 = .2$ , while the control group demonstrated no change. These results indicate that the treatment group reduced externalizing behaviors significantly compared with the control group and reduced attention problems significantly pre-to-post, while control group did not change externalizing behaviors significantly pre-to-post.

### Attention Problems

Results of analysis of Attention Problems ratings revealed a statistically significant interaction effect of Time (rating 1 to rating 2)  $\times$  Group Membership (treatment, control), Wilks'  $\lambda = .87$ ,  $F(1, 63) = 9.57$ ,  $p = .003$ ,  $\eta_p^2 = .13$ . The treatment group decreased significantly,  $p < .001$ ,  $\eta^2 = .26$ , while the control group demonstrated no change. These results indicate that the treatment group reduced attention problems significantly compared with the control group and reduced attention problems significantly pre-to-post, while the control group did not change attention problems significantly pre-to-post.

### Internalizing

Results of analysis of Internalizing behavior ratings did not reveal a statistically significant interaction effect of Time (rating 1 to rating 2)  $\times$  Group Membership (treatment, control), Wilks'  $\lambda = .97$ ,  $F(1, 63) = 1.47$ ,  $p = .23$ ,  $\eta_p^2 = .02$ .

### Self-Efficacy

Results of analysis of SES ratings revealed a statistically significant interaction effect of

Time (rating 1 to rating 2)  $\times$  Group Membership (treatment, control), Wilks'  $\lambda = .88$ ,  $F(1, 57) = 7.63$ ,  $p = .008$ ,  $\eta_p^2 = .12$ . The treatment group increased significantly,  $p = .042$ ,  $\eta^2 = .1$ , while the control group demonstrated no change. These results indicate that the treatment group increased self-efficacy significantly compared with the control group and increased self-efficacy significantly with preratings compared with post, while the control group did not change self-efficacy significantly.

### Clinical Significance

**Use of a broad, comprehensive indicator.** Our use of the TRF Total Problems score may be a good indicator of clinical significance, or the effects of interventions on a clients' everyday functioning in addition to targeted symptoms (Kazdin, 2003), as, for example, some types of interventions might target certain types of behaviors, such as rule-breaking or social problems, showing progress in the targeted area, but not in other areas such as anxiety or depression. This should not be overstated, as our referrals may have begun with fewer problems in areas such as internalizing that are less related to the descriptions of significantly disruptive behavior that guided referrals. Also the Total Problems score simply includes more items (120 vs. the 32 of Externalizing, 33 of Internalizing, and 26 of Attention Problems). Yet still, significant change in Total Problems, which could include decreases in some problem areas and increases in others, would be the best measure of overall functioning.

**Consideration of clinical verses normal range behaviors.** Achenbach and Rescorla (2001) provide TRF cutoff scores to:

significantly discriminate between children who are referred for mental health or special education services for behavioral/emotional problems and demographically similar children who are not referred . . . the borderline and clinical ranges help users identify scores that are of enough concern to warrant consideration of needs for professional help. (p. 90)

Thus, movement from clinical or borderline to normal can be a check for clinical significance. Out of 46 students in the treatment group, 38 began in borderline to clinical level Total Problems scores, 39 in Externalizing, and 24 in Attention Problems, with some multiple standard deviations above the cut off scores in

each area. Of those above the borderline to clinical cut off scores in each area, six (16%) improved to normal levels in Total Problems, seven (18%) in Externalizing, and 11 (46%) in Attention Problems in the nine treatment weeks.

**Support from normally occurring school data.** As a further check of clinical significance, we obtained quarterly school-year data from our two largest sites for 46 students served (note that this is not an exact match to the 46 of the treatment group, as quarterly data were not available for all in the treatment group, and some of the students with quarterly data are students from the control group who were served after the control period). Of the 46 with quarterly data available, 24 had records of disciplinary referrals considered significant by school administrators (multiple referrals per month in previous school year or in first 2 months for students new to the school). Of those 24, there was a 47% reduction in disciplinary referrals and a 61% reduction in suspension from the quarter before treatment to the first quarter of treatment. Of the 46 with quarterly data available, 38 had a histories of absences considered significant by school administrators (over 10 in previous school year or more multiple absences per month for the first 2 months for students new to the school). Of those 38, there was a 40% reduction in absences from the quarter before treatment to the first quarter of treatment.

### Discussion

The statistical and clinical significance of the present findings evidence the positive impact of CCPT for highly disruptive behavior in elementary school-age children. It is especially important that this impact is documented in high-poverty schools, as we know that children growing up in concentrations of poverty face numerous disadvantages and are at high risk of school failure (Bradshaw, 2002; Cunha et al., 2005; Duncan et al., 2012; Strelitz & Lister, 2008); diminished cognitive, social, and emotional development (Evans & English, 2002; Farah et al., 2006; Kishiyama et al., 2009; Knudsen et al., 2006); and can be predicted to complete less school, earn less income, require more food assistance, and are more likely to be arrested than children growing up out of poverty (Duncan et al., 2012). Even aside from the

high-poverty context, we can know that without effective intervention, highly disruptive behavior in elementary school years predicts misery continuing into adulthood, including criminal behavior and violence, and serious mental and physical health issues (Barkley, 2016; Darke et al., 2003; Dodge & Pettit, 2003; Flory, Milich, Lynam, Leukefeld, & Clayton, 2003; Odgers et al., 2008), even when controlling for confounding factors (Fergusson et al., 1997, 2005), and with impacts not only for the children with highly disruptive behavior, but also for each child's peers and schools (Simon, 2016).

The positive impact findings of the present study are similar to patterns in results (improvement in dependent variables; with control groups demonstrating less progress, no change, or evidence of worsening behaviors) in CCPT studies with similar clients or problem areas, including: elementary schoolchildren exhibiting aggressive problem behaviors (Ray et al., 2009), symptoms of ADHD (Ray, Schottelkorb, & Tsai, 2007), low self-efficacy (Fall, 1999), and preschool children of low income families and with clinical levels of disruptive behaviors (Bratton et al., 2013). In a meta-analysis, Lin and Bratton (2015) summarized moderate to large effect sizes in CCPT studies in categories of presenting issues including global behavior problems, externalizing behavior problems, and self-efficacy, with greater improvement evidenced in global problems (similar to this study), possibly resulting from changes in multiple areas of problem behaviors, especially as troubled children often exhibit symptoms in different problem areas at the same time (Copeland, Shanahan, Costello, & Angold, 2009).

We surmise a number of possible reasons why internalizing scores were not evidenced as changed in teacher ratings. Disruptive behavior can adversely affect all students' learning. Thus, teachers have to attend to, and are trained to manage externalizing behaviors. Therefore, it follows that teachers may not as readily notice negative internalizing behaviors. Anecdotally, while we noticed most individuals' internalizing behavior decreasing or staying about the same (some started never having been rated high on internalizing behaviors), we noticed a subgroup whose internalizing behavior ratings increased as their externalizing behaviors decreased. Our assumption in those cases was that as externalizing behaviors decreased, and thus

demanded less of the teacher's attention, the teacher was better able to notice internalizing behaviors such as signs of sadness or anxiety.

The findings of this study suggest the importance of *the therapy hour* for highly troubled children in schools. We use "the therapy hour" as a figure of speech, as in this study the weekly therapy hour was provided in 2 half-hour sessions for convenience of school scheduling. But in our view, the therapy hour—consistent time with a counselor focused on therapeutic relationship and child clients' self-direction and self-expression to process experience—is often the missing piece for effective intervention. This seemed to be the case for participants in this study who had extensive interventions available (family support, teacher support, mentoring, guidance counseling) yet lacked the therapy hour evidenced as making the significant difference in this study.

CCPT would seem to provide the optimally efficient therapy hour for children. CCPT is based on the premise that within the therapeutic context of genuine empathy to enhance and focus a child's awareness of experience, and unconditional positive regard and limits to create the safety needed to enable self-expression and processing of experience, children will progress, will move beyond blocks to self-actualization, including mistaken self-perceptions of what is possible for self, and misinterpreted meanings internalized from experiences. Child-centered play therapists work from a confidence that within the carefully designed structure for therapeutic relationship, children make both increasingly mature choices in day-to-day behaviors, as well as select and act on increasingly self-responsible choices in major life directions or ways of being (Axline, 1947; Cochran & Cochran, 2015; Cochran, Nordling, et al., 2010; Guernsey, 2001; Landreth, 2012).

Especially for children living in poverty, it is understandably difficult to accomplish significant changes in context due to the myriad of difficulties that parents in poverty face and the self-perpetuating social factors of poverty (Children's Defense Fund, 2007; Cunha et al., 2005; Evans & English, 2002). Thus, it seems critical to see in these findings that CCPT can be effective in changing troubling behavior and generating learning-related self-efficacy from the child's therapy, even without requiring fur-

ther changes in schools or living situations that had not been effective before adding CCPT.

Especially for real-world setting application, it is important to see the broad and powerful applicability of CCPT suggested in the findings of this study. Principals, with teacher input, referred students they saw as meeting our definition of having highly disruptive behavior, and we accepted referrals without regard for potential diagnoses, causes, or individual characteristics within our definition of *significantly disruptive behavior* provided to school administrators.

Further, most participants were served by treatment providers who were having initial experiences with CCPT, and with most being MS students having first experiences providing any therapeutic services, suggesting that while certainly an introductory skills-based course in CCPT is needed, plus close supervision, the approach is robust and can be broadly effective, even with novices within the approach and within the counseling field.

### Limitations, Recommendations for Research, and Implications for Practice

**Nonrandom assignment.** While we attempted random assignment, in some cases administrators requested services sooner versus allowing half of the referred students to wait through the planned control period. This does not appear to have been largely impactful, as requests to serve sooner were not based on initial teacher ratings, and some sites had students waiting with higher negative scores than others who were served immediately. The requests to serve sooner were nonsystematic, and we tested for important or likely areas of difference (e.g., severity and key demographics). Yet, the lack of random assignment is a limitation in that it is possible that there was some unknown difference between the treatment and control groups. A follow-up study, with more sites, plus more capacity to serve more students at the same time (i.e., more counselors and more playroom space), enabling a large number of referrals who are all ready to start on the same date would be helpful to confirm apparent effects of the intervention for the population. This arrangement, however, would differ from the typical ways that services are provided by counselors in schools (i.e., attending to each referral

from administrator or teacher at the time the referral is made), and in addition, might be limited to serving students whose difficulties do not stand out with the level of severity and persistence as the referrals targeted in this study.

**Most teacher raters not blinded.** It is possible that teacher awareness of services versus waiting period affected ratings. Yet, if teachers were affected to more positive ratings following treatment, it would seem that ratings of Internalizing Composite items of the TRF would have changed similarly to items within the Attention Problems subscale and Total Problems. Further, some of the teachers worked under intense pressure, especially in sites not meeting or nearly not meeting adequate yearly progress. In those cases, it would seem that some teachers could feel pressure for negative ratings, hoping that nonimprovement through intervention would justify removing a highly disruptive student to special programs outside of her/his classroom.

To confirm or clarify findings, we would like to see follow-up studies with larger sample sizes, and other efforts to address potential bias of nonblinded raters. We would like to see more studies in high-poverty schools and targeting most highly troubling behaviors, thus taking most effective research methods to areas and problems of most high need.

### Implications for Practice

It is our hope that practitioners from counseling and related fields will see the potential to develop CCPT within their practice, especially for high-need children and families, and specifically for reaching high-need children in real-world settings who might not otherwise be reached without services in schools. Further, there may be unique implications for counselors serving children with highly underdeveloped self-responsibility from this study. When reviewing referrals with school administrators, we noted high levels of administrator doubt that students referred could *ever* come to make mature and effective behavioral choices. And from our combined 40+ years of experience providing and supervising CCPT, we found many of the children in this study to require unusually frequent limit-setting in sessions. The approach to limit-setting in the CCPT sessions of this

study, originally developed by Louise Guerney and represented in [Cochran, Nordling, et al. \(2010\)](#), maintains a profound focus and faith in facilitating the child's existential choices in moments of impasse. Each therapist met the child with warmth and empathy through each moment of impasse, while allowing the child to maintain responsibility, to experience, and to learn from experience of (a) feeling and processing of the impact of a necessary limit, (b) choosing to search for an alternative that meets his or her unique need in self-expression, and (c) selecting and acting on the new path to self-expression. In this approach to limit-setting in CCPT, the therapist provides empathy, of course, but no guidance or alternative, instead maintaining her sole focus and faith in the child's experience, process, reactions, and ability to self-regulate and make choices.

### Conclusion

Too often highly troubled children who live in poverty fall through the gaps in the safety net of existing school and social services. Without effective services, these children are at high risk of being funneled into the school-to-prison pipeline following from disruptive behavior at far too young an age ([Children's Defense Fund, 2007](#); [Laura, 2014](#); [Wald & Losen, 2007](#)). Yet, we can know from these findings specific to children with highly disruptive behavior in high-poverty schools, as well as the body of research evidencing the effectiveness of CCPT ([Lin & Bratton, 2015](#)), that children who enter school disadvantaged, distressed, and disruptive are not destined for the juvenile correction system, or to lives of misery with the additional costs to peers, schools, and society. Rather, while social change is needed ([Children's Defense Fund, 2007](#)), even while progress to this much-needed change is inadequate, significant change through a troubled child's internal world is possible, and is effective in changing behavior, and enhancing the child's well-being. The child's therapy hour, or even half hour two times per week, focused in the child's self-expression and processing of experience, self-responsibility, and choice in therapeutic relationship—CCPT—can make a significant, powerful, and practical difference in the lives and school success of children in great need of our care and effective outreach.

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