CHILD-CENTERED PLAY THERAPY (CCPT) WITH LATINA/O CHILDREN EXHIBITING SCHOOL BEHAVIOR PROBLEMS: COMPARATIVE EFFECTS OF DELIVERY BY SPANISH-SPEAKING AND ENGLISH-SPEAKING COUNSELORS

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The shortage of bilingual counselors is one barrier to young Latina/o children receiving mental health services. Child-centered play therapy (CCPT) is a developmentally responsive intervention based on the premise that play is children's natural means of communication across cultures. This randomized controlled study examined the effects of CCPT with young Spanish-speaking Latina/o children exhibiting clinical levels of school behavior problems. Participants were 57 pre-K to kindergarten Latina/o children (72% male; mean age = 4.0) randomly assigned to three treatment groups: CCPT with Spanish-speaking, bilingual counselors; CCPT with English-speaking, monolingual counselors; or active control (bilingual mentoring). Monolingual counselors participated in cultural competency training and supervision with bilingual counselors and supervisors. According to independent observers and teachers blinded to children's group assignment, both the bilingual CCPT group and the monolingual CCPT group demonstrated moderate treatment effects over bilingual mentoring, yet between-group differences were not statistically significant. Analysis of within-group change over time indicated that children in both CCPT interventions demonstrated statistically significant improvement, while the mentoring group did not. The percentage of children in each treatment group who improved from clinical to normal behavioral functioning suggests the clinical significance of the findings: 80% bilingual CCPT, 70% monolingual CCPT, 15% bilingual mentoring. Overall, findings indicate that CCPT, whether delivered by bilingual counselors or culturally-competent, monolingual counselors, is a promising intervention for young Latina/o children exhibiting behavior problems.

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CHILD-CENTERED PLAY THERAPY (CCPT) WITH LATINA/O CHILDREN EXHIBITING SCHOOL BEHAVIOR PROBLEMS: COMPARATIVE EFFECTS OF DELIVERY BY SPANISH-SPEAKING AND ENGLISH-SPEAKING COUNSELORS

Latinas/os are the fastest growing minority group in the changing demographics of the United States. This ethnic group accounts for 17% of the total U.S. population, and by 2060, it will constitute approximately 29% (U.S. Census Bureau, 2015). This population is highly represented in the public school system. In 2012, Latina/o children represented 24% of the total enrollment in pre-kindergarten through 12th grade, and it is expected that by 2024, they will make up 29% of the enrollment (Musu-Gillette et al., 2016). Unfortunately, Latina/o children in the United States face diverse challenges that place them at risk for developing behavioral problems. For instance, researchers have pointed out that Latina/o children are less prone to academic achievement than their White peers (Kena et al., 2015; NCES, 2003). It has also been documented that Latinas/os have the highest rate of dropouts compared to students from other ethnic and racial groups (Kena et al., 2015; Musu-Gillette et al., 2016; National Task Force on Early Childhood Education for Hispanics, 2007). Risk factors, including language difficulties, acculturation stress, and poverty, make young Latina/o children more vulnerable to developing behavioral troubles, relational difficulties, and communication problems (Turney & Kao, 2012). Without early intervention, childhood behavior problems tend to remain stable over the child's lifetime and are associated with long-term consequences, including a variety of mental health disorders, youth violence, and delinquency (Turney & Kao, 2012; Vazsonyi & Chen, 2010).

It seems evident that there is a need for early mental health interventions for young Latina/o children (Turney & Kao, 2012; Vazsonyi & Chen, 2010). Yet, Latinas/os are often underrepresented in the mental health field (Avila & Bramlett, 2013; Ojeda, Flores, Rosales, &

Morales, 2011; Snowden & McClellan, 2013). Multiple scholars (Arredondo, Gallardo-Cooper, Delgado-Romero, & Zapata, 2014; Baumann, Rodriguez, & Parra-Cardona, 2011; Santiago-Rivera, 1995; Santiago-Rivera, Arredondo, & Gallardo-Cooper, 2002; Shattell, Hamilton, Starr, Jenkins, & Hinderliter, 2008; Snowden & McClellan, 2013) have also pointed out that there is not just a need to provide mental health interventions to this population, but most importantly, such interventions must be culturally responsive to the needs of Latinas/os. For instance, interventions should consider the cultural values and linguistic aspects that are often referred to as prominent barriers for Latinas/os when accessing mental health services (Castaño, Biever, Gonzalez, & Anderson, 2007; McCaffrey & Moody, 2015).

In this regard, child-centered play therapy (CCPT)—a counseling intervention for children—has been shown to be effective with young children from diverse cultures, including Latina/o children (Ceballos & Bratton, 2010; Garza & Bratton, 2005; Lin & Bratton, 2015). However, little research has been conducted regarding the effectiveness of this intervention and the linguistic aspects when delivering CCPT to young Spanish-speaking Latina/o children. For the purposes of this study, the term *Spanish-speaking Latina/o children* is loosely used to refer to children who reported having Spanish as their first language and who might speak English to some extent. Also, the terms *Latina/o* and *Hispanic* are often used interchangeably in the mental health literature. For this study, I use the term Latina/o.

Latina/o Cultural Values

Latinas/os represent a heterogeneous group due to diverse experiences and backgrounds, such as documented status in the United States, level of acculturation, language preference, socioeconomic status, and geographical place of birth. The Latina/o population comprises people from many countries of origin. In the last U.S. Census in 2010 (U.S. Census Bureau, 2012), 64%

of Latinas/os reported being from Mexican origin, followed by 9.2% of Puerto Rican descent, and 3.5% from Cuban origin. The rest was accounted for by Latinas/os from various countries in Central America, South America, and the Dominican Republic. More than half of the total number of Latinas/os living in the United States are primarily distributed in three states: California, accounting for 27.8%; Texas, accounting for 18.7%; and Florida, accounting for 8.4% (U.S. Census Bureau, 2012). It is also estimated that of the 58 million Latinas/os living in the United States (U.S. Census Bureau, 2015), 11 million hold undocumented status (Krogstad, Passel, & Cohn, 2017).

Nonetheless, even though Latinas/os may have different experiences, they also tend to share some common cultural values. In fact, Arredondo et al. (2014) has encouraged the utilization of Latina/o-centered approaches in which the integration of Latina/o cultural values is a key aspect of mental health interventions. From an ethical perspective, counseling professionals have the obligation to respond in a culturally sensitive manner to clients by understanding their worldviews and honoring their cultural values when providing services (American Counseling Association [ACA], 2014).

More specifically, for counselors working with Latina/o children and their families, Drewes (2006) has encouraged attitudes and practices that promote family ties, respect, and interpersonal relationships. Similarly, Ceballos and Bratton (2010) noted those attitudes are fundamental components of some Latina/o cultural values such as *familismo, personalismo,* and *respeto*, values that are particularly important to consider when working with Latina/o children and their families.

Familismo [Familism] is a collectivistic worldview in which the family members are willing to sacrifice themselves for the welfare of the family (López-Baez, 1997; Santiago-Rivera

et al., 2002) or place the needs of friends or family members—including extended family—before their own (Sue & Sue, 2016). Familismo is often misunderstood as dependence, immaturity, or lack of initiative, which could lead to erroneous impressions or even incorrect diagnoses of children. It is expected that clients from Latina/o origin may take a few sessions to begin feeling comfortable (López-Baez, 2006). Personalismo [personalism] is a term used to describe Latina/os' preferences for warm and caring personal interactions (Arredondo et al., 2014). Latinas/os value relationships in which they show a significant amount of emotional investment with family and friends (Santiago-Rivera et al., 2002). Counselors who understand the value of personalismo might be prepared for informal "chit-chats," close proximity, personal questions from clients, and—depending on the structure of the service—sharing food in informal gatherings (Ojeda et al., 2011). The cultural value of respeto [respect] refers to a demonstration of unconditional respect and deference toward elders and authority figures such as parents, teachers, aunts, and uncles (Ojeda et al., 2011). For instance, respeto is an important consideration in parent consultations on the progress of their child. For example, it would be important for parents to hear the child's progress in terms of becoming less defiant and more compliant with social norms (Garza, Kinsworthy, & Watts, 2009).

Considerations in Counseling Latinas/os

Although mental health problems are considerably prevalent among Latinas/os in the United States (Center for Behavioral Health Statistics and Quality, 2015), and despite the fact that they are the largest minority group in the country (U.S. Census Bureau, 2012), Latinas/os are frequently underrepresented in mental health services (Avila & Bramlett, 2013; Ojeda et al., 2011; Snowden & McClellan, 2013). Major factors contributing to disparities in mental health care of Latinas/os are, on the one hand, social structure factors such as poverty, level of

education, and lack of health insurance, and on the other hand, cultural barriers (Arredondo et al., 2014; Avila & Bramlett, 2013; De Jesus & Xiao, 2014). In 2010, 6.1 million Latina/o children lived in poverty, a situation that is highly associated with uninsured rates (Lee & Matejkowski, 2012). Approximately 24% of Latinas/os lack health insurance (U.S. Census Bureau, 2015), and only 6.8% have access to mental health services (U.S. Department of Health and Human Services, 2011). It has been documented that the lack of health insurance is directly associated with disparities in the use of services, especially preventive care (Avila & Bramlett, 2013). Although systemic barriers are major factors contributing to Latinas/os lack of access to mental health services, cultural barriers also contribute to the underutilization of mental health services. For example, unfamiliarity with counseling and psychological services, mistrust of governmental institutions, and lack of understanding of the role of mental health professionals are not only reasons why Latinas/os underutilize services, but also a motive to drop out of therapy prematurely (Santiago-Rivera, 1995). For purposes of this study I address three specific aspects related to cultural barriers and its importance for the counseling process: level of acculturation, race and ethnicity, and language. It is important to note that cultural factors are by no means limited to these three aspects.

Level of acculturation

In broad terms, the concept of acculturation encompasses a process that is dynamic and non-static by nature and that "explain[s] how individuals adapt to and change in new environments" (Santiago-Rivera et al., 2002, p. 38). Based on Berry's (1997) work, Coll and Marks (2012), provided the following definition:

> The term acculturation typically denotes a process by which an individual (or group of individuals) encounters a new cultural context and begins a series of complex social, interpersonal, and context-sensitive psychological processes of assuming new cultural

> attitudes, abilities and traditions while maintaining (or not maintaining) those from the individual's culture of origin. (p. 7)

The level of acculturation might be directly associated with stress within the family system. Some Latinas/os may maintain their cultural values while others may assimilate new values and reject their own (Sue & Sue, 2016). Assessing the level of acculturation in Latina/o children and families is crucial to gaining a better understanding of cultural barriers or strengths that could potentially interfere or help during the counseling process. For instance, counselors may evaluate the level of acculturation by exploring more about generational status, residential history, country of origin (if appropriate), and language, among other factors.

Racial/Ethnic Match

Santiago Rivera and colleagues observed (2002) that Latina/o clients may experience traditional mental health services as impersonal, particularly when services are delivered by non-Latina/o counselors. On the contrary, authors note, Latinas/os often report feeling more understood if the mental health professional shares similar cultural values. However, researchers (Verdinelli & Biever, 2013) have stated that results from studies are inconsistent and have not provided strong evidence for ethnic matching as being critical in therapeutic outcomes for Latinas/os. Cabral and Smith (2011) conducted a meta-analysis in which they investigated the effects of racial/ethnic matching between clients and therapists. The study concluded that initially clients tend to have a strong preference for working with a counselor with a similar ethnic background. However, findings suggested that there are not benefits on intervention outcomes from counselor-client ethnic/racial matching. Authors stated that "the greatest relevance of ethnic/matching occurs prior to therapy and during the initial sessions of therapy when the therapeutic alliance is being formed" (Cabral & Smith, 2011, p. 545). Thus, according to Cabral and Smith (2011) the debate should focus more attention on multicultural

competencies, adjusting interventions to client's culture, and the relationship. In fact, Arredondo et al. (2014) argue that ethnic matching is not critical in counseling Latinas/os, stating, "cultural competency preparation will guide responsive and ethical practice" (p. 218). Some scholars have pointed out that when counseling Latinas/os a more crucial factor than ethnic/race matching is language (Arredondo et al., 2014; Santiago-Rivera, 1995; Santiago-Rivera et al., 2002).

Language

The U.S. is considered the fifth-largest Spanish-speaking country in the world and Spanish is the second-most-often spoken language (Ryan, 2013). According to recent statistics (Ryan, 2013), 26% of the Latina/o population is not proficient in English, 56.3% speaks English "well," and 17.8% speaks English "very well" to "well." The number of Latinas/os who are bilingual has been increasing, especially because children formally start learning English at very young ages (Mallikarjun, Newman, & Novick, 2017). However, most Latina/o families have a preference for speaking Spanish at home (Santiago-Rivera et al., 2002). Additionally, it is important to consider that emotions are learned in the mother tongue, which for many Latina/o children is Spanish (Arredondo et al., 2014).

The implications for language in counseling are crucial because linguistic barriers can lead to limited or poor quality services, misdiagnosis, and/or early termination of treatment (Kohrt & Kennedy, 2015; Santiago-Rivera, 1995; Snowden & McClellan, 2013; Verdinelli & Biever, 2013). Communicating in English-oriented mental health services is a challenge for many Latina/o families because language "introduces a significant barrier of its own" (Snowden & McClellan, 2013, p. 1628).

This is particularly challenging because the growth of bilingual mental health professionals has not been commensurate with the growth of Spanish-speaking Latinas/os

(Arredondo et al., 2014; Kohrt & Kennedy, 2015). Ethically, counselors are obligated to arrange for accommodations when linguistic barriers exist (American Counseling Association, 2014). Due to the high rates of Spanish-speaking Latina/o children in need of mental health interventions and the shortage of Spanish-speaking counselors, English-speaking therapists often face the dilemma of refusing to treat Spanish-speaking children or attempting to provide services in English (McGee, 2010; Tovar, 2015). Nonetheless, little scholarly attention has been paid to this issue, and the effects of delivering counseling interventions to Spanish speakers in English are unknown. Research is needed to investigate the effects of language in counseling treatment outcomes to identify early mental health services that are most responsive to the developmental and cultural needs of young Spanish-speaking Latina/o children.

Child-Centered Play Therapy

Play therapy is a developmentally effective counseling intervention with children (Bratton, Ray, Rhine, & Jones, 2005) that allows them to express their thoughts, feelings, and behaviors through children's natural medium of communication, play (Axline, 1947; Landreth, 2012; Schaefer & O'Connor, 1983). The use of play in counseling is based on the evidence that play is the universal language of children (Landreth, 2012) and is crucial for children's development across cultures (Gil & Drewes, 2006). From a developmental perspective, Piaget (1959) noted that abstract thinking is a process that takes place at approximately the age of 11; until then, children's experiences are projected in concrete ways. Therefore, play becomes an ideal therapeutic ally because it bridges the gap between concrete thinking and abstract experiences, such as feelings (Landreth, 2012).

Child-centered play therapy is a humanistic approach based on person-centered theory and is founded in the philosophy that each person is continuously striving toward self-

actualization (Axline, 1947). As in person-centered theory, the healing factor in CCPT is the relationship, a relationship based on three conditions from the therapist: genuiness, unconditional positive regard, and empathic understanding. In CCPT, children “play out” feelings and problems, just as adults “talk out” difficulties with the therapist. Play is children's most natural medium of communication (Axline, 1947; Landreth, 2012) and toys are children’s words through which they express their anxieties, fears, fantasies, guilt, etc. Thus, CCPT is an attitude, a way of being; it is an approach in which children, rather than their problems, are the most important element in therapy (Landreth, 2012). The therapeutic relationship that is developed during the counseling process is the primary vehicle that promotes growth and change (Landreth, 2012; Ray, 2011). The CCPT approach is based on the belief that when children are provided with an opportunity to be themselves, they learn to be creative in facing problems that were previously stressful (Axline, 1947; Landreth, 2002).

Of play therapy approaches, CCPT is the most used (Lambert et al., 2007) and the most researched with over 60 outcome studies published since 1995 (Bratton et al., 2015). Recently, CCPT including CCPT-based filial therapy was evaluated and listed by the National Registry of Evidence-based Programs and Practices (2017) as an effective or promising intervention for several childhood disorders. Meta-analyses have provided further supports for the efficacy of CCPT. Lin and Bratton (2015) found that CCPT approaches, including CPRT/filial therapy, showed an overall moderate treatment effect size on a range of children’s presenting issues, while Ray, Armstrong, Balkin, & Jayne (2015) found that school-based CCPT demonstrated statistically significant improvement in emotional and behavioral problem symptoms. Specific to CCPT with minority groups, Lin and Bratton’s (2015) findings indicated that CCPT demonstrated statistically significant stronger treatment effects for children from ethnic minority

groups compared to White children. This finding supports literature that suggests play is a universal language for children (Landreth, 2012; Gil & Drewes, 2006). Lin and Bratton (2015) concluded that "CCPT is particularly responsive to the needs of diverse populations of children and provides support for its consideration as a culturally responsive counseling intervention for children" (p. 93).

More specifically, CCPT research has been also conducted with Latina/o populations, and overall findings have suggested the effectiveness of this approach with Latina/o children and families (Ceballos & Bratton, 2010; Garza & Bratton, 2005; McGee, 2010; Villareal, 2008). Interestingly, research with this population has been conducted in English and Spanish. For example, Garza and Bratton (2005) investigated the effectiveness of CCPT using bilingual play therapists with Spanish-speaking Latina/o children. Similarly, Ceballos and Bratton (2010) provided CPRT delivered by bilingual counselors to Spanish-speaking Latina/o parents. Villareal (2008) investigated the effects of CPRT when delivered by English-speaking Latina/o therapists to English-speaking Latina/o parents. Overall, the mentioned studies suggested that children participating in CCPT demonstrated statistically significant improvements and moderate to large effect sizes in internalizing and externalizing behaviors. More recently, McGee (2010) studied the effects of CCPT when delivered by monolingual English-speaking play therapists to Spanish-speaking children. Participants in this study were 24 Spanish-speaking Latina/o children in prekindergarten through second grade who presented with behavior problems. Children received 8 sessions of CCPT, once a week for 30 minutes. Overall, results indicated no statistically significant benefits for the CCPT group conducted by an English-speaking counselor as compared to the wait list group. Findings indicated, moderate effect sizes on overall and externalizing behaviors for children participating in CCPT.

Research with Latina/o children and families have suggested that CCPT is a culturally responsive approach because it appears to align with the cultural values of Latinas/os. In addition, play might be helpful in facilitating communication when there are linguistic differences between the child and the play therapist. In this manner, the use of English-speaking therapists could potentially help to meet the needs for Spanish-speaking Latina/o children (McGee, 2010). Research is needed to determine if the language and/or ethnicity of the play therapist impacts the outcome of CCPT with Spanish-speaking Latina/o children. Specifically, research is needed that is conducted in a culturally competent manner to achieve reliable outcomes (Ojeda et al., 2011). Eap and Nagayama Hall (2008) stated that "conducting random control trial research with diverse populations involves an understanding of the complex interactions between the client's cultural world and the treatment being offered" (p. 437).

Purpose of the Study

Due to the rapid growth of the Latina/o population whose primary language is Spanish, and the lack of bilingual counseling services, monolingual English-speaking counselors are often required to provide counseling services to Spanish-speaking children and families (McGee, 2010; Tovar, 2015). Child-centered play therapy is a developmentally appropriate intervention for children that has demonstrated positive outcomes with the Latina/o population. Additionally, the use of play could potentially help to bridge the gap when linguistic differences exist between child and therapist. This study explored the effects of CCPT with Spanish-speaking young Latina/o children exhibiting school behavior problems. More specifically, the purpose of this study was to address three research questions:

1. What is the effect of CCPT on Latina/o children's behavior problems when conducted by bilingual play therapists compared to a control condition, as reported by teachers and observers?

2. What is the effect of CCPT on Latina/o children's behavior problems when conducted by monolingual play therapists compared to a control condition, as reported by teachers and observers?

3. What is the effect of CCPT on Latina/o children's behavior problems when conducted by bilingual play therapists compared to monolingual play therapists, as reported by teachers and observers?

For purposes of this study I use the term *bilingual play therapist* to refer to a counselor trained in CCPT procedures who self-identified as Latina/o and is fluent in both English and Spanish language. The term *monolingual play therapist* is used to refer to a counselor trained in CCPT procedures who self-identified as non-Latina/o and speaks only English. The control condition is used to refer to the paraprofessional bilingual mentor who self-identified as Latina/o.

Methods

I conducted a randomized controlled design to examine the effects of CCPT with Spanish-speaking Latina/o children who exhibited behavioral problems in school. An a priori mixed between-within ANOVA G* power analysis yielded a target sample size of 14 participants per group, for a total of 42 participants. Based on Cohen's (1988) recommendations, I set the G*power calculation with an alpha level of .05, a moderate effect (f =.25), and a minimum power at .80 for three groups over three points of measure. To allow for attrition, I targeted a total sample of 60 children, 20 per group.

Participants

Participants were young children from four schools serving low-income children in one suburban school district in the southwest United States. Children met the following criteria to participate in the study: (a) Latina/o or Hispanic between the ages of 3½ and 5 enrolled in Head Start pre-school, pre-kindergarten, or kindergarten; (b) Spanish as their primary language and enrolled in the English as a Second Language (ESL) program; (c) in the borderline or clinical range according to the teachers' report in the Caregiver-Teacher Report Form (Achenbach &

Rescorla, 2000) in either the Externalizing, Internalizing, or Total Problems scale; and (d) not receiving any other mental health services at the same time of this study.

Initially, I recruited 66 potential participants, of which 57 met the inclusion criteria and completed the study. Parents whose children did not meet the inclusion criteria mentioned above were provided with a list of referrals to local counseling and university clinics. Participants who met the criteria were randomly assigned to the three treatment groups. Participants were 72% male with a mean age of 4.0. Figure 1 shows participant recruitment and detailed demographics by group.

Instrumentation

Caregiver-Teacher Report Form 1½-5

The Caregiver-Teacher Report Form 1½-5 (C-TRF; Achenbach & Rescorla, 2000) measures behavioral, emotional, and social functioning in preschool children and is designed to be completed by a caregiver or teacher who knows the child in the school or daycare environment. This instrument is composed of 99 scaled items that respondents rate as 0 (*not true*), 1 (*somewhat or sometimes true*), or 2 (*very true or often true*), based on their experience with the child in the preceding two months.

For purposes of this study, the midtest and posttest asked teachers for changes in children's behavioral problems during the last two weeks. The C-TRF also includes three open-ended questions that ask for the child's information regarding illness or disability, other concerns, and the best things the child does. This instrument can be completed in about 10 to 15 minutes. The C-TRF displays results in profiles that include percentiles and T scores, plus normal, borderline, and clinical ranges. The C-TRF include a *Syndrome Scale Profile* comprised of Internalizing, Externalizing, and Total Problems.

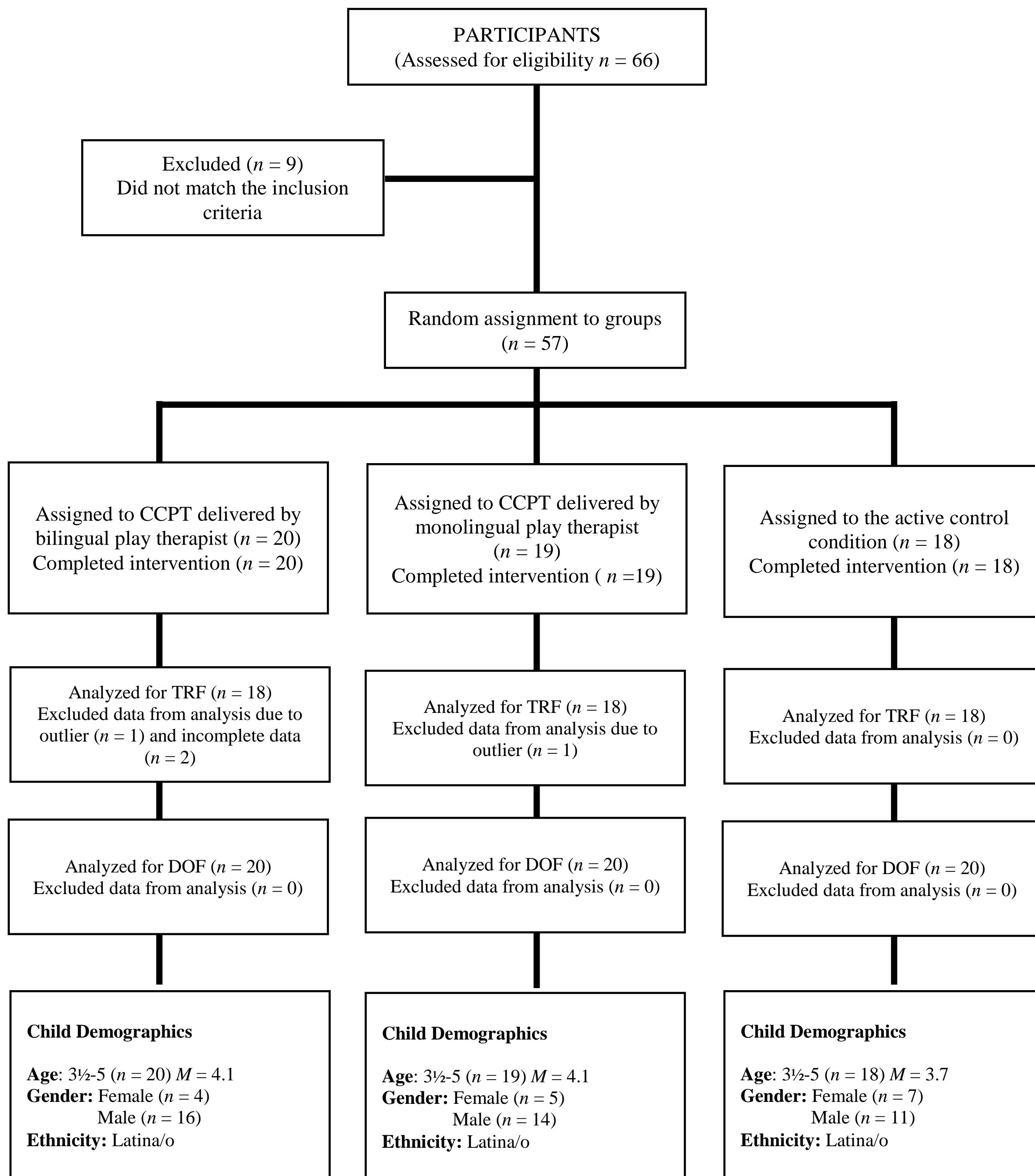

Figure 1. Participants flow chart.

The validity and reliability of the C-TRF have been demonstrated in multiple studies (Achenbach & Rescorla, 2000; Carey, Furlong, & Pavelski, 1997). Across all the scales,

Achenbach and Rescorla (2000) reported a test-retest reliability with a mean interval of 8 days of .81 for the C-TRF. Additionally, in a 12-month period, stability correlation for C-TRF was .59 over a 3-month period. The C-TRF has also shown evidence for validity, supported in content validity, criterion-related validity, and construct validity. In addition, applications of the C-TRF have been studied in different countries and translated into 58 languages, including Spanish. The CTRF has been identified as a sensitive instrument across race/ethnicity, income level, and language (Achenbach & Rescorla, 2010).

Direct Observation Form

The Direct Observation Form (DOF; McConaughy & Achenbach, 2009) is an instrument designed to rate children's behaviors in class, recess, or another group setting. During an interval of 10 minutes, observers describe in a narrative form children's behaviors, affects, and interactions. Additionally, the child is rated for being on-task or off-task for five seconds at the end of each minute. At the end of the 10-minute period, the observers rate the child's behaviors described in 88 items using a 0-1-2-3 scale, with 0 being a no occurrence to 3 being a definite occurrence with severe intensity and frequency. Item 99 is an open-ended question for the observer to note any other problem not addressed in the previous items.

Due to children's variability of behaviors in different settings or circumstances, the DOF software scoring program requires at least two observations of the observed child. McConaughy and Achenbach (2009) encouraged three to six sets of observations for each case. To follow strict protocols, this study required three observations for each targeted child. In addition, observations were made at different times of the day as outlined by McConaughy and Achenbach.

Profiles for the DOF in the classroom include: Syndrome scale (comprised of sluggish cognitive tempo, immature/withdrawn, attention problems, intrusive, and oppositional), the Total

Problems and On-Task profile, and the DSM-Oriented scale (including the Attention Deficit/Hyperactivity Problems subscale, Inattention subscale, and the Hyperactivity-Impulsivity subscale). The DOF also provides an Aggressive scale to rate behaviors in recess or a non-classroom setting. For purposes of this study, I used the Total Behavior Problems Scale.

Across all the subscales, the interrater reliability ranged from .71 to .97 (M = .79). For the Total Problem Behaviors Scale, the interrater reliability was .97. The test-retest reliability mean reported was .58 across all problem scales and .72 for the Total Problems scale. The DOF has also showed evidence for the validity, supported in content validity and criterion-related validity.

Procedures

Upon receiving approval from the participating school district and the University of North Texas (UNT) Institutional Review Board, I recruited children from two Head Start pre-schools and two elementary schools, following the schools' existing procedures for identifying children for counseling. Consent forms of identified children were provided to parents in both English and Spanish. Next, teachers were asked to provide their consent as well and complete the C-TRF. Data collection occurred two weeks prior to the intervention.

Once I collected all consent forms and pretest assessments of children who met the inclusion criteria, objective raters completed pretest DOFs for children. Raters were master's level counseling students with previous training in child development. Raters were required to review the scoring procedures in the DOF manual (McConaughy & Acenbach, 2009) as well as participate in an intensive training to ensure an acceptable level of interrater reliability before they completed any observations for data collection. I followed Stemler's (2004) 70% recommendation for an acceptable quality of interrater reliability for consistency estimates. A

Pearson correlation coefficient was obtained to determine the level of agreement. Raters attained a degree of consistency of $r = .82$.

Following collection of pretest data, I randomly assigned children to the three treatment groups. I utilized block randomization by school to control for any differences in school environment and to ensure as equal number of participants as possible in each group. I randomized participants using a random numbers table. The result was as follows: CCPT delivered by bilingual therapists, $n = 20$; CCPT delivered by monolingual play therapists, $n = 19$; and active control condition delivered by the bilingual mentors, $n = 18$.

Children received 30-minute play therapy or reading mentoring sessions twice a week for a period of nine weeks. Initially, participants in the three groups were expected to receive 18 sessions. However, due to school holidays, absences, and extenuating circumstances from play therapists or reading mentors, participants received between 16 and 18 sessions with a mean number of session of 18 ($Mo = 8$). Once the interventions were completed, children in the bilingual mentoring group received nine weeks of play therapy intervention. Teachers and raters completed assessments at three different points of this study: at pretest (prior to any intervention), midtest (after four weeks of the intervention), and a post-assessment (after nine weeks of the study). Finally, to maintain confidentiality, all research records were stored in a double-locked cabinet in the principal investigator’s office area, which was accessible only to the research team.

Treatment Groups

Experimental Group Procedures

The two experimental groups consisted of CCPT delivered by a bilingual Latina/o play therapist and CCPT delivered by a monolingual non-Latina/o play therapist. Play therapists in

the two experimental groups followed the CCPT protocol treatment manual (Ray, 2011). Prior to the delivery of the intervention, bilingual and monolingual play therapists attended training in the CCPT protocol and providing culturally competent play therapy to Spanish-speaking Latina/o children. For this study, providing culturally competent training was essential to address the linguistic and cultural differences between Latino children and monolingual play therapists. Additionally, weekly supervision was provided by a bilingual and a monolingual supervisor with advanced training in CCPT procedures. Supervision began each week with a discussion centered on specific linguistic and cultural challenges. Monolingual play therapists were encouraged to consult in supervision whenever there were linguistic challenges.

All sessions were conducted in specially equipped playrooms in the schools following the recommended toys and materials for CCPT (Landreth, 2012) and the additional list recommended by Garza and Bratton (2005) for using culturally responsive toys and materials in CCPT with Latina/o children. Counselors recorded their play sessions for the purposes of supervision and to ensure treatment integrity. Play therapists included counselor professionals with at least a master's degree (n = 9). Bilingual play therapists included two females and one male who identified as Latina/o. Monolingual play therapists included three females and three males, all who self-identified as White. All play therapists had completed at least two play therapy courses and engaged in supervised practice in CCPT for at least one year.

As suggested by Garza and Bratton (2005), bilingual play therapists introduced the playroom in both Spanish and English and communicated to children that they could speak English or Spanish or both. With the intent of being culturally and ethically responsive, a bilingual play therapist introduced children to the monolingual play therapist and the playroom

using both languages. The bilingual play therapist also emphasized that the monolingual play therapist did not speak Spanish so he was not able to respond back in Spanish.

Parent and teacher consultations are an important component in the therapeutic process of CCPT. However, to ensure study validity, previous experimental CCPT research procedures (Bratton et al., 2013; Wilson, 2016) had included instructions to play therapists to refrain from engaging in communication with teachers or parents. In the present study, I attempted to balance cultural sensitivity while maintaining high levels of validity. Play therapists were asked to engage in active empathic listening with teachers and parents whenever they attempted to communicate, but not to provide feedback to teachers or parents about their student/child of focus. Once the study terminated, play therapists provided feedback and consultation to teachers and parents.

Control Group Procedures

The intention of the bilingual mentoring (RM) group was to control for the internal validity threat of attention (Nock, Janis, & Wedig, 2008). Also, this active control group helped to blind teachers about what intervention children were receiving. In bilingual mentoring, mentors provided a special time for a child in which they read books, colored, or drew. Bilingual mentors were volunteer students self-identified as Latina/o who had completed at least two years of university. Bilingual mentors were screened for previous experience working with children and trained on reading mentoring procedures. Mentoring training was conducted prior to the beginning of the study and was provided by a doctoral student in the counseling program who had had previous experience with mentors in the school system. All mentors were provided with the same kit of materials that included coloring sheets, reading books (bilingual), colors, crayons, pencils, and an audio recorder. All mentoring sessions were held in a designated area at the

participating schools, were audio recorded, and checked for adherence to the protocol. There were no children in these groups that appeared to need more intensive or immediate counseling services. At the end of the study, all children in the bilingual mentoring group received nine weeks of CCPT delivered by a bilingual play therapist. As play therapists, reading mentors were asked to engage in active empathic listening whenever teachers approached them. However, they were asked to not share any feedback or specific information about the child's experiences. Parent consultations for children in this group were held by the lead researcher.

Results

I performed a 2 (Group) x 3 (Times) repeated measures ANOVA on the dependent variables, including the C-TRF Total Problems score and DOF Total Problems score. Each analysis reasonably met the assumptions of level of measurement, random sampling, normal distributions, and homogeneity of variance. I established an alpha level of .05 to test for significant mean differences. Several researchers (Hedges, 2008; Henson, 2006; McGough & Faraone, 2009; Sullivan & Feinn, 2012) have underscored the importance of effect sizes and clinical significance in research, arguing that practical and clinical significance provide a more comprehensive evaluation of the efficacy of interventions. For this research study, practical significance was reported using partial eta squared (n_p^2) effect sizes which I interpreted using the guidelines proposed by Cohen (1988): .01 (*small*), .06 (*medium*), and .14 (*large*). Clinical significance is defined as the impact of the intervention on clients' everyday life (Kazdin, 1999). I determined the clinical significance of the findings by examining the percentage of children who moved from clinical or borderline scores to normal scores on the C-TRF.

Table 1 presents pre, mid, and posttest means and standard deviations on the dependent variables (C-TRF and DOF Total problems) for the three group conditions: CCPT delivered by a

bilingual play therapist, CCPT delivered by a monolingual play therapist, and the active control condition delivered by a bilingual mentor. Note that three participants were removed from the data analysis on the C-TRF; two due to incomplete data and one as a statistical outlier.

Table 1

Descriptive Statistics for Each Group on C-TRF and DOF Total Problems

		CCPT Spanish-Speaking (*n* = 18)		CCPT English-Speaking (*n* = 18)		Control Group (*n* = 18)	
		M	*SD*	*M*	*SD*	*M*	*SD*
C-TRF Total Problems	Pretest	61.722	4.184	61.944	4.304	62.888	7.521
	Midtest	54.277	7.168	57.833	7.571	59.500	7.213
	Posttest	51.944	9.926	51.111	7.828	57.111	9.151
		CCPT Spanish-Speaking (*n* = 20)		CCPT English-Speaking (*n* = 19)		Control Group (*n* = 18)	
DOF Total Problems	Pretest	55.150	5.173	54.263	6.349	54.555	5.802
	Midtest	50.700	3.798	50.684	6.377	52.666	5.646
	Posttest	48.400	4.546	49.263	5.713	51.666	5.0176

Note. Three participants were removed from the data analysis on the C-TRF; two due to incomplete data and one as a statistical outlier.

Research Question 1. Effects of CCPT Delivered by a Bilingual Play Therapist Compared to an Active Control Condition

Teacher Report

Results for the Total Problems on the C-TRF indicated no statistically significant interaction effect between time and treatment groups, $F(1, 34) = 1.759$, $p = .188$, and a medium effect size $\eta_p^2 = .096$, indicating that CCPT demonstrated a moderate treatment effect on reducing child behavior problems compared to the active control/mentoring group. Additionally, results indicated a statistically significant main effect for time $F(1, 34) = 14.365$, $p = .001$ with a large effect size $\eta_p^2 = .465$, indicating that according to teachers' report, when participants from

the experimental and control conditions were grouped together, participants demonstrated statistically significant improvement in behavior problems over time.

Because the main effect for time was statistically significant, I calculated a one-way ANOVA for each treatment condition to explore within-group differences. To avoid Type I error that can occur from multiple hypothesis testing I established an alpha level of .025 to detect statistical significant mean differences; I followed this procedure for all one-way ANOVA calculations. Results indicated that the CCPT bilingual group demonstrated statistically significant improvement from pre to mid to posttests $F(1, 17) = 12.651$, $p = .001$ and the treatment effect was large $\eta_p^2 = .613$. Analysis of the active control/mentoring group indicated no statistically significant difference across time $F(1, 17) = 3.057$, $p = .075$ yet the effect size was large $\eta_p^2 = .276$. Although the effect size for both conditions was considered large, the treatment effect for CCPT was almost three times as great as for the mentoring group. Visual analysis of mean scores depicted in Figure 2 supports the greater improvement of the CCPT group.

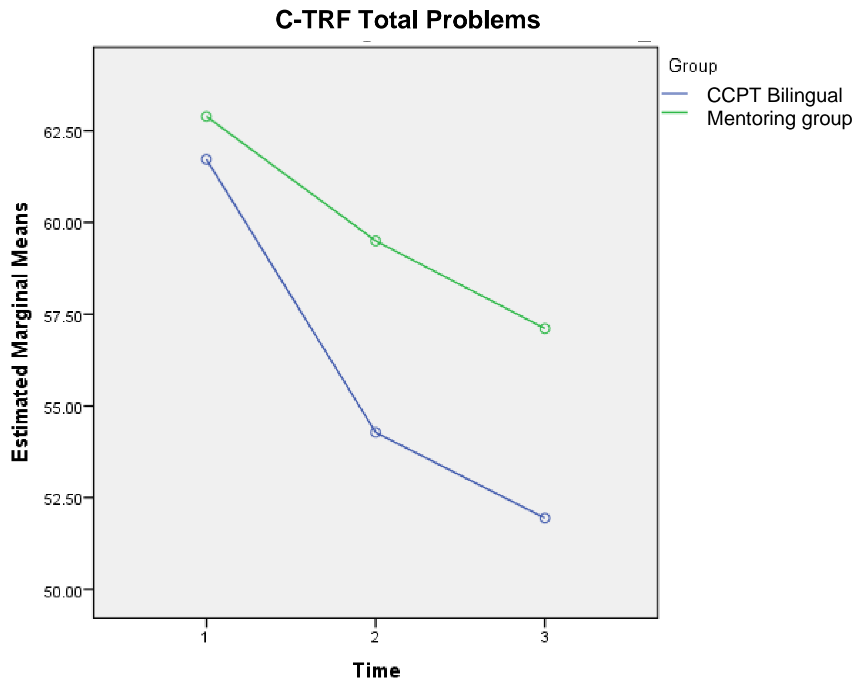

Figure 2. Mean scores on C-TRF total problems scores.

Direct Observation Rating

Results for the Total Problems on the DOF indicated no statistically significant interaction effect between time and treatment groups, $F(2, 36) = 1.440$, $p = .251$, and a medium effect size $\eta_p^2 = .076$, indicating that CCPT demonstrated a moderate treatment effect on reducing child behavior problems compared to the active control/mentoring group. There was a statistically significant difference for main effect of time $F(2, 36) = 8.969$, $p = .001$ with a large effect size $\eta_p^2 = .339$, indicating that according to observers' report, when participants from the experimental and control conditions were grouped together, participants demonstrated statistically significant improvement in behavior problems over time.

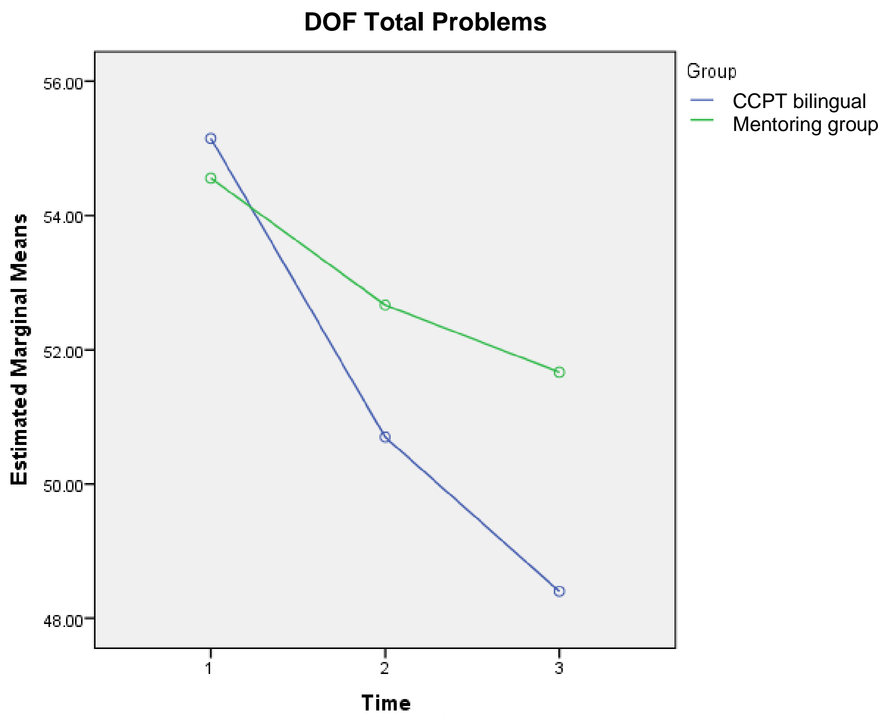

Figure 3. Mean scores on DOF Total Problems scores.

Because the main effect for time was statistically significant, I calculated a one-way ANOVA for each treatment condition to explore within-group differences. Results indicated that the CCPT group demonstrated statistically significant improvement from pre to mid to posttests; $F(1, 19) = 14.021$, $p = .001$ and the treatment effect was large $\eta_p^2 = .594$. Analysis of the active

control/mentoring group indicated no statistically significant difference across time $F(1, 19) = 1.097$, $p = .358$ and a medium effect size $\eta_p^2 = .121$. The treatment effect for CCPT was almost five times as great as for the mentoring group. Visual analysis of mean scores depicted in Figure 3 supports the greater improvement of the CCPT group.

Research Question 2. Effects of CCPT Delivered by a Monolingual Play Therapist Compared to an Active Control Condition

Teacher Report

Results for the Total problems on the C-TRF indicated no statistically significant interaction effect between time and treatment groups, $F(2, 34) = 1.317$, $p = .282$, and a medium effect size $\eta_p^2 = .074$, indicating that CCPT demonstrated a moderate treatment effect on reducing child behavior problems compared to the active control/mentoring group. There was a statistically significant difference for main effect of time $F(2, 34) = 13.621$, $p = .001$ with a large effect size $\eta_p^2 = .452$, indicating that according to teachers' report, when participants from the experimental and control conditions were grouped together, participants demonstrated statistically significant improvement in behavior problems over time.

Because the main effect for time was statistically significant, I calculated a one-way ANOVA for each treatment condition to explore within-group differences. Results indicated that the CCPT group demonstrated statistically significant improvement from pre to mid to posttests $F(1, 17) = 15.594$, $p = .001$ and the treatment effect was large $\eta_p^2 = .661$. As reported in the one-way ANOVA findings for Research Question 1, analysis of the active control/mentoring group indicated no statistically significant difference across time, and the effect size was large (.276). Although the effect sizes for both conditions are noteworthy, the treatment effect for CCPT was almost three times as great as for the mentoring group. Visual analysis of mean scores depicted in Figure 4 supports the greater improvement of the CCPT group.

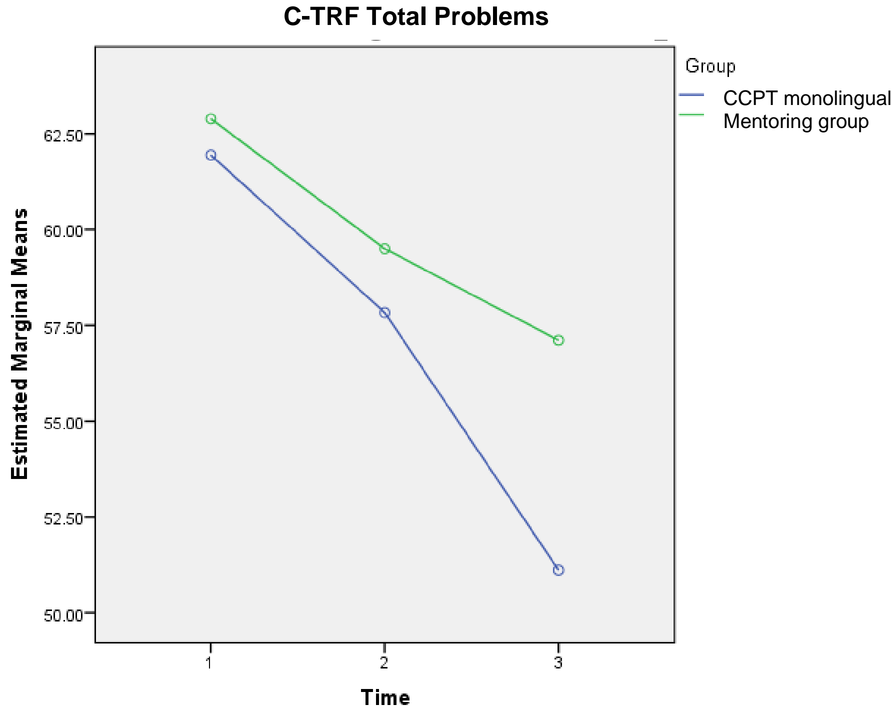

Figure 4. Mean scores on C-TRF Total Problems scores.

Direct Observation Rating

Results for the Total Problems on the DOF indicated no statistically significant interaction effect between time and treatment groups, $F(1, 35) = .438$, $p = .649$, and a small effect size η_p^2=.025., indicating that CCPT demonstrated a small treatment effect on reducing child behavior problems compared to the active control/mentoring group. There was a statistically significant difference for main effect of time $F(1, 35) = 6.183$, $p = .005$ with a large effect size $\eta_p^2 = .267$, indicating that according to observers' report, when participants from the experimental and control conditions were grouped together, participants demonstrated statistically significant improvement in behavior problems over time.

Because the main effect for time was statistically significant, I calculated a one-way ANOVA for each treatment condition to explore within-group differences. Results indicated that the CCPT group demonstrated statistically significant improvement from pre to mid to posttests

$F(1,18) = 8.993$, $p = .002$ and the treatment effect was large $\eta_p^2 = .514$. As reported in the the one-way ANOVA findings for Research Question 1, analysis of the active control/mentoring group indicated no statistically significant difference across time, and the effect size was medium (.121). Although effect sizes for both conditions are noteworthy, the treatment effect for CCPT was almost four times as great as for the mentoring group. Visual analysis of mean scores depicted in Figure 5 supports the greater improvement of the CCPT group.

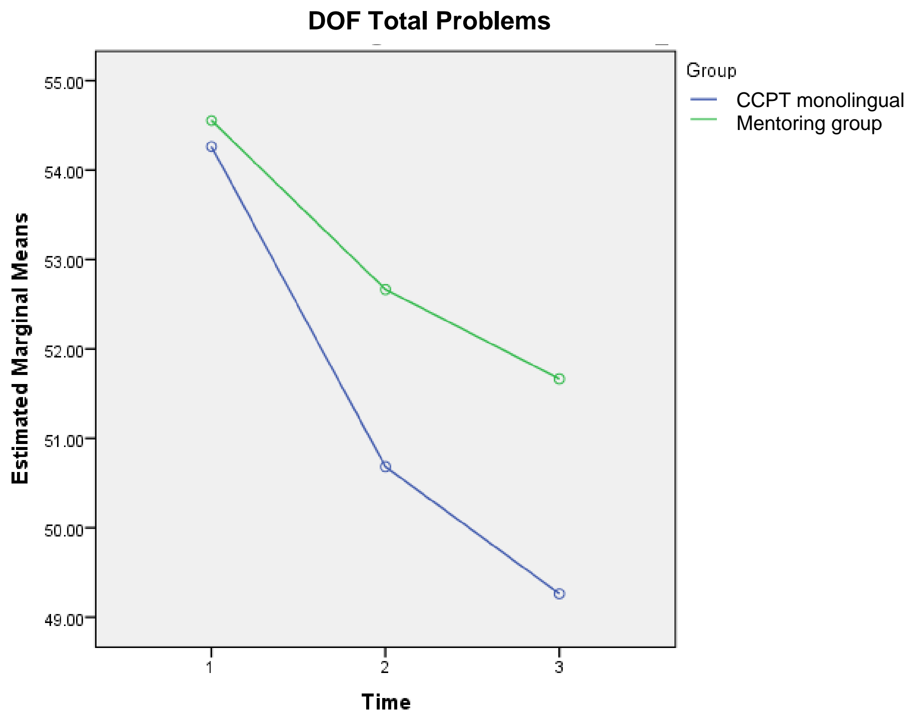

Figure 5. Mean scores on DOF Total Problems scores.

Research Question 3. Effects of CCPT Delivered by a Bilingual Play Therapist Compared to a CCPT Delivered by a Monolingual Play Therapist

Teacher Report

Results for the Total Problems on the C-TRF indicated no statistically significant interaction effect between time and treatment groups, $F(2, 34) = 1.661$, $p = .205$, and a medium effect size $\eta_p^2 = .091$. Visual examination of Figure 6 shows that although the two interventions

showed similar improvement at posttest, bilingual CCPT showed greater improvement from pre to mid than monolingual CCPT.

There was a statistically significant difference for main effect of time $F(2, 34) = 26.396$, $p = .001$ with a large effect size $\eta_p^2 = .615$, indicating that according to teachers' report, when participants from the experimental and control conditions were grouped together, participants demonstrated statistically significant improvement in behavior problems over time. Because the main effect for time was statistically significant, I examined the results from the one-way ANOVAs previously conducted for each treatment condition. As reported in the one-way ANOVA findings for Research Questions 1 and 2, both CCPT bilingual and monolingual groups demonstrated statistically significant improvement over time with similarly large treatment effects, .613 and .661 respectively. Figure 6 graphically depicts that children in the monolingual and bilingual CCPT groups improved to a similar level of functioning following the treatment phase, although the rate of change over time for each group differed.

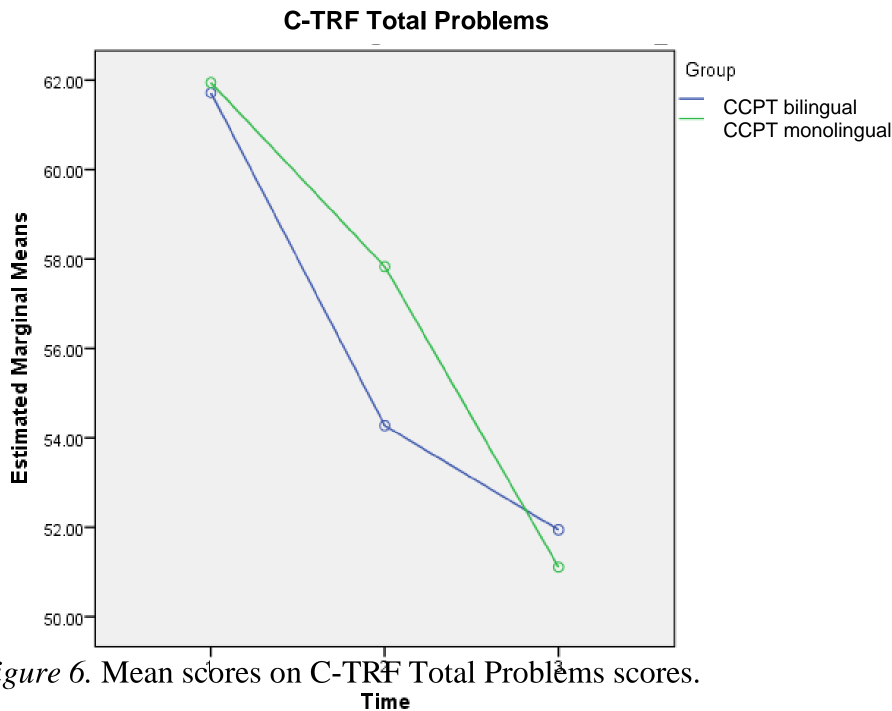

Figure 6. Mean scores on C-TRF Total Problems scores.

Direct Observation Rating

Results indicated no statistically significant interaction effect between time and treatment groups, $F(1, 37) = .537$, $p = .589$, and a small effect size $\eta_p^2 = .029$. There was a statistically significant difference for main effect of time $F(1, 37) = 22.138$, $p = .001$ with a large effect size $\eta_p^2 = .552$, indicating that according to observers' report, when participants from the experimental and control conditions were grouped together, participants demonstrated statistically significant improvement in behavior problems over time.

Because the main effect for time was statistically significant, I examined the results from the one-way ANOVAs previously conducted for each treatment condition. As reported in the one-way ANOVA findings for Research Questions 1 and 2, both CCPT bilingual and monolingual groups demonstrated statistically significant improvement across time and similarly large treatment effects, .594 and .514 respectively. Visual analysis of mean scores depicted in Figure 7 supports the improvement at the end of the intervention of both CCPT groups.

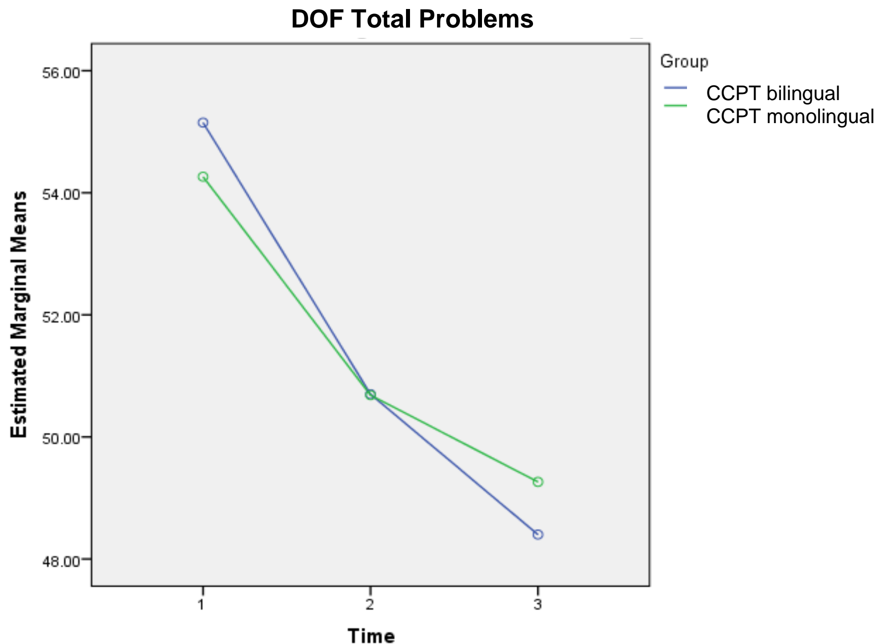

Figure 7. Mean scores on DOF Total Problems scores.

Clinical Significance

Clinical significance was analyzed based on the percentage of children who improved from borderline or clinical to normal on C-TRF Total Behaviors: 80% of children in the bilingual CCPT group and 70% of children in the monolingual CCPT group moved to normative functioning, while only 15% of children in the active control group improved to the normal range.

Discussion

This research study aimed to investigate the effects of CCPT on Spanish-speaking Latina/o children exhibiting behavioral problems. Specifically, the study sought to examine the effects of CCPT when delivered by a bilingual play therapist or a monolingual play therapist as compared to an active control condition delivered by a bilingual mentor. Although teachers and objective raters did not observe statistically significant differences between groups, the clinical and practical significance of the results suggested greater improvement in children who participated in either CCPT delivered by bilingual play therapists or CCPT delivered by culturally competent, monolingual play therapists as compared to children who participated in the active control condition.

The moderate treatment effects for bilingual and monolingual CCPT over the active control condition on children's global behavior problems are consistent with the findings from Lin and Bratton's (2015) meta-analytic review of CCPT research, and slightly better than the Ray et al. (2015) meta-analysis of school-based CCPT. Specific to the Latino population, the present findings are consistent with controlled outcome research examining effects of CCPT approaches on Latina/o children's behavioral problems (Ceballos & Bratton, 2010; Garza & Bratton, 2005). A strength of the present study is the use of blinded, direct observers as one of

two sources of measurement for assessing child behavior. With the exception of pre to midpoint findings for the two CCPT groups discussed further below, results reported by teachers and direct observers were consistent. The consistent ratings across teachers and independent observers provides greater confidence in the findings and answers the limitation cited in the majority of play therapy research (Bratton, 2015)—the need for multiple sources of assessment for a single outcome variable, one being an independent evaluator.

The current results, along with findings from the small body of existing research on CCPT approaches with Latina/o children, are particularly encouraging considering the need for empirically supported counseling services that are culturally responsive to Latina/o children and families. Historically, Latinas/os face risk factors including language differences and level of acculturation from the dominant culture, as well as poverty (NCES, 2003; Turney & Kao, 2012). Such factors have been correlated with the development of behavioral problems in Latina/o children, including aggressive behaviors (Vazsonyi & Chen, 2010), communication problems, and struggles with relationships (Turney & Kao, 2012). Additionally, Latina/o children are statistically less likely to succeed academically (Kena et al., 2015; NCES, 2003) and more likely to drop out of school when compared to other ethnic groups (Kena et al., 2015; Musu-Gillette et al., 2016; National Task Force, 2007). Without early intervention, childhood behavior problems tend to be stable over the child's lifetime and are associated with long-term consequences including a variety of mental health disorders, youth violence, and delinquency (Turney & Kao, 2012; Vazsonyi & Chen, 2010). Considering the robust data regarding the need for mental health interventions for Latina/o children, the present results provide an optimistic outlook indicating that CCPT may be a viable culturally responsive counseling intervention for reducing Spanish-speaking Latina/o children's global behavior problems.

Overall, findings are promising given the well-documented shortage of bilingual services for Latina/o children (Tovar, 2015), and suggest the effectiveness of CCPT with young Spanish-speaking children whether delivered by bilingual play therapists or culturally competent, monolingual play therapists. Multiple scholars have noted that play is the universal language of children (Axline, 1947; Landreth, 2012; Ray, 2011). Based upon results from this study, play might not only help to bridge the gap between concrete and abstract thinking as Piaget (1959) proposed, play might also serve to bridge the gap in linguistic differences between counselor and child. However, it is important to highlight that results from this research are based on the specific procedures followed in this study, namely providing cultural competency training and culturally-responsive supervision to monolingual, non-Latina/o counselors to provide ethical and responsible services to the participating children. Providing interventions in a language other than children's first or only language should be cautiously examined. The ACA Code of Ethics (2014) mandates counselors to arrange appropriate services when client and counselor have linguistic differences. Yet, in practice, counseling professionals (McGee, 2010; Tovar, 2015) have noted that due to the lack of bilingual counselors, mental health professionals working with Spanish-speaking children often face the ethical dilemma of providing services in a different language or not providing services at all. The present study aimed to ethically address the shortage of available bilingual services by providing counselors with Latino culture-specific training prior to intervention and culturally-responsive supervision throughout the intervention phase. These procedures were designed to bridge the gap in linguistic and cultural differences between children and counselors, particularly for the monolingual counselors to minimize differences in language. It is important to note that participants in the present study were young children between three-and-a-half and five years of age attending an English as a Second

Language (ESL) program. Thus, even if the children were not bilingual, English language was not unfamiliar to them. And as stated previously, CCPT allows children to use play as a means of self-expression, which may have helped to bridge the gap in language difference and contributed to ethical practice.

Results from this study also suggest that children in the bilingual mentoring group benefitted from having a special time with a bilingual mentor. Research examining the effects of school-based mentors trained and supervised in foundational CCPT skills indicate beneficial effects on young children's behaviors problems (Dafoe, 2017; Jones, Rhine, & Bratton, 2002). Hence, another potential solution to address the growing shortage of bilingual services in schools is to train and supervise Spanish-speaking, Latina/o mentors in therapeutic play skills grounded in CCPT.

The present study also suggests valuable information regarding CCPT's effectiveness for reducing Latina/o children's behavioral problems as CCPT appears to be a culturally responsive approach when working with this population regardless of cultural and linguistic differences between child and therapist. Landreth (2012) proposed that CCPT is responsive across cultures. In CCPT, the counselor provides a relationship in which the child is fully accepted and uniquely valued, with no expectation for the child to be different. The CCPT attitudes of empathy, warmth, and unconditional acceptance are conveyed nonverbally as well as verbally, thus transcend language. When the child experiences the therapeutic conditions from the therapist, the child feels accepted and prized and then is able to explore self-actualizing potential in healthier ways. This is particularly important for Spanish-speaking Latina/o children who move between two different cultures and two different languages. The therapy provides a non-judgmental relationship in which children lead the counseling process and the therapist follows them

(Landreth, 2012). Thus, CCPT also provides an opportunity for children to explore their cultural identities and linguistic preferences.

Findings from the current study align with those from studies suggesting that CCPT approaches are consistent with Latina/o cultural values (Ceballos & Bratton, 2010; Garza & Bratton, 2005). The emphasis on the relationship as the essential therapeutic factor for healing and change is a strong fit with the value of personalismo. Latinas/os tend to prefer warm and caring personal interactions (Arredondo et al., 2014). Cultural values and systemic barriers to Latinas/os accessing counseling services are important elements that need to be understood by mental health professionals when providing services to Latina/o children. Cultural training is imperative when working with Latinas/os in order to enhance therapeutic outcomes (Arredondo et al., 2014; Baumann et al., 2011; Santiago-Rivera, 1995; Santiago-Rivera et al., 2002; Shattell et al., 2008; Snowden & McClellan, 2013). Another factor in providing culturally-responsive services in accessibility. Due to mistrust and fear of governmental organizations, especially from undocumented immigrant families, Latinas/os often refrain from seeking counseling services in the community (Santiago-Rivera, 1995). Schools provide a familiar and safe setting that could potentially provide Latina/o children and families with greater access to mental health services.

Limitations and Recommendations

Although results from this study are encouraging and offer a viable solution for the shortage of culturally responsive counseling interventions for Spanish-speaking Latina/o children, limitations exist and should be considered when interpreting results. A major limitation is small sample size. Given the moderate treatment effects, a larger sample size might result in statistically significant differences among groups and more reliable results. In addition, the generalizability of results is limited to the specific Latina/o population in which the study took

place, including geographical location and school characteristics (Head Start Program and Title I schools). It is important to consider that the Latina/o population is a heterogeneous group with multiple intersectionalities such as country of origin, level of acculturation, language, socioeconomic status, generational status, and documented status, among other elements (Santiago-Rivera et al., 2002). In this regard, future studies might include more detailed and specific demographic information about the Latina/o population that is being studied.

The results from this research study were based on 16 to 18 play sessions. Due to the values of familismo and respeto, it has been noted that children may take a few more sessions to feel comfortable in the playroom as compared to non-Latina/o children (Drewes, 2006; López-Baez, 2006). Therefore, it might be important for future researchers to consider a greater number of sessions for this population. Similarly, because of the importance of family to Latina/o cultures, future studies should consider CCPT treatment procedures that include parent involvement. Additionally, follow-up studies are needed to investigate the long-term effects of CCPT for this population. Studies targeting specific disorders (e.g., anxiety and disruptive behaviors) could provide beneficial information on the relative effects of CCPT for various presenting issues.

The study design did not explore the impact of therapist language and ethnicity as separate variables, thus this omission represents another major limitation and should be addressed in future research. Similarly, children's primary language was based on parents' report rather than formal assessment. Future researchers should consider assessing children's level of English and Spanish fluency as well as level of acculturation as a mediator of treatment outcome when counseling Latino children. Finally, it is important to acknowledge the researcher's own biases. Due to the lack of bilingual Latina/o counselors, I, as lead researcher, took several roles

throughout the research study that might have resulted in a bias when analyzing results. Similarly, my ethnicity might have also led to racial biases.

Implications for Practice

The findings from the present study provide relevant information for play therapists when providing services to Spanish-speaking Latina/o children presenting with problem behaviors. Results suggest that CCPT is not only an effective intervention, but also a developmentally and culturally sensitive intervention with Spanish-speaking Latina/o children whether delivered by a Spanish-speaking Latina/o play therapist or a culturally competent, monolingual English-speaking play therapist. The findings lend credence to the therapeutic use of play, as the universal language of children, to bridge the gap in linguistic differences between therapists and children. Practitioners are cautioned to understand and use these results in the context of the training and supervision procedures followed for ethical practice and to ensure that the monolingual, non-Latino counselors are culturally competent and responsive to the participating children's needs. These findings suggest that for this population of children, ongoing supervision delivered by a bilingual professional counselor trained in CCPT may be an especially important component to the successful delivery of CCPT by a monolingual counselor.

Ideally, mental health services for Spanish-speaking children should be provided by bilingual counselors trained to deliver culturally responsive services to this population. Unfortunately, there is a shortage of bilingual counselors, particularly those trained to work with young Latina/o children. The present study findings offer a promising solution to the gap in services for this population and suggest that bilingual counselors trained in CCPT could maximize their efforts by training and supervising monolingual counselors and thus provide Latina/o children with greater accessibility to the services they need.

Conclusion

As an ethnic group, Latina/o children are highly represented in primary school grades, representing 25% of the total enrollment in the United States (Snyder & Dillow, 2015). It has been also documented that Latina/o children face diverse challenges that place them at risk to develop behavioral problems. Without early intervention, childhood behavior problems tend to be stable over the child's lifetime and are associated with long-term consequences, including a variety of mental health disorders, youth violence, and delinquency (Turney & Kao, 2012; Vazsonyi & Chen, 2010). Yet, Latina/o children and families have been historically underserved in the mental healthcare system due to systemic and cultural barriers (Avila & Bramlett, 2013; Ojeda et al., 2011; Snowden & McClellan, 2013). Particularly for Spanish-speaking Latina/o families, language represents a significant barrier to accessing counseling services (Castaño et al., 2007; McCaffrey & Moody, 2015). The present study indicates that CCPT delivered by both bilingual and monolingual counselors trained and supervised in culturally responsive attitudes and procedures offers a viable solution to the shortage of developmentally responsive mental health services for Latina/o children.

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APPENDIX A

EXTENDED LITERATURE REVIEW

The review of the relevant literature for the present work includes the following topics: (a) Latinas/os in the United States, (b) other considerations in counseling Latinas/os, and (c) child-centered play therapy (CCPT).

Latinas/os in the United States

The terms Latina/o and Hispanic are often used interchangeably, not only in the mental health literature, but also in other fields of study. In contemporary times, the term Latina/o has gained major acceptance among leaders in the field due to its progressive connotation (Arredondo et al., 2014; Chavez-Korell, Delgado-Romero, & Illes, 2012; Gibbs, Huang, & Associates, 2003; Santiago-Rivera et al., 2002; Sue & Sue, 2016). For the purposes of this study, I use the term Latina/o. Although it is not the purpose of this work to debate what term is more appropriate, I consider it necessary to briefly elaborate on my decision to use the term Latina/o.

The term Hispanic was created by the Office of Management and Budget in 1978 with the purpose of collecting census data and categorizing people, not by country of origin or cultural background, but rather by language, Spanish. The term Hispanic has become a label that may often reinforce the mistaken assumption that individuals bearing that label are a homogenous ethnic group or even a race (Santiago-Rivera et al., 2002). Therefore, the term Hispanic lacks personal meaning because in many cases people prefer to be identified by their country of origin. Additionally, because of *la conquista española* [the Spanish conquest] the term Hispanic may evoke negative connotations of colonization, disempowerment, and slavery (Santiago-Rivera & Altarriba, 2002). Finally, the term Hispanic also excludes people from some other Latin American countries such as Brazil because they do not speak Spanish (Arredondo et al., 2014; Santiago-Rivera & Altarriba, 2002). In contrast, the term Latina/o embraces the indigenous cultural roots of people who identify as Mexican, Cuban, Puerto Rican, Central American, and

South American (Arredondo et al., 2014). In addition, the term Latina/o breaks with "sexist Spanish grammatical conventions" (Chavez-Korell et al., 2012, p. 676) and represents a "political consciousness and a sense of ethnic pride" (Santiago-Rivera & Altarriba, 2002, p. 21).

Latinas/os are the fastest growing minority group in the U.S., representing 17% of the total population with 55 million people (U.S. Census Bureau, 2015). Historically, the trends for the Latina/o population have shown a gradual increase and in most recent decades substantial growth. For example, between 1980 and 2000 the population increased from 14.6 to 35.3 million and between 2000 to 2010 from 35.3 to 50.4 million (U.S. Census Bureau, 2010). By 2060, Latinas/os will constitute approximately 29% of the U.S. population (U.S. Census Bureau, 2015).

Latinas/os represent a heterogeneous group with different characteristics and life circumstances. Some Latinas/os have been in the United States for generations whereas others might have just arrived and hold an undocumented status in the country. Thus, level of acculturation, language preference, socioeconomic status, and geographical place of birth are some examples of how Latinas/os may vary among each other. For instance, the Latina/o population comprises people from many countries of origin. In the last U.S. Census in 2010, Mexicans made up 64% of the Latina/o population, followed by 9.2% Puerto Ricans, and 3.5% Cubans (U.S. Census Bureau, 2010). The rest was accounted for by Latinas/os from various countries in Central America, South America, and the Dominican Republic. More than half of the total number of Latinas/os living in the U.S. are primarily distributed in three states: California, accounting for 27.8%; Texas, accounting for 18.7%; and Florida, accounting for 8.4% (U.S. Census Bureau, 2010). It is also estimated that of the 58 million Latinas/os living in the United States (U.S. Census Bureau, 2015), 11 millions hold undocumented status (Krogstad et al., 2017).

Although Latinas/os are not a homogenous ethnic group, most of them maintain and share similar aspects of their cultural and ethnic heritage (Altarriba & Santiago-Rivera, 1994). The following description of Latinas/os' risk factors, cultural values, and considerations for counseling, were written with the intention of providing a framework for a better understanding of most Latinas/os living in the United States and not to label Latinas/os into categories. First, it is important to recognize that this ethnic group faces multiple factors that place them at high risk of developing mental health problems (Altarriba & Santiago-Rivera, 1994).

Latina/o Children and Risk Factors

It is estimated that there are 10.2 million Latinas/os under the age of 9 in the United States (U.S. Census Bureau, 2012). This ethnic group is especially highly represented in the public school system. According to recent data from the National Center for Educational Statistics (NCES; Snyder & Dillow, 2015), Latina/o children comprise 25.8% of the total enrollment in public elementary school and by 2024 they will make up 29% of children in the school system (Musu-Gillette et al., 2016). Unfortunately, Latina/o children face diverse challenges that place them at risk of developing behavioral problems. For instance, researchers have pointed out that Latina/o children are less prone to academic achievement than their White peers (Kena et al., 2015; NCES, 2003). It has also been documented that Latinas/os have the highest rate of school dropouts compared to students from other ethnic and racial groups (Kena et al., 2015; Musu-Gillette et al., 2016; National Task Force, 2007). Vazsonyi and Chen (2010) have also pointed out that Latinas/os are at a more elevated risk of presenting aggressive behaviors in comparison with other ethnic groups. Risk factors including language, acculturation, and poverty make young Latina/o children more vulnerable to developing behavioral concerns, struggling with relationships, and experiencing problems with communication (NCES, 2003;

Turney & Kao, 2012). Without early intervention, childhood behavior problems tend to be stable over the child's lifetime and are associated with long-term consequences including a variety of mental health disorders, youth violence, and delinquency (Turney & Kao, 2012; Vazsonyi & Chen, 2010). Therefore, early mental health interventions for young Latina/o children are imperative (Turney & Kao, 2012; Vazsonyi & Chen, 2010). Additionally, multiple scholars (Arredondo et al., 2014; Baumann et al., 2011; Santiago-Rivera, 1995; Santiago-Rivera et al., 2002; Shattell et al., 2008; Snowden & McClellan, 2013) have actively promoted and advocated for increased provision of culturally responsive mental health services to the Latina/o population by incorporating Latina/o cultural values.

Latina/o Cultural Values in Counseling

Mental health professionals have an ethical obligation to respond in a culturally sensitive manner to clients by understanding their worldviews and honoring their cultural values when providing services (ACA, 2014; American Psychological Association [APA], 2010; National Association of Social Workers Code of Ethics, 2008). According to the ACA (2014) Code of Ethics, "counselors actively attempt to understand the diverse cultural backgrounds of the clients they serve" (p. 4). This recognition of the effects of race, ethnicity, and other cultural identities in individuals' mental health is not new (Brady-Amoon, 2011). Since the 1990s, a series of cultural competencies have been delineated in an attempt to promote and facilitate counseling interventions that are culturally sensitive to the needs of certain populations (Arredondo et al., 1996; Sue, Arredondo, & McDavis, 1992). The most recent revision of the multicultural competencies (endorsed by the Association for Multicultural Counseling and Development, a division of the ACA) "offers counselors a framework to implement multicultural and social justice competencies into counseling theories, practice, and research" (Ratts et al., 2015, p. 3).

This document includes four domains that are crucial to multicultural and social justice competence development: counselor self-awareness, client worldview, counseling relationship, and counseling and advocacy interventions.

These efforts to provide culturally sensitive counseling services, particularly to minority groups, have led to promotion of using Latina/o-centered approaches specifically when working with Latinas/os. In such approaches, the integration of Latina/o cultural values is a key aspect of mental health interventions. For instance, for counselors working with Latina/o children and their families, Drewes (2006) encouraged attitudes and practices that promote family ties, respect, and interpersonal relationships. Similarly, Ceballos and Bratton (2010) noted three cultural values—*familismo, personalismo,* and *respeto*—that are particularly important to consider when working with Latina/o children and families. Garza et al. (2009) also remarked on the significance of these Latina/o values and emphasized the importance of understanding that these values are strongly related to each other and interact in a dynamic way. Because Latinas/os are a heterogeneous group, the following cultural values are presented as a framework for helping mental health practitioners understand the experience of many Latina/o families and are not intended to stereotype values among all Latina/o families. As López-Baez (2006) stated, "Counselors who understand values embraced by [Latina/o] culture can adjust their interventions to meet this population's needs" (p. 189).

Familismo. Familismo [Familism] is a collectivistic worldview in which the family members are willing to sacrifice themselves for the welfare of the family (López-Baez, 1997; Santiago-Rivera et al., 2002) or place the needs of friends or family members—including extended family—before their own (Sue & Sue, 2016). Family is one of the most important values in the Latina/o culture and is maintained over generations (Drewes, 2006). According to

Santiago-Rivera et al. (2002), Latina/os have a strong orientation toward family, attempting to keep strong, close relationships with members, including not only nuclear but also extended family members such as grandparents, uncles, aunts, and cousins, as well as close friends. This family orientation intensifies interdependence, cohesiveness, loyalty, and cooperation among members (Santiago-Rivera et al., 2002). As a result, parents, particularly mothers, have the life-long expectation to have very close relationships with their children (Drewes, 2006). In summary, López-Baez (2006) described three orientations strongly related with familismo: "a perceived obligation to provide material and emotional support to the members of the extended family, the reliance on relatives for help and support, and the perception of relatives as behavioral and attitudinal referents" (p. 189).

Another factor to consider within familismo is that the structure of traditional Latina/o families tends to be hierarchical and sex roles are usually clearly defined. For example, authority is placed in parents and other adults. In particular, fathers are seen as the primary authority figure, while Latina mothers are expected to fully commit to family and place children before themselves (Arredondo et al., 2014). Children are expected to obey parents and have close relationships with their siblings. Particularly, older siblings are expected to protect the younger ones. Sometimes, female children act as surrogate mothers when the maternal figure is absent (Sue & Sue, 2016).

The implications of the value of familismo for counseling are several. First, due to tight family bonds, members of Latina/o families are expected to seek help within the family and not outside of the system. Therefore, it is important to consider that when Latina/o families ask for mental health services they have already exhausted all family resources (Sue & Sue, 2016). Second, the acculturation process may challenge some family members' beliefs in familismo.

For instance, some members may feel this value as controlling and want to distance themselves from the family or avoid family functions (Arredondo et al., 2014). Some family members may also have different expectations and visions of roles, which can cause friction within the family system (Sue & Sue, 2016). Third, professionals often misunderstand familismo as dependence, immaturity, or lack of initiative, which could lead to erroneous impressions or even incorrect diagnosis of clients. It is expected that clients from Latina/o origin may take a few sessions to begin to talk about sensitive family topics (López-Baez, 2006).

Personalismo. Another characteristic of collectivistic cultures is personalismo [personalism], a term used to describe Latina/os' preferences for warm and caring personal interactions (Arredondo et al., 2014). Latina/os value relationships in which they show a significant amount of emotional investment with family and friends (Santiago-Rivera et al., 2002). Garza and Watts (2010) defined personalismo as behaviors and actions that show respect, concern, and interest for others; thus, such relationships are often warm, friendly, and personal in nature. Furthermore, Latinas/os are expected to maintain this quality of relationships with immediate and extended family, as well as with friends (Santiago-Rivera et al., 2002). López-Baez (2006) also stresses that with personalismo is a tendency to share personal information and preference for physical closeness with other people. In this regard, Latinas/os have a strong value for personal interactions over impersonal, institutional, or formal ones.

This conflict may have important implications about how Latinas/os respond to mental health services, treatment, and research procedures, which are often impersonal and formal (Santiago-Rivera et al., 2002). For instance, counselors who understand the value of personalismo might be prepared for informal "chit-chats," personal questions from clients, and depending on the structure of the service, sharing food in informal gatherings (after a group

session for example, or during school lunch; Ojeda et al., 2011). Other behaviors to consider involving personalismo are to have close proximity to clients, to greet clients with a warm and firm handshake, and to demonstrate concern by using facial expressions or placing a hand on the client's shoulder. In fact, personalismo may be the reason why a client decides whether or not to return to counseling (Arredondo et al., 2014). Personalismo appears to be aligned, not only with Latina/o cultural values, but also with person-centered ones, in which unique, genuine, warm, and caring relationships are developed and valued (Garza & Watts, 2010).

Respeto. The cultural value of respeto [respect] refers to a demonstration of unconditional respect and deference toward elders and authority figures such as parents, teachers, aunts, and uncles (Ojeda et al., 2011). Some other hierarchical systems regarding authority and decision making that Latina/o communities follow are based on gender, age, social and economic status, and authority (Garza & Watts, 2010). Children are expected to *portarse bien* [be well-mannered] and obey rules or norms set by authority figures; deviations from such norms are not accepted (Garza & Watts, 2010). Additionally, confrontational or direct statements in contradiction with the authority figure is seen as culturally inappropriate (López-Baez, 2006).

Ojeda et al. (2011) pointed out that the value of respeto becomes relevant in the process of both practice and research due to the position of authority that the practitioner or researcher might have toward the participant, especially if they are from a White culture. Professionals need to be aware of the position of authority and power they occupy in the view of many Latina/o families. For instance, in many cases, the counselor may possess a higher level of education, may be a male, and/or may be a documented citizen in the U.S. Power differences can be lessened by asking families to refer to the counselor using *tu* (informal form of *you* in Spanish) instead of *usted* (formal form of *you* in Spanish). Conversely, the counselor may use *usted* to refer to clients

unless the client invites the counselor to call them by *tu* (Ojeda et al., 2011). Some researchers (Garza et al., 2009; Garza & Watts, 2010), have pointed out that respeto is an important consideration in parent consultations regarding the progress of their child. For example, it would be important for parents to hear the child's progress in terms of becoming less defiant and more compliant with social norms (Garza et al., 2009).

By incorporating Latina/o values into practice and research, practitioners and researchers respond in a culturally sensitive manner to the needs of this population. However, other considerations, including language and ethnicity of counselor and client, are also important in counseling the Latina/o population.

Other Considerations in Counseling Latina/os

Although mental health problems are considerably prevalent among Latinas/os in the United States (Center for Behavioral Health Statistics and Quality, 2015), and despite the fact that they are the largest minority group in the country (U.S. Census Bureau, 2010), Latinas/os are frequently underrepresented in mental health services (Avila & Bramlett, 2013: Ojeda et al., 2011; Snowden & McClellan, 2013). Major factors contributing to disparities in mental health care of Latinas/os are, on the one hand, social structure factors such as poverty, level of education, and lack of health insurance; and on the other hand, cultural barriers (Arredondo et al., 2014; Avila & Bramlett, 2013; De Jesus & Xiao, 2014).

According to the Pew Research Center (2015), the number of Latina/o children living in poverty set a historical record in 2010, with 6.1 million children, more than any other ethnic or racial group. As a result, Latinas/os living in poverty present with higher uninsured rates (Lee & Matejkowski, 2012). In this regard, approximately 24% of Latinas/os lack health insurance (U.S. Census Bureau, 2015) and only 6.8% have access to mental health services (U.S. Department of

Health and Human Services, 2011). It has been documented that the lack of health insurance is directly associated with disparities in the use of services, especially preventive care (Avila & Bramlett, 2013; De Jesus & Xiao, 2014). Research has suggested that expanding health insurance coverage is crucial to bridging mental health disparities (De Jesus & Xiao, 2014; Lee & Matejkowski, 2012).

In addition to social structure factors, cultural barriers can significantly impact the use of mental health services (De Jesus & Xiao, 2014). Some cultural aspects contributing to Latinas/os' underutilization of mental health services is unfamiliarity with counseling and psychological services as well as lack of understanding of the role of mental health professionals (Santiago-Rivera, 1995). According to Santiago-Rivera (1995), cultural factors are not only an important reason why Latinas/os underutilize services but also a motive to drop out of therapy prematurely or a cause of misdiagnosis, especially when services are not culturally sensitive. Latina/o clients may experience traditional mental health services as impersonal, particularly when services are delivered by non-Latina/o counselors who are not culturally trained (Santiago-Rivera et al., 2002). Some research has suggested for example, that Latina/o clients often report feeling more understood if the mental health professional shares similar cultural values (Santiago-Rivera et al., 2002). In fact, racial/ethnic matching has been a topic of debate and study with its implications for counseling.

Racial/Ethnic Match

According to the Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues (U.S. Department of Health and Human Services, 2013), the total of minority racial/ethnic groups accounted for about 30% of the mental health professionals in the country. More specifically, the report indicated that they made up 19.2% of psychiatrists, 5.1% percent of

psychologists, 17.5% percent of social workers, 10.3% percent of counselors, and 7.8% of marriage and family therapists. From the total workforce of the mental health providers, Latinas/os represented 11% of those professionals. The disparities in ethnic demographics in the mental health work force have led to a call for culturally competent services across mental health disciplines. Extending culturally competent services to include matching counselor-client ethnicity has been a subject of debate. For example, Santiago-Rivera et al. (2002) mentioned that clients from ethnic minorities may feel more understood by counselors who share similar ethnic background because they might have undergone similar experiences of oppression, marginalization, and racism. Similarly, in a qualitative research study, Latina/o bilingual psychotherapists reported feeling a stronger connection with Latina/o clients because of sharing similar cultural backgrounds (Verdinelli & Biever, 2009). However, Verdinelli and Biever (2013) also stated that results from research studies are inconsistent and have not provided strong evidence for ethnic matching as being critical in therapeutic outcomes for Latinas/os.

Cabral and Smith (2011) conducted a meta-analysis in which they investigated the effects of racial/ethnic matching between clients and therapists. Using quantitative research, they examined 154 studies of which 52 explored racial and ethnic matching, 81 described clients' perceptions of therapists, and 53 analyzed therapeutic outcomes across race and ethnicity. The study included four races/ethnicities: Asian American, Black/African American, Hispanic/Latina(o) American, and White/European American. Overall results suggested that clients: (a) have a moderately strong initial preference (d = .60) for counselors of the same race/ethnicity, (b) tend to perceive more positively (d = .32) counselors from the same race/ethnicity, and (c) indicate almost no benefit (d = .09) on intervention outcomes from counselor-client ethnic/racial matching. Results of this meta-analysis suggests that "the greatest

relevance of ethnic/matching occurs prior to therapy and during the initial sessions of therapy when the therapeutic alliance is being formed" (Cabral & Smith, 2011, p. 545). The findings also indicated that Latinas/os have a slightly more positive perception of a therapist with a similar ethnic/racial background. However, Latina/o clients did not evaluate differently to counselors from other ethnicities/races when reporting clinical outcomes. In addition, current trends in counseling Latina/o children and families acknowledge that even if Latinas/os have a stronger preference for working with a counselor with the same ethnic/racial background this may not be possible due to the scarcity of bilingual and Latina/o professionals. Thus, according to Cabral and Smith (2011), the debate should focus more attention on multicultural competencies, adjusting interventions to the client's culture, and the relationship. In fact, Arredondo et al. (2014) argue that ethnic matching is not critical in counseling Latinas/os, because "cultural competency preparation will guide responsive and ethical practice" (p. 218). Some scholars have pointed out that when counseling Latinas/os language and level of acculturation are more crucial factors than ethnic/race matching (Arredondo et al., 2014; Santiago-Rivera, 1995; Santiago-Rivera et al., 2002).

Level of Acculturation

The concept of acculturation has been a focus of study in different disciplines, including sociology and anthropology (Santiago-Rivera et al., 2002). Due to the impact of acculturation on human behavior, the mental health field has turned attention to this phenomenon in the last few decades. In broad terms, the concept of acculturation encompasses a process that is dynamic and non-static by nature and that "explain[s] how individuals adapt to and change in new environments" (Santiago-Rivera et al., 2002, p. 38). Based on Berry's (1997) work, Coll and Marks (2012) provided the following definition:

> The term acculturation typically denotes a process by which an individual (or group of individuals) encounters a new cultural context and begins a series of complex social, interpersonal, and context-sensitive psychological processes of assuming new cultural attitudes, abilities and traditions while maintaining (or not maintaining) those from the individual's culture of origin. (p. 7)

The complexities of the acculturation process are particularly evident within the Latina/o population in the United States, in which the level of acculturation varies drastically, especially among those recently migrating to the country. For instance, in immigrant Latina/o families, the level of acculturation determines the extent to which Latina/o parents and children adhere or not to Latina/o values and their practices versus American cultural values. Acculturation involves a new learning process of attitudes and behaviors, which is itself a stressful process (Santiago-Rivera et al., 2002). Berry's (1997) model has been used to explain the dynamics of the acculturation process for Latinas/os in the United States. Berry proposed four acculturation strategies that represent how migrants tend to respond to adaptation in a new environment: (a) assimilation, (b) separation, (c) integration, and (d) marginalization. *Assimilation* is defined as the wish to embrace the new culture while rejecting one's own, including interacting with people from the new culture and avoiding interaction with people from the culture of origin. On the contrary, *separation* refers to individuals who attach to their culture of origin and reject the host culture. An intermediate level is called *integration*, which describes the degree to which individuals maintain their cultural values of origin and at the same time interact with the dominant social groups and their cultural norms. Finally, *marginalization* is used to define situations in which individuals have little or no interest for maintaining their cultural background and little or no interest in interacting with the host culture. Arredondo et al. (2014) asserted that

depending on life circumstances, it is possible for Latinas/os to move in and out of the acculturation strategies.

The implications of acculturation on Latinas/os are several. For instance, Marin (as cited in Santiago-Rivera et al., 2002) noted that as Latinas/os become more acculturated, at some surface level they may forget important cultural and traditional events while incorporating knowledge about the new culture. At a moderate level, Marin stated, "Latinas/os may lose proficiency in the Spanish language, and at a more profound level there may be changes in core values, beliefs, and norms that guide behavior" (as cited in Santiago-Rivera et al., 2002, p. 38). In fact, for Santiago-Rivera et al. (2002), Latinas/os who were born in the United States or migrated when young children may feel more attached to the values and beliefs that are more like the U.S. culture.

Recent data indicated that the number of foreign born Latinas/os reached its peak at 40% in 2000 (Stepler & Brown, 2016); since then, it has decreased, and in 2014, the percentage of foreign born Latinas/os was 34.9%. In this context, generational status provides some measurement about the acculturation level and its impact on mental health (Coll & Marks, 2012). Coll and Marks (2012) defined first-generation as an individual who is foreign born with foreign born parents as well. A second-generation individual is a person who is born in the United States with at least one foreign born parent. Finally, a third-generation individual is one who is born in the United States as well as both parents. Even if the definition seems straightforward, the authors warned that sometimes generational status is not as easy to determine as it appears to be. For example, some researchers (e.g., Linton & Jimenez, 2009; Rumbaut & Portes, as cited in Coll & Marks, 2012) have used the *1.5 generation* term to denote those who were foreign born and migrated to the United States as young children. The study of generational status becomes

relevant because it has been documented that compared to first-generation individuals, those from second or later generations are associated with higher levels of delinquency "when acculturation reduces family attachment, decreases parental control, and increases peer associations" (Bui, 2012, p. 138).

Although generational status provides important information regarding the level of acculturation of Latinas/os, it is not an ideal measurement by itself. Other elements, such as specific cultural norms, beliefs, values, traditions, customs, religious adherence, and reasons for immigration (if immigrant), must be considered (Altarriba & Santiago-Rivera, 1994; Sue & Sue, 2016). The implications for the assessment of acculturation level in Latinas/os become crucial because it "can help the counselor the extent to which maladaptive behaviors are associated with the conflict often experienced by some Hispanics who are unable to cope effectively with the transition" (Santiago-Rivera, 1995, p. 15). Additionally, exploring the degree of a client's level of acculturation provides the counselor with a frame of reference about how the client perceives and potentially could respond to counseling (Sue & Sue, 2016). Although language should be considered when assessing the level of acculturation in Latinas/os, it is an element that needs to be considered separately because of its complexity and implication for communication when counseling Latinas/os (Santiago-Rivera, 1995).

Language

Language is the medium to communicate and transmit beliefs and cultural traditions. Ethnic minorities in the United States use language as a means of identity and pride (Altarriba & Santiago-Rivera, 1994). During the last years, the use of languages other than English spoken at home has increased dramatically (Ryan, 2013). Due to the large number of Latinas/os in the population, it is not surprising that Spanish is the second-most-often spoken language in the

country and that the United States is the fifth-largest Spanish-speaking country in the world (Ryan, 2013). According to recent statistics (Ryan, 2013), of those Latinas/os for whom Spanish is their first language 26% of them are not proficient in English, 56.3% speak English "very well," and 17.8% speak English "very well" to "well." In other words, the number of bilingual Latinas/os has increased during the last years. Nevertheless, most of the population appears to still have a strong preference for speaking Spanish at home (Santiago-Rivera et al., 2002).

Language barriers are correlated with health disparities in Latina/o children, limited or poor quality services, misdiagnosis, and/or early termination of treatment (Avila & Bramlett, 2012; Kohrt & Kennedy, 2015; Santiago-Rivera, 1995; Snowden & McClellan, 2013; Verdinelli & Biever, 2013). Communicating in English-oriented mental health services is a challenge for many Latina/o families because language "introduces a significant barrier of its own" (Snowden & McClellan, 2013, p. 1628). In addition to the systemic barriers, language is also the instrument to communicate emotions. Thus, the implications of language in counseling need to be highly considered. In fact, researchers have actively advocated for an increase in the number of bilingual counselors and their proper training (Altarriba & Santiago-Rivera, 1994; Biever et al., 2002; Castaño et al., 2007; Santiago-Rivera & Altarriba, 2002; Verdinelli & Biever, 2009, 2013).

The use of language in counseling. The growth in the number of bilingual mental health professionals has not been commensurate with the growth of Spanish-speaking Latinas/os (Arredondo et al., 2014; Kohrt & Kennedy, 2015). This lack of workforce creates a gap between mental health services and the Latina/o community, contributing not only to barriers in accessing counseling services but also in inaccurate assessments, ineffective counseling, and early dropouts (Altarriba & Santiago-Rivera, 1994).

In response to the linguistic barriers, counselors have used interpreters in an attempt to

bridge such barriers. However, it has been documented that counselors often face several challenges when using interpreters. For instance, Altarriba and Santiago-Rivera (1994) pointed out that both counselor and client might experience a lack of connection due to the time that it takes to translate. Additionally, issues related to confidentiality may arise, creating some potential discomfort from client. Some other scholars (Arredondo et al., 2014; Kohrt & Kennedy, 2015) have also voiced their concerns because interpreters quite often lack training in mental health procedures, are unfamiliar with clinical terms resulting in miscommunication, lack the skills to establish a therapeutic relationship, and omit or substitute information. The interpretation process is further complicated when using children or other family members as interpreters (Biever et al., 2002; Castaño et al., 2007). Clients may experience embarrassment or feel inhibited, or children may not be emotionally prepared to handle some of the topics discussed. Thus, the implications of using translators when linguistic barriers exist between client and therapist should be examined (Biever et al., 2002; Castaño et al., 2007).

In addition, language is not only a critical factor when counseling Latinas/os because of the lack of Spanish-speaking or bilingual counselor professionals but also because language communicates emotional expression (Guttfreund, 1990). Emotions are learned in the mother tongue, which for many Latina/o children is Spanish (Arredondo et al., 2014). In fact, some researchers have emphasized the importance of language match, stating that counselors who are not fluent in Spanish are not a good fit for clients whose primary language is Spanish and who are not fluent in English (Arredondo et al., 2014; Santiago-Rivera, 1995). Altarriba and Santiago-Rivera (1994) wrote, "The inability of psychotherapists to communicate in the dominant language of their clients can compromise the quality of services delivered" (p. 667). Thus, evaluating the ability of Latina/o clients to communicate in either Spanish, English, or

both languages is crucial for the counseling process. For instance, on the one hand it has been well-documented that Latina/o clients who are Spanish-dominant speakers may be more concerned about pronunciation and the correct use of words and phrases rather than the content (Altarriba & Santiago-Rivera, 1994). On the other hand, it has also been noted that Spanish-dominant clients tend to be more optimistic, emotionally invested, and engaged in the therapeutic process when they are able to use their first language in counseling (Altarriba & Santiago-Rivera 1994; Arredondo et al., 2014; Biever et al., 2002; Guttfreund, 1990; Santiago-Rivera & Altarriba, 2002; Santiago-Rivera et al., 2002; Verdinelli & Biever, 2009).

With respect to clients who are bilingual to some degree, Santiago-Rivera and Altarriba (2002) pointed out that they might more easily express a significant cognition or emotional experience in the language in which a precipitating event occurred. When bilingual Latina/o clients "learn emotion words in their first language, those words are stored at a deeper level of representation than their second language counterparts" (Santiago-Rivera & Altarriba, 2002, p. 33). Individuals may express emotional experience differently; thus, they may alternate between one language and another in different ways. Altarriba and Santiago-Rivera (1994) identified two processes in which Latina/o clients may utilize two different languages: language mixing and language switching. Language mixing refers to the clients' preference for mixing both English and Spanish in one sentence, phrase, or idea. Latinas/os may use mixing language as a reflection of their cultural heritage (Altarriba & Santiago-Rivera, 1994). Language mixing provides important cues about words that might be important for clients. For instance, a simple word may represent a meaningful experience for clients, or the use of such words may indicate avoidance of a certain experience (Santiago-Rivera & Altarriba, 2002). The term language switching is used to make reference to bilingual clients who consistently use one language for a period of

time and then switch to the other language (Altarriba & Santiago-Rivera, 1994). Language switching can occur as a way of distancing from emotional experiences and seeing them from a more cognitive perspective, but also as a way to repress painful experiences (Altarriba & Santiago-Rivera, 1994). Altarriba and Santiago-Rivera (1994) wrote, "Emotional expression in the native language is more spontaneous and less inhibited, and more defensive styles of behaviors are generated in the non-dominant language" (p. 391). Language switching could be potentially used as a tool to facilitate clients' emotional expression (Santiago-Rivera, Altarriba, Poll, Gonzales-Miller, & Cragun, 2009).

The existing literature about the implications of language in counseling Latinas/os has been focused on the adult population. Little has been studied about the effects of language on counseling outcomes with young Spanish-speaking Latina/o children. Such information seems important, considering that most Latina/o children speak Spanish prior to formal schooling (Ryan, 2013) and that a large number tend to maintain Spanish as their primary language (Santiago-Rivera et al., 2002).

Due to the high numbers of Spanish-speaking Latina/o children in need of mental health interventions and the shortage of Spanish-speaking counselors, English-speaking therapists often face the dilemma of refusing to treat Spanish-speaking children or attempting to provide services in English (McGee, 2010; Tovar, 2015). To explore the efficacy of English-speaking therapists providing counseling services to Spanish-speaking children McGee (2010) conducted an experimental study with 24 Spanish-speaking Latina/o children from four to eight years old. Specifically, McGee (2010) aimed to investigate the effects of CCPT with Spanish-speaking Latina/o children when delivered by an English-speaking counselor, recognizing that this practice, if proven effective, had the potential to provide services to a growing population of

children that otherwise would not receive services. McGee further based his research hypothesis on the fundamental tenet of play therapy— play is children's natural medium of communication (Axline, 1947) and toys are children's words (Ginnot, 1960). The idea of implementing play therapy with this population seems also to have some support in the hypothesis of Vaño and Pennebaker (1997) who pointed out that "knowledge of emotion language is adaptive for bilingual students within an educational setting" (p. 197). McGee (2010) hypothesized that play could bridge the gap between language differences; thus, play therapy could be considered a viable treatment option when children and therapist do not speak the same language. However, it is also imperative to note that little research has been conducted in this topic and that there are no current guidelines for implementing such practice.

Child-Centered Play Therapy

Child-centered play therapy is a developmentally appropriate counseling intervention for children that is founded on the philosophy and principles of person-centered theory (Axline, 1947; Landreth, 2012; Ray, 2011). Currently, CCPT is the most practiced (Lambert et al., 2007) and researched play therapy approach in the United States (Ray & Bratton, 2010). For purposes of this work, I review the following topics: (a) theoretical principles of CCPT, (b) CCPT research, and (c) CCPT research with Latina/o children.

Theoretical Principles of Child-Centered Play Therapy

CCPT is based in the work of Carl Rogers and his theory of person-centered counseling and psychotherapy. Virginia Axline (1947) adapted Rogers' theory to work with children, which she called non-directive play therapy and which is currently known as CCPT in the United States. As Axline (1947) noted, CCPT is more than a group of techniques, "it is a basic philosophy of human capacities which stresses the ability within the individual to be self-

directive" (pp. 25-26). In his theory, Rogers (1951) provided an extensive framework based upon 19 propositions that are the basis for person-centered theory including the healing aspects of the theory and conditions for therapeutic change. Roger's propositions encompass the following:

1. Every individual exists in a continually changing world of experience of which they are the center.

2. The organism reacts to the field as it is experienced and perceived. This perceptual field is, for the individual, "reality."

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

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

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

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

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

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

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

10. The values are attached to experiences, and the values are part of the self-structure, in some instances are values experienced directly by the organism, and in some instances are values introjected or taken over from others, but perceived in distorted fashion, as though they had been experienced directly.

11. As experiences occur in the life of the individual, they are (a) symbolized, perceived, and organized into some relationship to the self; (b) ignored because there is no perceived relationship to the self-structure; or (c) denied symbolization because the experience is inconsistent with the structure of the self.

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

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

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

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

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

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

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

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

Child-centered play therapy is a parallel of the person-centered approach with adults. Nevertheless, because children have different needs than adults, CCPT covers specific needs for children and therapists (Axline, 1947). In CCPT, children “play out” feelings and problems, just as adults “talk out” difficulties with the therapist. Play is children's most natural medium of communication (Axline, 1947; Landreth, 2012), and toys are children’s words through which they express their anxieties, fears, fantasies, guilt, etc.. Additionally, the world of children is based on concrete experiences that are communicated through play (Landreth, 2012). In fact, Piaget (1959) noted that abstract thinking is a developmental process that takes place at approximately the age of 11; until then, children’s experiences are projected in concrete ways. Play becomes an ideal therapeutic ally because it bridges the gap between concrete thinking and abstract experiences, such as feelings (Landreth, 2012). Thus, play provides a safe medium to express such emotions because the act takes place in fantasy (Landreth, 2012). As Axline (1947)

pointed out, “play therapy is based upon the fact that play is the child’ natural medium of self-expression” (p. 9).

Although the child's play is symbolic, the therapist does not interpret its content in CCPT. Rather, CCPT is an attitude, a way of being; it is an approach in which children, rather than their problems, are the most important element in therapy (Landreth, 2012). The therapeutic relationship that is developed during the counseling process is the primary vehicle that promotes growth and change (Landreth, 2012). The approach is based on the belief that when children are provided with an opportunity to be themselves, they learn to be creative in facing problems that were previously stressful (Axline, 1947; Landreth, 2012). Also, CCPT is present-oriented because children’s dynamics are constantly changing and therefore, they do not have the same impact they did in the past. Axline (1947) created some guidelines for the applications of CCPT that she called “the eight basic principles.” The principles include the following:

1. The therapist must develop a warm, friendly relationship with the child, in which good rapport is established as soon as possible.
2. The therapist accepts the child exactly as he is.
3. The therapist establishes a feeling of permissiveness so that the child feels free to express his feelings completely.
4. The therapist is alert to recognize the feelings the child is expressing and reflects those feelings back to him in such a manner that he gains insight into his behavior.
5. The therapist maintains a deep respect for the child's ability to solve his own problems if given an opportunity to do so. The responsibility to make choices and institute change lies with the child.
6. The therapist does not attempt to direct the child's actions or conversations in any

manner. The child's leads the way; the therapist follows.

7. The therapist does not attempt to hurry the therapy. It is a gradual process and is recognized as such by the therapist.
8. The therapist establishes only those limitations that are necessary to anchor the therapy to the world of reality and to make the child aware of his responsibility in the relationship. (pp. 73-74)

The purpose of the eight basic principles is to bring consistency and a careful methodology to the way that counselors introduce this therapeutic intervention to the child (Axline, 1947). The principles are guidelines for establishing the therapeutic relationship (Landreth, 2012). In the words of Axline (1947), "It is not a verbal explanation of what this is all about, but by establishing the relationship" (p. 74). Additionally, Landreth (2012) stated that CCPT has the following 10 objectives: (a) develop a more positive self-control, (b) assume greater self-responsibility, (c) become more self-directing, (d) become more self-accepting, (e) become more self-reliant, (f) engage in self-determined decision making, (g) experience a feeling of control, (h) become sensitive to the process of coping, (i) develop an internal source of evaluation, and (j) become more trusting of himself (pp. 84-85).

The objectives of CCPT, as described by Axline's (1947) principles, provide general guidelines to therapists about this approach. The objectives are by no means individualized goals but rather broad therapeutic objectives (Landreth, 2012) as CCPT does not attempt to mold the child or have control over him. In CCPT, children have the opportunity to discover their own strengths and limitations.

Rogers (1942) pointed out that the belief in the capacity of the child to help himself or herself is not a product of faith but a product of the experience of the work with children. It is not

coincidence that up to date CCPT is the play therapy approach in the United States with the longest history of research to supports its use, dating back to the 1940s (Bratton et al., 2005; Ray & Bratton, 2010).

Child-Centered Play Therapy Research

The effectiveness of play therapy has been documented for more than 60 years (Bratton & Ray, 2000; Ray & Bratton, 2010). Recently, the Association for Play Therapy published a document entitled the *Evidence-Based Practice Statement: Play Therapy* (Ray & McCullough, 2015) that reviews all play therapy outcome research studies from 2000 to present. The purpose, as the authors stated, is to "provide evidence regarding the effectiveness of play therapy and guidance on the practice of play therapy, evaluating the level, quality, and application of play therapy as a mental health intervention for children" (Ray & McCullough, 2015, p. 1). Similarly, the Center for Play Therapy developed a website, *Evidence-Based Child Therapy* to house the *Play Therapy Outcome Research Database,* a comprehensive play therapy research data base of quantitative outcome research from 1995 to present (Bratton et al., 2015). Specifically, the database provides detailed information and data about research studies such as theoretical treatment models, research designs, study characteristics, sample characteristics, measurements, and study findings. The advantage of this database is that it is an interactive tool in which the user can sort the research by study characteristics. For instance, a recent sort revealed that CCPT was the most researched play therapy treatment model with 17 randomized controlled studies, six non-randomized controlled studies, six experimental single case studies, and 11 single group studies for a total of 40 studies over the past 20 years.

Both the *Evidence-Based Practice Statement: Play Therapy* (Ray & McCullough, 2015) and the *Play Therapy Outcome Research Database* (Bratton et al., 2015) are efforts toward

recognizing play therapy as an evidence-based mental health practice with children. Evidence-based interventions are the current gold standard for mental health interventions. Rubin and Bellamy (2012) defined evidence-based practice as the "process for making practice decisions in which practitioners integrate the best research evidence available with their practice expertise and with client attributes, preferences, and circumstances" (p. 7). In fact, CCPT has recently been recognized by the National Registry of Evidence-Based Programs and Practices (2017) as a promising intervention for general functioning and well-being, anxiety disorders and symptoms, and disruptive disorders and behaviors.

It is important to note that evidence-based practices respond to the effectiveness of interventions through a series of scientific and methodological procedures commonly known as evidentiary hierarchy for evidence-based practice (Rubin & Bellamy, 2012). The hierarchy is a list of different types of studies that support the effectiveness of an intervention. At the top of the evidentiary hierarchy are systemic reviews and meta-analyses. Meta-analyses are a compilation of experimental and quasi-experimental designs; the purpose is to calculate the average strength of the intervention. Due to the vast research in the play therapy literature, researchers have attempted to demonstrate the effectiveness of play therapy as an evidence-based practice through the use of four meta-analyses: LeBlanc and Ritchie (2001), Bratton et al. (2005), Lin and Bratton (2015), and Ray et al. (2015).

LeBlanc and Ritchie (2001) published the first meta-analysis in play therapy, which included 42 studies from 1945 to 2001. The researchers concluded that play therapy demonstrated, on average, a medium to large effect size (0.66). Findings suggested that involving parents in the therapeutic process (e.g., filial therapy/CPRT) was correlated with greater outcomes. Additionally, authors found that the optimal number of play therapy sessions

was between 30 to 35. Finally, predictors such as sex, age, presenting problem, and the use of other interventions in addition to play therapy services were not statistically significant.

Bratton et al. (2005) conducted the largest meta-analysis of play therapy outcomes in which they reviewed 93 treatment-control comparison studies from 1953 to 2000. The authors concluded that play therapy demonstrated an overall treatment effect size of 0.80, indicating a large, statistically significant treatment effect across many social, emotional, and behavioral difficulties. Specifically, play therapy demonstrated moderate to large treatment effects on reducing internalizing and externalizing behavioral problems and aggression. Similarly, play therapy interventions demonstrated moderate to large treatment effects on increasing self-esteem, social skills, social adjustment, and academic achievement. Additionally, findings revealed that when play therapy was delivered by parents (paraprofessionals) using filial therapy model, the mean effect size (1.15) was statistically significantly greater than when delivered by professionals. In the same meta-analysis, humanistic approaches—primarily CCPT—exhibited larger effect sizes than non-humanistic/behavioral interventions.

More recently, two meta-analyses examined the effectiveness of CCPT studies only. Ray et al. (2015) conducted a meta-analysis including 23 studies from 1970 to 2011 in which CCPT was conducted in elementary schools. Results indicated statistically significant effects with small to medium effect sizes for externalizing behaviors ($d = .34$), internalizing behaviors ($d = .21$), total problems ($d = .34$), self-efficacy ($d = .29$), academic concerns ($d = .36$), and other behaviors ($d = .36$). This meta-analysis included a diverse ethnic representation, in which Latina/o children comprised 23% of the sample. Findings are particularly relevant because CCPT was not only demonstrated to be an effective intervention in the schools, but also because it might be culturally responsive to children from different backgrounds.

Another meta-analysis specifically investigating the effectiveness of CCPT was Lin and Bratton's (2015) in which they analyzed 52 controlled outcome studies from 1995 to 2010. The authors found a statistically significant overall moderate treatment effect size of 0.47 for children participating in CCPT compared to children who received no treatment or children participating in control groups. Findings also revealed medium to large effect sizes for the categories of self-efficacy, global behavioral problems, and caregiver-child relationship stress. Further analysis revealed that children of seven years and younger obtained a statistically significant larger effect size (0.53) than the children eight years and older. This suggests that play therapy has substantial benefit in children under seven years old. Full parent involvement (filial therapy/CPRT) was another predictor that revealed a statistically significant moderate effect size (.59) in comparison with partial or no caregiver involvement. Another major finding was related to ethnicity; researchers found a large effect size (0.76) for minority groups including African American, Latina/o, Asian American, and others, which suggest that play therapy might be culturally responsive to the needs of diverse ethnic groups.

In this regard, CCPT has been shown highly effective with diverse cultures (Lin & Bratton, 2015); and particularly pertinent to this proposed study, CCPT has demonstrated beneficial effects for Latina/o children in the United States (Garza & Bratton, 2005; McGee, 2010; Trostle, 1988). Additionally, child-parent relationship therapy (CPRT), an approach used to train parents in using CCPT principles, has shown positive results (Ceballos & Bratton, 2010; Villareal, 2008). It is also noteworthy to mention that leaders in the field of Latina/o studies (e.g., Arredondo et al., 2014) have recognized CCPT as an effective, culturally sensitive intervention with Latina/o children.

Child-Centered Play Therapy Research with Latina/o Populations

A thorough review of CCPT research literature revealed that the earliest outcome study focused on Latina/o children was conducted by Trostle (1988). Trostle investigated the effects of group CCPT with 48 bilingual Puerto Rican children compared to an active control group (free play). Children were randomly assigned to either the CCPT group (n = 24, six groups with four children in each group) or the active control group (n = 24). Children in the experimental group participated in group CCPT for 40 minutes once a week for 10 weeks while children in the comparison group participated in free play with their peers in the classroom for 40 minutes once a week for 10 weeks. According to Trostle's report, most of the children spoke predominantly Spanish at home and had lived in the United States for at least six months prior to the beginning of the intervention. Results indicated no statistically significant interaction effect for the three variables analyzed: (a) self-esteem, (b) play behaviors, and (c) social acceptance levels between the experimental and the control group. However, children in the group CCPT condition demonstrated statistically significant improvement in self-control and free play ratings from pretest to posttest. Effect sizes were not reported. Trostle (1988) concluded that group CCPT appeared to facilitate social and adaptive skills for Puerto Rican children in the school setting. Nevertheless, a few limitations were evident in this study. For example, no information was presented regarding the validity and reliability of the assessments administered and if they were administered in English or Spanish. Another possible flaw that could have potentially impacted the results was the difference in the means at pretest between the experimental and control group. In this regard, no details were given about criteria for participants, thus, factors such as clinical levels of behavioral problems could have been impacted the progress of the intervention.

After Trostle's (1988) publication, the CCPT research literature with Latina/o children—specifically investigating the effectiveness of the intervention—experienced a long absence in the field. In this millennium, studies by Ceballos and Bratton (2010), Garza and Bratton (2005), McGee (2010), and Villarreal (2008) represent a reemerging interest in research in CCPT with Latina/o children.

Garza and Bratton (2005) investigated the effectiveness of CCPT with Latina/o children at risk for academic failure as compared to a curriculum-based intervention. Participants were 29 Spanish-speaking Latina/o children from kindergarten to fifth grade randomly assigned to the CCPT intervention or to a curriculum-based intervention used at the school. Parents were blinded to group assignments. Both treatment providers were bilingual and identified as Latina/o. Play therapists followed the principles of CCPT. Findings indicated that CCPT demonstrated statistically significant results and a large treatment effect (d = .76) on externalizing behaviors of Latina/o children compared to the curriculum group. Although results indicated that CCPT demonstrated a moderate treatment effect size (d = .60) for internalizing problems, the findings were not statistically significant. Garza and Bratton discussed cultural considerations and implemented practices that were consistent with Latina/o values. For instance, they made home visits to administer assessments to have a more personal interaction with parents and children. In addition, they included culturally sensitive toys in the playroom, and children were encouraged to speak in their language of preference, either English or Spanish.

McGee's (2010) study examining CCPT with Spanish-speaking Latina/o children is particularly relevant to the present research due to its characteristics. McGee aimed to investigate the efficacy of CCPT with Spanish-speaking Latina/o children when the intervention was provided by an English-speaking play therapist compared to a waitlist control group. Participants

were 24 Spanish-speaking Latina/o children in pre-kindergarten through second grade (four to eight years old) who presented with adjustment difficulties, externalizing problems, and internalizing problems. Children were randomly assigned to the CCPT intervention delivered by an English-speaking play therapist or the waitlist control group. Therapy was provided weekly for a period of eight weeks for a total of eight sessions. Study findings revealed no statistically significant differences between groups on measures of self-esteem, internalizing, externalizing, or overall behaviors. However, a statistically significant main effect for time indicated that children from the CCPT group decreased on overall and externalizing behaviors from pretest to posttest, as reported by teachers. Limitations of this study included the small sample size and the lack of information regarding reliability and validity of instrumentation, specifically for the Latina/o population. Additionally, the author does not mention if cultural adaptations were made to meet the needs of Spanish-speaking Latina/o children.

CPRT research with Latina/o populations. Child-parent relationship training (CPRT) is a 10-session filial model designed to train parents in CCPT principles so they can use such skills with their own children during play sessions. Villareal (2008) investigated the effects of CPRT with 13 English-speaking Latina/o parents whose children presented with behavioral problems. Parents were randomly assigned within their school to either the treatment condition (n = 6) or the waitlist control group (n = 7). According to parents' reports, children whose parents participated in the CPRT intervention exhibited a statistically significant decrease in internalizing and externalizing behaviors compared to those on the waitlist control group. Teacher reports indicated no statistically significant change in children. Villarreal adapted the CPRT intervention by incorporating toys that were relevant to the Latina/o culture. She also included values of personalismo by reaching out to parents during the week and showing

willingness to provide in-home services. Additionally, Villarreal (2008) pointed out that CPRT honored the *familia* value of Latinas/os. A major limitation of this study is the small sample size and the number of data analyses run.

Similarly, Ceballos and Bratton (2010) used CPRT with 48 low-income Latina/o Spanish-speaking immigrant parents. Participants were first generation immigrants who had resided in the United States for more than 10 years prior to the beginning of the study and who had identified Spanish as their primary language. Parents were randomly assigned to the experimental group (n = 24), or the the waitlist control group (n = 24). Parents in the CPRT group met weekly in a small group of five to seven parents for a period of two hours for 11 weeks. Parents in the experimental group reported statistically significant decreases in their children's internalizing and externalizing behaviors with large effect sizes ($\eta 2$ = .56 and .59 respectively) when compared to those in the wait-list group. Researchers adapted the traditional CPRT manual (Bratton, Landreth, Kellam, & Blackard, 2006) by incorporating traditional values such as personalismo and familia. For instance, researchers reported being flexible in covering the content of the manual, often allowing extra time for parents to share at the beginning of the weekly sessions and making phone calls to participants during the week to check in with them about their weekly play sessions. In addition, the CPRT manual was translated into Spanish. In fact, the translation of the manual during this study resulted in a published Spanish translation of the CPRT parent manual (Bratton, Landreth, & Ceballos, 2012). The translation is compiled on a CD that also contains cultural considerations, parent resources and training, and marketing materials for Latina/o families.

APPENDIX B

EXTENDED METHODOLOGY

I conducted a randomized controlled design to examine the effects of CCPT with Spanish-speaking Latina/o children who exhibited behavioral problems in school. An a priori mixed between-within ANOVA G* power analysis yielded a target sample size of 14 participants per group, for a total of 42 participants. Based on Cohen's (1988) recommendations, I set the G*power calculation with an alpha level of .05, a moderate effect (f =.25), and a minimum power at .80 for three groups over three points of measure. To allow for attrition, I targeted a total sample of 60 children, 20 per group.

Purpose of the Study

Due to the rapid growth of the Latina/o population whose primary language is Spanish, and the lack of bilingual counseling services, monolingual English-speaking counselors are often required to provide counseling services to Spanish-speaking children and families (McGee, 2010; Tovar, 2015). Child-centered play therapy is a developmentally appropriate intervention for children that has demonstrated positive outcomes with the Latina/o population. Additionally, the use of play could potentially help to bridge the gap when linguistic differences exist between child and therapist. This study explored the effects of CCPT with Spanish-speaking young Latina/o children exhibiting school behavior problems.

Definition of Terms

For the purposes of this study I operationally defined the following terms:

Child-centered play therapy (CCPT) is defined as "a developmentally appropriate modality of facilitating therapy with children from a person-centered philosophy" (Ray, 2011, p. 294). In CCPT, a play therapist (trained in play therapy procedures) provides a safe relationship to the child, using play as the natural medium of communication to facilitate the expression of emotions, thoughts, and behaviors (Landreth, 2012).

Bilingual play therapist is defined as the play therapist trained in CCPT procedures who speaks fluently both Spanish and English languages, and reported their ethnicity as Latina/o.

Monolingual play therapist is defined as the play therapists trained in CCPT procedures who speak only English, and reported their ethnicity as non-Latino.

Behavior problems is operationally defined by the total problems scale in the Caregiver-Teacher Report Form for ages 1½ to 5 as the sum of problems including emotionally reactive, anxious depressed, somatic complaints, withdrawn, sleep problems, attention problems, and aggressive behavior (Achenbach & Rescorla, 2000).

Research Questions

The present study addressed three research questions:

1. What is the effect of CCPT on Latina/o children's behavior problems when conducted by bilingual play therapists compared to a control condition, as reported by teachers and observers?
2. What is the effect of CCPT on Latina/o children's behavior problems when conducted by monolingual play therapists compared to a control condition, as reported by teachers and observers?
3. What is the effect of CCPT on Latina/o children's behavior problems when conducted by bilingual play therapists compared to monolingual play therapists, as reported by teachers and observers?

Participants

Participants were young children from four schools serving low-income children in one suburban school district in the southwest United States. Children met the following criteria to participate in the study: (a) Latina/o or Hispanic between the ages of three-and-a-half and five

enrolled in Head Start pre-school, pre-kindergarten, or kindergarten; (b) Spanish as their primary language and enrolled in the English as a Second Language (ESL) program; (c) in the borderline or clinical range according to the teachers' report in the Caregiver-Teacher Report Form in either the Externalizing, Internalizing, or Total Problems scale; and (d) not receiving any other mental health services at the same time of this study.

Initially, I recruited 66 potential participants, of which 57 met the inclusion criteria and completed the study. Parents whose children did not meet the inclusion criteria mentioned above were provided with a list of referrals to local counseling and university clinics. Overall, participants consisted of 16 female and 41 male children between the ages of three-and-a-half and five (M = 4.0) attending pre-kindergarten or kindergarten. Parents identified all children as Latina/o. Children assigned to the experimental group delivered by a bilingual Latina/o play therapist was composed of four females and 16 males between the ages of three and five years old (M = 4.1). Children in the CCPT group delivered by an English-speaking non-Latina/o play therapist consisted of five females and 14 males between the ages of three and five years old (M = 4.1). The reading mentoring control group was composed of seven females and 11 males between the ages of three and five years old (M = 3.7). All parents' children reported their child's primary language as Spanish. However, due to children being exposed to English in the ESL program in their school, some children could also communicate either fully or partially in English (expressing some specific words or phrases in English). Figure B1 shows participant recruitment, assignment, and demographics.

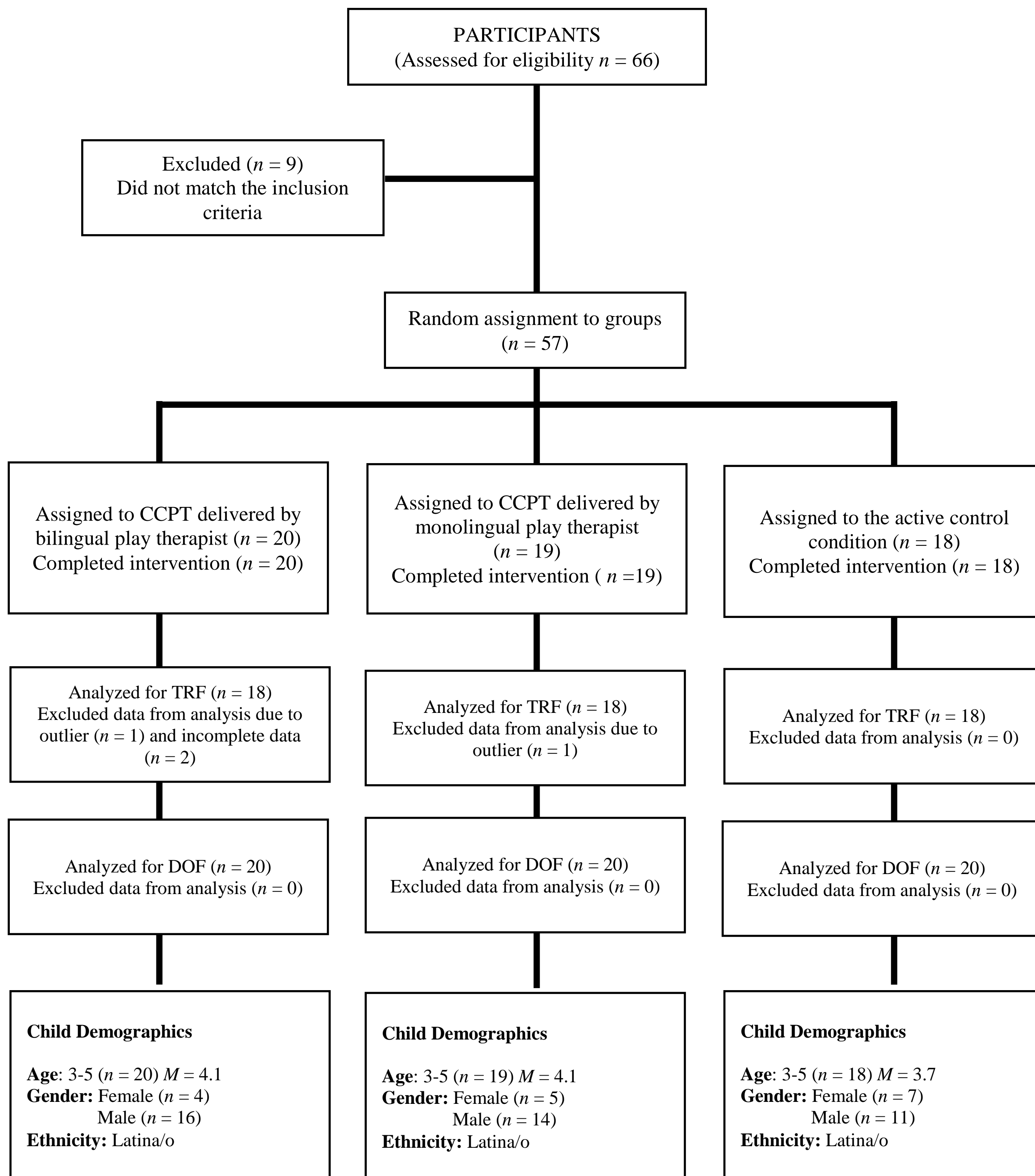

Figure B1. Participants flow chart.

Instrumentation

Caregiver-Teacher Report Form 1½-5

The Caregiver-Teacher Report Form 1½-5 (C-TRF; Achenbach & Rescorla, 2000) measures behavioral, emotional, and social functioning in preschool children and is designed to be completed by a caregiver or teacher who knows the child in the school or daycare environment. This instrument is composed of 99 scaled items that respondents rate as 0 (*not true*), 1 (*somewhat or sometimes true*), or 2 (*very true or often true*), based on their experience with the child in the preceding two months. For purposes of this study, midtest and posttest asked teachers for changes in children's behavioral problems during the last two weeks. The C-TRF also includes three open-ended questions that ask for the child's information regarding illness or disability, other concerns, and the best things the child does. This instrument can be filled out in about 10 to 15 minutes.

The C-TRF displays results in profiles that include percentiles and T scores, plus normal, borderline, and clinical ranges. The C-TRF includes a *Syndrome Scale Profile* that comprising Internalizing, Externalizing, and Total Problems. The first scale is composed of emotionally reactive, anxious depressed, somatic complaints, and withdrawn behaviors. The Externalizing Problems scale comprises attention problems and aggressive behavior. Finally, the total problems subscale is the sum of the internalizing and externalizing problems. Additionally, the C-TRF provide a DSM-oriented profile that include five scales: affective problems, anxiety problems, pervasive/developmental problems, attention deficit/hyperactivity problems, and oppositional defiant problems.

The validity and reliability of the C-TRF have been demonstrated in multiple studies (Achenbach & Rescorla, 2000; Carey, Furlong, & Pavelski, 1997). Across all the scales,

Achenbach and Rescorla (2000) reported a test-retest reliability with a mean interval of eight days of .81 for the C-TRF. Additionally, in a 12-month period, stability correlation for C-TRF was .59 over a 3-month period. The C-TRF has also shown evidence for validity, supported in content validity, criterion-related validity, and construct validity. In addition, applications of the C-TRF have been studied in different countries and translated into 58 languages, including Spanish. The CTRF has been identified as a sensitive instrument across race/ethnicity, income level, and language (Achenbach & Rescorla, 2010).

Direct Observation Form

The Direct Observation Form (DOF; McConaughy & Achenbach, 2009) is an instrument designed to rate children's behaviors in class, recess, or another group setting. During an interval of 10 minutes, observers describe in narrative form children's behaviors, affects, and interactions. Additionally, the child is rated for being on-task or off-task for five seconds at the end of each minute. At the end of the 10-minute period, the observers rate the child's behaviors as described in 88 items using a 0-1-2-3, 0 being a no occurrence to 3 being a definite occurrence with severe intensity and frequency. Item 99 is an open-ended question for the observer to note any other problem not covered in the previous items.

Due to children's variability of behaviors in different settings or circumstances, the DOF software scoring program requires at least two observations of the observed child. McConaughy and Achenbach (2009) encouraged three to six sets of observations for each case. To follow strict protocols, this study required three observations for each targeted child. In addition, observations were made at different times of the day as outlined by McConaughy and Achenbach.

The DOF profiles are provided displaying raw scores, T scores, and percentiles for each scale. Profiles for the DOF in the classroom include: Syndrome scale (comprised by sluggish

cognitive tempo, immature/withdrawn, attention problems, intrusive, and oppositional), the Total Problems and On-Task profile, and the DSM-Oriented scale (including Attention Deficit/Hyperactivity Problems, Inattention subscale, and Hyperactivity-impulsivity subscale). The DOF also provides an Aggressive scale to rate behaviors in recess or a non-classroom setting. For purposes of this study, I used the Total Behavior Problems scale.

Across all the subscales, the interrater reliability ranged from .71 to .97 (M = .79). For the Total Problem Behaviors Scale, the interrater reliability was .97. The test-retest reliability mean reported was of .58 across all problem scales and .72 for the Total Problems scale. The DOF has also showed evidence for the validity, supported in content validity and criterion-related validity.

Procedures

Upon receiving approval from the participating school district and the University of North Texas Institutional Review Board (IRB), I recruited children from two Head Start pre-schools and two elementary schools, following the schools' existing procedures for identifying children for counseling. Consent forms of identified children were provided to parents in both English and Spanish. Next, teachers with parental consent were asked to provide their consent as well and complete the C-TRF. Data collection occurred two weeks prior to intervention

Once I collected all consent forms and pretest assessments of children who met the inclusion criteria, objective raters completed pretest DOFs for children. Raters were master's level counseling students with previous training in child development. Raters were required to review the scoring procedures in the DOF manual (McConaughy & Acenbach, 2009) as well as participate in an intensive training to ensure an acceptable level of interrater reliability before they completed any observations for data collection. I followed Stemler's (2004) 70% recommendation for an acceptable quality of interrater reliability for consistency estimates. A

Pearson correlation coefficient was obtained to determine the level of agreement. Raters attained a degree of consistency of $r = .82$.

Following collection of pretest data, I randomly assigned children to the three treatment groups. I utilized block randomization by school to control for any differences in school environment and to ensure as equal number of participants as possible in each group. I randomized participants using a random numbers table. The result was as follows: CCPT delivered by bilingual therapists, $n = 20$; CCPT delivered by monolingual play therapists, $n = 19$; and active control condition delivered by the bilingual mentors, $n = 18$.

Children received 30-minute play therapy or reading mentoring sessions twice a week for a period of nine weeks. Initially, participants in the three groups were expected to receive 18 sessions. However, due to school holidays, absences, and extenuating circumstances from play therapists or reading mentors, participants received between 16 and 18 sessions with a mean number of session of 18 ($Mo = 8$). Once the interventions were completed, children in the bilingual mentoring group received nine weeks of play therapy intervention. Teachers and raters completed assessments at three different points of this study: at pretest (prior to any intervention), midtest (after four weeks of the intervention), and a post-assessment (after nine weeks of the study). Finally, to maintain confidentiality, all research records were stored in a double-locked cabinet in the principal investigator's office area, which was accessible only to the research team.

Treatment Groups.

Experimental group procedures. The two experimental groups consisted of CCPT delivered by a bilingual Latina/o play therapist and CCPT delivered by a monolingual non-Latina/o play therapist. Play therapists in the two experimental groups followed the CCPT

protocol treatment manual (Ray, 2011). Prior to the delivery of the intervention, bilingual and monolingual play therapists attended training in the CCPT protocol and providing culturally competent play therapy to Spanish-speaking Latina/o children. For this study, providing culturally competent training was essential to address the linguistic and cultural differences between Latino children and monolingual play therapists. Additionally, supervision was delivered by a bilingual and monolingual supervisor with advanced training in CCPT procedures. Supervision began each week with a discussion centered on specific linguistic and cultural challenges. Monolingual play therapists were encouraged to consult in supervision whenever there were linguistic challenges.

All sessions were conducted in specially equipped playrooms in the schools following the recommended toys and materials for CCPT (Landreth, 2012) and the additional list recommended by Garza and Bratton (2005) for using culturally responsive toys and materials in CCPT with Latina/o children. Counselors recorded their play sessions for the purposes of supervision and to ensure treatment integrity. Play therapists included counselor professionals with at least a master's degree (n = 9). Bilingual play therapists included two females and one male who identified as Latina/o. Monolingual play therapists included three females and three males, all who self-identified as White. All play therapists had completed at least two play therapy courses and engaged in supervised practice in CCPT for at least one year.

As suggested by Garza and Bratton (2005), bilingual play therapists introduced the playroom in both Spanish and English and communicated to children that they could speak English or Spanish or both. With the intent of being culturally and ethically responsive, a bilingual play therapist introduced children to the monolingual play therapist and the playroom

using both languages. The bilingual play therapist also emphasized that the monolingual play therapist did not speak Spanish so he was not able to respond back in Spanish.

Parent and teacher consultations are an important component in the therapeutic process of CCPT. However, for the purpose of ensuring study validity, previous experimental CCPT research procedures (Bratton et al., 2013; Wilson, 2016) included instructions to play therapists to refrain from engaging in communication with teachers or parents. In the present study, I attempted to balance culturally sensitivity while maintaining high levels of validity. Play therapists were asked to engage in active empathic listening with teachers and parents whenever they attempted to communicate, but not to provide feedback to teachers or parents about their student/child of focus. Once the study terminated, play therapists provided feedback and consultation to teacher and parents.

Control group procedures. The intention of the bilingual mentoring (RM) group was to control for the internal validity threat of attention (Nock, Janis, & Wedig, 2008). Also, this active control group helped to blind teachers about what intervention children were receiving. In bilingual mentoring, mentors provided a special time for a child in which they read books, colored, or drew. Bilingual mentors were volunteer students self-identified as Latina/o who had completed at least two years of university. Bilingual mentors were screened for previous experience working with children and trained on reading mentoring procedures. Mentoring training was conducted previous to the beginning of the study and was provided by a doctoral student in the counseling program who had had previous experience with mentors in the school system. All mentors were provided with the same kit of materials that included coloring sheets, reading books (bilingual), colors, crayons, pencils, and an audio recorder. All mentoring sessions were held in a designated area at the participating schools, were audio recorded, and checked for

adherence to the protocol. There were no children in these groups that appeared to need more intensive or immediate counseling services. At the end of the study, all children in the bilingual mentoring group received nine weeks of CCPT delivered by a bilingual play therapist. As play therapists, reading mentors were asked to engage in active empathic listening whenever teachers approached them. However, they were asked to not share any feedback or specific information about the child’s experiences. Parent consultations for children in this group were held by the lead researcher.

APPENDIX C

UNABRIDGED RESULTS

I performed a 2 (Group) x 3 (Times) repeated measures ANOVA on the dependent variables, including the C-TRF Total Problems score and DOF Total Problems score. Each analysis reasonably met the assumptions of level of measurement, random sampling, normal distributions, and homogeneity of variance. I established an alpha level of .05 to test for significant mean differences. Several researchers (Hedges, 2008; Henson, 2006; McGough & Faraone, 2009; Sullivan & Feinn, 2012) have underscored the importance of effect sizes and clinical significance in research, arguing that practical and clinical significance provide a more comprehensive evaluation of the efficacy of interventions. For this research study, practical significance was reported using partial eta squared (n_p^2) effect sizes which I interpreted using the guidelines proposed by Cohen (1988): .01 (small), .06 (medium), and .14 (large). Clinical significance is defined as the impact of the intervention on clients' everyday life (Kazdin, 1999). I determined the clinical significance of the findings by examining the percentage of children who moved from clinical or borderline scores to normal scores on the C-TRF.

Table C1 presents pre, mid, and posttest means and standard deviations on the dependent variables (C-TRF and DOF Total problems) for the three group conditions: CCPT delivered by a bilingual play therapist, CCPT delivered by a monolingual play therapist, and the active control condition delivered by a bilingual mentor. Note that three participants were removed from the data analysis on the C-TRF; two due to incomplete data and one as a statistical outlier.

Table C1

Descriptive Statistics for Each Group on C-TRF and DOF Total Problems

		CCPT Spanish-Speaking (*n* = 18)		CCPT English-Speaking (*n* = 18)		Control Group (*n* = 18)	
		M	*SD*	*M*	*SD*	*M*	*SD*
C-TRF Total Problems	Pretest	61.722	4.184	61.944	4.304	62.888	7.521
	Midtest	54.277	7.168	57.833	7.571	59.500	7.213
	Posttest	51.944	9.926	51.111	7.828	57.111	9.151
		CCPT Spanish-Speaking (*n* = 20)		CCPT English-Speaking (*n* = 19)		Control Group (*n* = 18)	
DOF Total Problems	Pretest	55.150	5.173	54.263	6.349	54.555	5.802
	Midtest	50.700	3.798	50.684	6.377	52.666	5.646
	Posttest	48.400	4.546	49.263	5.713	51.666	5.0176

Note: Three participants were removed from the data analysis on the C-TRF; two due to incomplete data and one as a statistical outlier.

Research Question 1. Effects of CCPT Delivered by a Bilingual Play Therapist Compared to an Active Control Condition

Teacher Report. Results for the Total Problems on the C-TRF indicated no statistically significant interaction effect between time and treatment groups, $F(1, 34) = 1.759$, $p = .188$, and a medium effect size $\eta_p^2 = .096$, indicating that CCPT demonstrated a moderate treatment effect on reducing child behavior problems compared to the active control/mentoring group. Additionally, results indicated a statistically significant main effect for time $F(1, 34) = 14.365$, $p = .001$ with a large effect size $\eta_p^2 = .465$, indicating that according to teachers' report, when participants from the experimental and control conditions were grouped together, participants demonstrated statistically significant improvement in behavior problems over time.

Because the main effect for time was statistically significant, I calculated a one-way ANOVA for each treatment condition to explore within-group differences. To avoid Type I error that can occur from multiple hypothesis testing I established an alpha level of .025 to detect statistical significant mean differences; I followed this procedure for all one-way ANOVA calculations. Results indicated that the CCPT bilingual group demonstrated statistically significant improvement from pre to mid to posttests $F(1, 17) = 12.651$, $p = .001$ and the treatment effect was large $\eta_p^2 = .613$. Analysis of the active control/mentoring group indicated no statistically significant difference across time $F(1, 17) = 3.057$, $p = .075$ yet the effect size was large $\eta_p^2 = .276$. Although the effect size for both conditions was considered large, the treatment effect for CCPT was almost three times as great as for the mentoring group. Visual analysis of mean scores depicted in Figure C1 supports the greater improvement of the CCPT group.

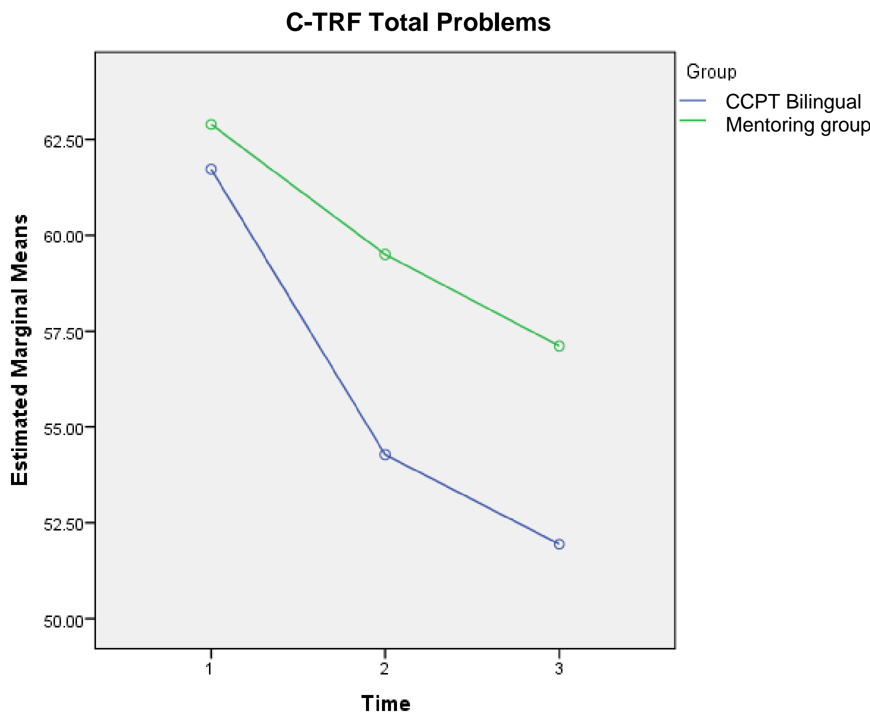

Figure C1. Mean scores on C-TRF total problems scores

Direct Observation Rating. Results for the Total Problems on the DOF indicated no statistically significant interaction effect between time and treatment groups, $F(2, 36) = 1.440$, $p = .251$, and a medium effect size $\eta_p^2 = .076$, indicating that CCPT demonstrated a moderate treatment effect on reducing child behavior problems compared to the active control/mentoring group. There was a statistically significant difference for main effect of time $F(2, 36) = 8.969$, $p = .001$ with a large effect size $\eta_p^2 = .339$, indicating that according to observers' report, when participants from the experimental and control conditions were grouped together, participants demonstrated statistically significant improvement in behavior problems over time.

Because the main effect for time was statistically significant, I calculated a one-way ANOVA for each treatment condition to explore within-group differences. Results indicated that the CCPT group demonstrated statistically significant improvement from pre to mid to posttests; $F(1, 19) = 14.021$, $p = .001$ and the treatment effect was large $\eta_p^2 = .594$. Analysis of the active control/mentoring group indicated no statistically significant difference across time $F(1, 19) = 1.097$, $p = .358$ and a medium effect size $\eta_p^2 = .121$. The treatment effect for CCPT was almost five times as great as for the mentoring group. Visual analysis of mean scores depicted in Figure C2 supports the greater improvement of the CCPT group.

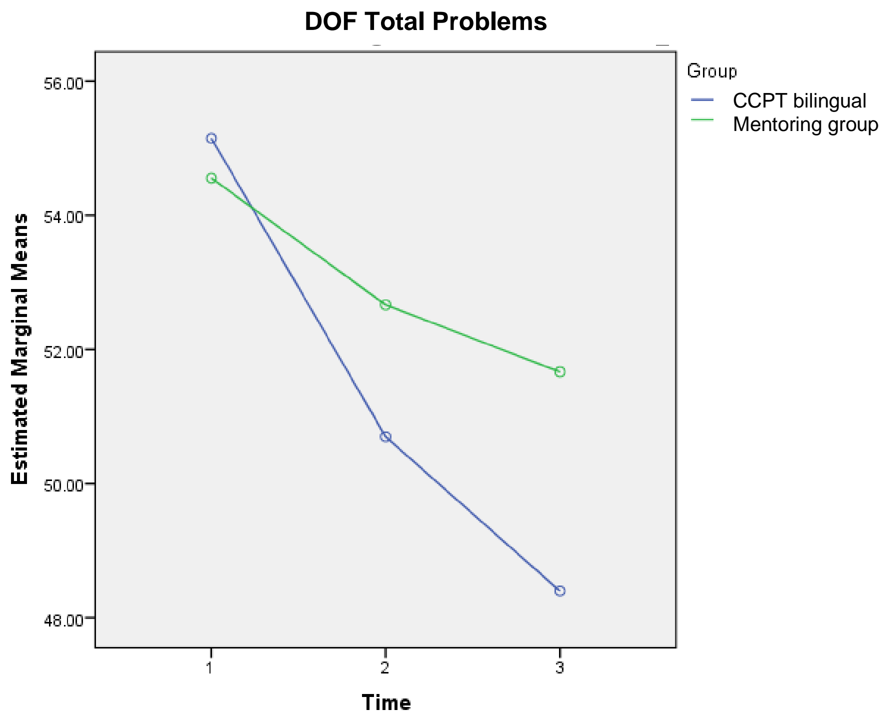

Figure C2. Mean scores on DOF Total Problems scores.

Research Question 2. Effects of CCPT Delivered by a Monolingual Play Therapist Compared to an Active Control Condition

Teacher Report. Results for the Total problems on the C-TRF indicated no statistically significant interaction effect between time and treatment groups, $F(2, 34) = 1.317$, $p = .282$, and a medium effect size $\eta_p^2 = .074$, indicating that CCPT demonstrated a moderate treatment effect on reducing child behavior problems compared to the active control/mentoring group. There was a statistically significant difference for main effect of time $F(2, 34) = 13.621$, $p = .001$ with a large effect size $\eta_p^2 = .452$, indicating that according to teachers' report, when participants from the experimental and control conditions were grouped together, participants demonstrated statistically significant improvement in behavior problems over time.

Because the main effect for time was statistically significant, I calculated a one-way ANOVA for each treatment condition to explore within-group differences. Results indicated that

the CCPT group demonstrated statistically significant improvement from pre to mid to posttests $F(1, 17) = 15.594$, $p = .001$ and the treatment effect was large $\eta_p^2 = .661$. As reported in the one-way ANOVA findings for Research Question 1, analysis of the active control/mentoring group indicated no statistically significant difference across time, and the effect size was large (.276). Although the effect sizes for both conditions are noteworthy, the treatment effect for CCPT was almost three times as great as for the mentoring group. Visual analysis of mean scores depicted in Figure C3 supports the greater improvement of the CCPT group.

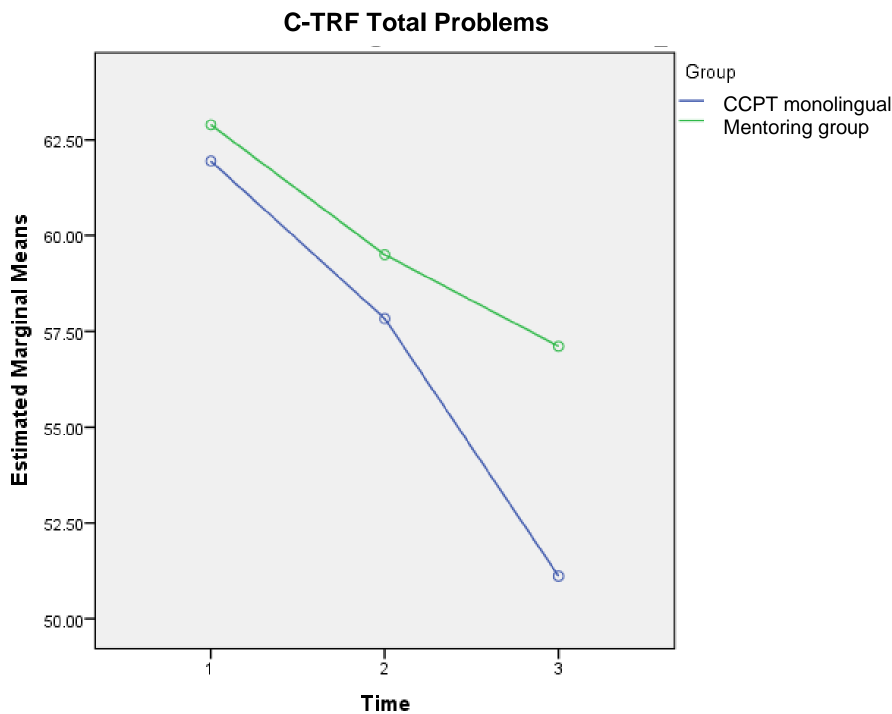

Figure C3. Mean scores on C-TRF Total Problems scores.

Direct Observation Rating. Results for the Total Problems on the DOF indicated no statistically significant interaction effect between time and treatment groups, $F(1, 35) = .438$, $p = .649$, and a small effect size η_p^2=.025., indicating that CCPT demonstrated a small treatment effect on reducing child behavior problems compared to the active control/mentoring group. There was a statistically significant difference for main effect of time $F(1, 35) = 6.183$, $p = .005$

with a large effect size η_p^2 = .267, indicating that according to observers' report, when participants from the experimental and control conditions were grouped together, participants demonstrated statistically significant improvement in behavior problems over time.

Because the main effect for time was statistically significant, I calculated a one-way ANOVA for each treatment condition to explore within-group differences. Results indicated that the CCPT group demonstrated statistically significant improvement from pre to mid to posttests $F(1,18) = 8.993$, $p = .002$ and the treatment effect was large η_p^2 = .514. As reported in the the one-way ANOVA findings for Research Question 1, analysis of the active control/mentoring group indicated no statistically significant difference across time, and the effect size was medium (.121). Although effect sizes for both conditions are noteworthy, the treatment effect for CCPT was almost four times as great as for the mentoring group. Visual analysis of mean scores depicted in Figure C4 supports the greater improvement of the CCPT group.

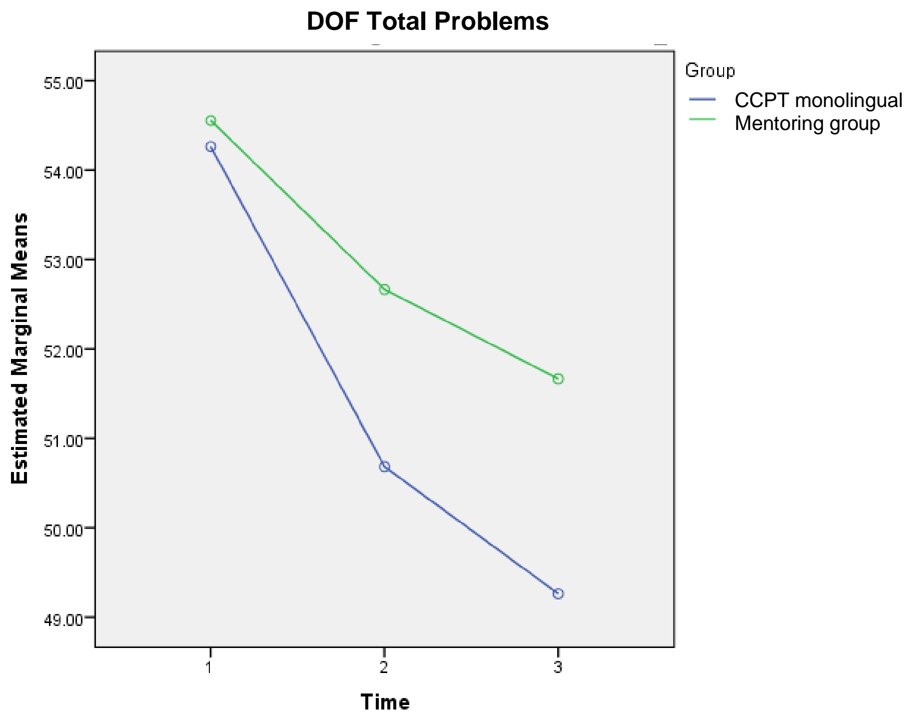

Figure C4. Mean scores on DOF Total Problems scores

Research Question 3. Effects of CCPT Delivered by a Bilingual Play Therapist Compared to a CCPT Delivered by a Monolingual Play Therapist

Teacher Report. Results for the Total Problems on the C-TRF indicated no statistically significant interaction effect between time and treatment groups, $F(2, 34) = 1.661$, $p = .205$, and a medium effect size $\eta_p^2 = .091$. Visual examination of Figure 6 shows that although the two interventions showed similar improvement at posttest, bilingual CCPT showed greater improvement from pre to mid than monolingual CCPT.

There was a statistically significant difference for main effect of time $F(2, 34) = 26.396$, $p = .001$ with a large effect size $\eta_p^2 = .615$, indicating that according to teachers' report, when participants from the experimental and control conditions were grouped together, participants demonstrated statistically significant improvement in behavior problems over time. Because the main effect for time was statistically significant, I examined the results from the one-way ANOVAs previously conducted for each treatment condition. As reported in the one-way ANOVA findings for Research Questions 1 and 2, both CCPT bilingual and monolingual groups demonstrated statistically significant improvement over time with similarly large treatment effects, .613 and .661 respectively. Figure C5 graphically depicts that children in the monolingual and bilingual CCPT groups improved to a similar level of functioning following the treatment phase, although the rate of change over time for each group differed.

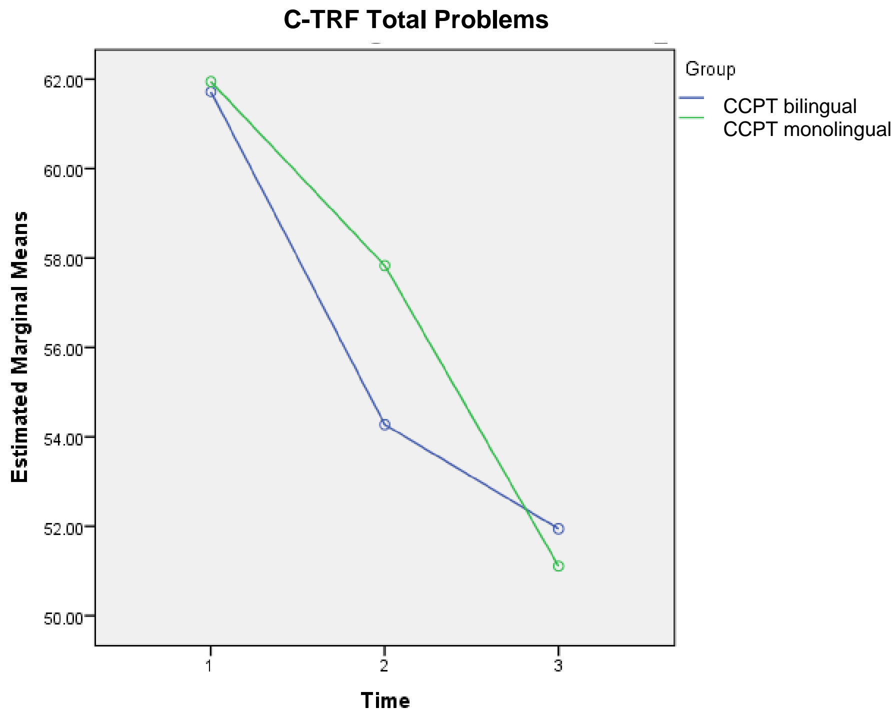

Figure C5. Mean scores on C-TRF Total Problems scores.

Direct Observation Rating. Results indicated no statistically significant interaction effect between time and treatment groups, $F(1, 37) = .537$, $p = .589$, and a small effect size $\eta_p^2 = .029$. There was a statistically significant difference for main effect of time $F(1, 37) = 22.138$, $p = .001$ with a large effect size $\eta_p^2 = .552$, indicating that according to observers' report, when participants from the experimental and control conditions were grouped together, participants demonstrated statistically significant improvement in behavior problems over time.

Because the main effect for time was statistically significant, I examined the results from the one-way ANOVAs previously conducted for each treatment condition. As reported in the one-way ANOVA findings for Research Questions 1 and 2, both CCPT bilingual and monolingual groups demonstrated statistically significant improvement across time and similarly large treatment effects, .594 and .514 respectively. Visual analysis of mean scores depicted in Figure C6 supports the improvement at the end of the intervention of both CCPT groups.

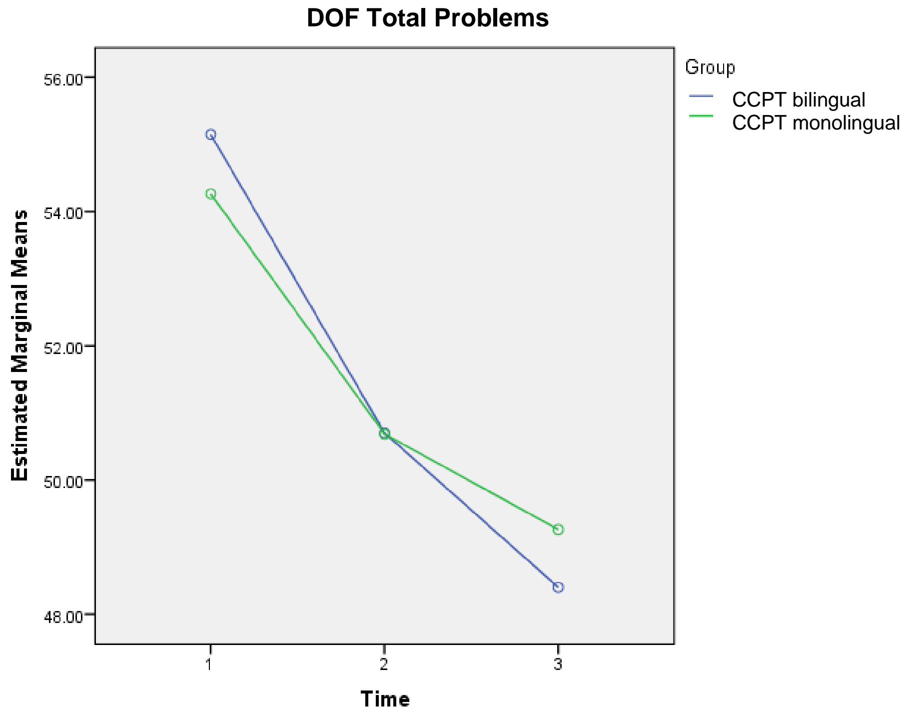

Figure C6. Mean scores on DOF Total Problems scores.

Clinical Significance

Clinical significance was analyzed based on the percentage of children who improved from borderline or clinical to normal on C-TRF Total Behaviors: 80% of children in the bilingual CCPT group and 70% of children in the monolingual CCPT group moved to normative functioning, while only 15% of children in the active control group improved to the normal range.

APPENDIX D

EXTENDED DISCUSSION

This research study aimed to investigate the effects of CCPT on Spanish-speaking Latina/o children exhibiting behavioral problems. Specifically, the study sought to examine the effects of CCPT when delivered by a bilingual play therapist or a monolingual play therapist as compared to an active control condition delivered by a bilingual mentor. Although teachers and objective raters did not observe statistically significant differences between groups, the clinical and practical significance of the results suggested greater improvement in children who participated in either CCPT delivered by bilingual play therapists or CCPT delivered by culturally competent, monolingual play therapists as compared to children who participated in the active control condition.

The moderate treatment effects for bilingual and monolingual CCPT over the active control condition on children's global behavior problems are consistent with the findings from Lin and Bratton's (2015) meta-analytic review of CCPT research, and slightly better than the Ray et al. (2015) meta-analysis of school-based CCPT. Specific to the Latino population, the present findings are consistent with controlled outcome research examining effects of CCPT approaches on Latina/o children's behavioral problems (Ceballos & Bratton, 2010; Garza & Bratton, 2005). A strength of the present study is the use of blinded, direct observers as one of two sources of measurement for assessing child behavior. With the exception of pre to midpoint findings for the two CCPT groups discussed further below, results reported by teachers and direct observers were consistent. The consistent ratings across teachers and independent observers provides greater confidence in the findings and answers the limitation cited in the majority of play therapy research (Bratton, 2015)—the need for multiple sources of assessment for a single outcome variable, one being an independent evaluator.

The current results, along with findings from the small body of existing research on CCPT approaches with Latina/o children, are particularly encouraging considering the need for empirically supported counseling services that are culturally responsive to Latina/o children and families. Historically, Latinas/os face risk factors including language differences and level of acculturation from the dominant culture, as well as poverty (NCES, 2003; Turney & Kao, 2012). Such factors have been correlated with the development of behavioral problems in Latina/o children, including aggressive behaviors (Vazsonyi & Chen, 2010), communication problems, and struggles with relationships (Turney & Kao, 2012). Additionally, Latina/o children are statistically less likely to succeed academically (Kena et al., 2015; NCES, 2003) and more likely to drop out of school when compared to other ethnic groups (Kena et al., 2015; Musu-Gillette et al., 2016; National Task Force, 2007). Without early intervention, childhood behavior problems tend to be stable over the child’s lifetime and are associated with long-term consequences including a variety of mental health disorders, youth violence, and delinquency (Turney & Kao, 2012; Vazsonyi & Chen, 2010). Considering the robust data regarding the need for mental health interventions for Latina/o children, the present results provide an optimistic outlook indicating that CCPT may be a viable culturally responsive counseling intervention for reducing Spanish-speaking Latina/o children’s global behavior problems.

Overall, findings are promising given the well-documented shortage of bilingual services for Latina/o children (Tovar, 2015), and suggest the effectiveness of CCPT with young Spanish-speaking children whether delivered by bilingual play therapists or culturally competent, monolingual play therapists. Multiple scholars have noted that play is the universal language of children (Axline, 1947; Landreth, 2012; Ray, 2011). Based upon results from this study, play might not only help to bridge the gap between concrete and abstract thinking as Piaget (1959)

proposed, play might also serve to bridge the gap in linguistic differences between counselor and child. However, it is important to highlight that results from this research are based on the specific procedures followed in this study, namely providing cultural competency training and culturally-responsive supervision to monolingual, non-Latina/o counselors to provide ethical and responsible services to the participating children. Providing interventions in a language other than children's first or only language should be cautiously examined. The ACA Code of Ethics (2014) mandates counselors to arrange appropriate services when client and counselor have linguistic differences. Yet, in practice, counseling professionals (McGee, 2010; Tovar, 2015) have noted that due to the lack of bilingual counselors, mental health professionals working with Spanish-speaking children often face the ethical dilemma of providing services in a different language or not providing services at all. The present study aimed to ethically address the shortage of available bilingual services by providing counselors with Latino culture-specific training prior to intervention and culturally-responsive supervision throughout the intervention phase. These procedures were designed to bridge the gap in linguistic and cultural differences between children and counselors, particularly for the monolingual counselors to minimize differences in language. It is important to note that participants in the present study were young children between three-and-a-half and five years of age attending an English as a Second Language (ESL) program. Thus, even if the children were not bilingual, English language was not unfamiliar to them. And as stated previously, CCPT allows children to use play as a means of self-expression, which may have helped to bridge the gap in language difference and contributed to ethical practice.

Results from this study also suggest that children in the bilingual mentoring group benefitted from having a special time with a bilingual mentor. Research examining the effects of

school-based mentors trained and supervised in foundational CCPT skills indicate beneficial effects on young children's behaviors problems (Dafoe, 2017; Jones, Rhine, & Bratton, 2002). Hence, another potential solution to address the growing shortage of bilingual services in schools is to train and supervise Spanish-speaking, Latina/o mentors in therapeutic play skills grounded in CCPT.

The present study also suggests valuable information regarding CCPT's effectiveness for reducing Latina/o children's behavioral problems as CCPT appears to be a culturally responsive approach when working with this population regardless of cultural and linguistic differences between child and therapist. Landreth (2012) proposed that CCPT is responsive across cultures. In CCPT, the counselor provides a relationship in which the child is fully accepted and uniquely valued, with no expectation for the child to be different. The CCPT attitudes of empathy, warmth, and unconditional acceptance are conveyed nonverbally as well as verbally, thus transcend language. When the child experiences the therapeutic conditions from the therapist, the child feels accepted and prized and then is able to explore self-actualizing potential in healthier ways. This is particularly important for Spanish-speaking Latina/o children who move between two different cultures and two different languages. The therapy provides a non-judgmental relationship in which children lead the counseling process and the therapist follows them (Landreth, 2012). Thus, CCPT also provides an opportunity for children to explore their cultural identities and linguistic preferences.

Findings from the current study align with those from studies suggesting that CCPT approaches are consistent with Latina/o cultural values (Ceballos & Bratton, 2010; Garza & Bratton, 2005). The emphasis on the relationship as the essential therapeutic factor for healing and change is a strong fit with the value of personalismo. Latinas/os tend to prefer warm and

caring personal interactions (Arredondo et al., 2014). Cultural values and systemic barriers to Latinas/os accessing counseling services are important elements that need to be understood by mental health professionals when providing services to Latina/o children. Cultural training is imperative when working with Latinas/os in order to enhance therapeutic outcomes (Arredondo et al., 2014; Baumann et al., 2011; Santiago-Rivera, 1995; Santiago-Rivera et al., 2002; Shattell et al., 2008; Snowden & McClellan, 2013). Another factor in providing culturally-responsive services in accessibility. Due to mistrust and fear of governmental organizations, especially from undocumented immigrant families, Latinas/os often refrain from seeking counseling services in the community (Santiago-Rivera, 1995). Schools provide a familiar and safe setting that could potentially provide Latina/o children and families with greater access to mental health services.

Subjective observations

Anecdotal data was gathered throughout this study by incorporating feedback from teachers and bilingual and monolingual play therapists. Data from teachers was collected through verbal report and the consultations teachers requested with play therapists. Information from play therapists was recorded during supervision or consultations with the leading researcher and was based on verbal report and analysis of video recordings from the play sessions. Feedback from play therapists included overall progress on children's behaviors as well as cultural and linguistic observations.

Play therapists relevant observations. Based on monolingual play therapist reports and video recordings, some observations regarding linguistic differences were noted. In some cases, Latina/o children demonstrated being able to either totally switch from Spanish to English language or use some words in English to communicate with the monolingual play therapist. In fact, being bilingual or able to communicate to some extent in two languages appeared to be

something children were proud of, as evidenced by their verbal statements. In other cases, when children did not speak any English, linguistic differences did not seem to distress children during play sessions. For instance, it was noted that children's play was intrinsically satisfying and when they needed something from a counselor they seemed to use more non-verbal behaviors to communicate what they needed.

Similarly, monolingual play therapists reported using more non-verbal behaviors to communicate empathic statements when there were linguistic differences with children. However, during the first few play sessions monolingual play therapists reported feeling uncertain and having a lack of trust about their level of competence because of the language barriers. Over time, play therapists reported increasing levels of trust in their ability to build a trusting relationship with the child. In this regard, there are important implications for counseling. For example, bilingual supervisors could help monolingual play therapists to normalize feelings of lack of competence and effectiveness on children's behaviors. Bilingual supervisors could also encourage more use of non-verbal behaviors to communicate and demonstrate empathy.

On the other hand, bilingual play therapists reported that even when children could navigate between English and Spanish, most of them had a strong preference for using Spanish consistently throughout the intervention. Particularly, children appeared to demonstrate preference for Spanish language when they exhibited nurturing play themes. On the contrary, children appeared to switch to English language or use words in English more often when exhibiting mastery play themes related to school topics.

As previously stated, playroom materials were added to be culturally responsive. Materials included toys that represent Latina/o culture such as dolls, kitchen items, and musical

instruments among others. Play therapists reported not noticing children's preferences for those toys; they reported children played equally with toys and materials. However, it was common for some children to bring into conversation their own or their parents' country of origin. For instance, some children stated they had visited Mexico or had family in Mexico. In one case, one child stated missing his extended family in Mexico.

Techers observations and comments. Overall, teachers verbally reported seeing more changes in children's behaviors on those participating in CCPT. In fact, reports from teachers and objective raters indicated a consistent pattern of change from pre to mid to posttest for the CCPT bilingual group and the bilingual mentoring group. Whereas, results for the CCPT monolingual, non-Latino group showed inconsistency between teachers and direct observers from pre to midtest, but indicated similar ratings for child behavior at the time of posttest. One possible explanation for the inconsistency in ratings could be explained by racial/ethnic match. Teachers had contact with treatment providers, while the independent raters did not. Thus, only teachers were aware of the ethnicity and language of treatment providers. It has been noted in literature that Latinas/os tend to initially feel more comfortable and rate more positively counselor professionals who share similar ethnic/racial background (Cabral & Smith, 2011; Santiago-Rivera et al., 2002). The present findings could suggest that teachers might have felt some initial level of mistrust and bias toward the monolingual play therapists and their ability to help Spanish-speaking children due to linguistic and ethnic differences. Although, if true, posttest findings suggest that teachers' perception changed over time; that is, by the end of the study teachers may have been more comfortable with the non-Latina/o treatment providers and rated children's improvement without bias. This finding is also consistent with literature (Cabral & Smith, 2011) which suggests that even if Latina/os express initial preference for counselors

with similar ethnic/racial background, this preference does not impact therapeutic outcomes over time.

In my personal and subjective experience with teachers, some of them initially reported some hesitancy about those children being with a monolingual play therapist. For instance, one teacher stated, “I don’t know if that is going to help, the child does not speak any English”. As the lead researcher, I shared with teachers that both, monolingual and bilingual providers were supervised by bilingual mental health professionals. Teachers also appeared to initially request consultations with the lead researcher and not with the monolingual play therapists. However, overtime, teachers appeared to build a relationship with monolingual play therapists and consultations request were directly addressed with them.

Finally, as the lead researcher I maintained relationship with teachers and I was often invited to celebrations or reunions. I was also often invited to spontaneous food gatherings with children and families. This is relevant because in a typical research interventions researchers are not encouraged to join such gatherings. However, for conducting research with Latino cultures this is something that might need to be further considered.

Limitations and Recommendations

Although results from this study are encouraging and offer a viable solution for the shortage of culturally responsive counseling interventions for Spanish-speaking Latina/o children, limitations exist and should be considered when interpreting results. A major limitation is small sample size. Given the moderate treatment effects, a larger sample size might result in statistically significant differences among groups and more reliable results. In addition, the generalizability of results is limited to the specific Latina/o population in which the study took place, including geographical location and school characteristics (Head Start Program and Title I

schools). It is important to consider that the Latina/o population is a heterogeneous group with multiple intersectionalities such as country of origin, level of acculturation, language, socioeconomic status, generational status, and documented status among others (Santiago-Rivera et al., 2002). In this regard, future studies might include more detailed and specific demographic information about the Latina/o population that is being studied.

The results from this research study were based on 16 to 18 play sessions. Due to the values of familismo and respeto, it has been noted that children may take a few more sessions to feel comfortable in the playroom as compared to non-Latina/o children (Drewes, 2006; López-Baez, 2006). Therefore, it might be important for future researchers to consider a greater number of sessions for this population. Similarly, because of the importance of family to Latina/o cultures, future studies should consider CCPT treatment procedures that include parent involvement. Additionally, follow-up studies are needed to investigate the long-term effects of CCPT for this population. Studies targeting specific disorders (e.g., anxiety and disruptive behaviors) could provide beneficial information on the relative effects of CCPT for various presenting issues.

The study design did not explore the impact of therapist language and ethnicity as separate variables, thus this omission represents another major limitation and should be addressed in future research. Similarly, children’s primary language was based on parents’ report rather than formal assessment. Future researchers should consider assessing children’s level of English and Spanish fluency as well as level of acculturation as a mediator of treatment outcomes when counseling Latino children. Finally, it is important to acknowledge the researcher’s own biases. Due to the lack of bilingual Latina/o counselors, I, as lead researcher,

took several roles throughout the research study that might have resulted in a bias when analyzing results. Similarly, my ethnicity might have also led to racial biases.

Implications for Practice

The findings from the present study provide relevant information for play therapists when providing services to Spanish-speaking Latina/o children presenting with problem behaviors. Results suggest that CCPT is not only an effective intervention, but also a developmentally and culturally sensitive intervention with Spanish-speaking Latina/o children whether delivered by a Spanish-speaking Latina/o play therapist or culturally competent, monolingual English-speaking play therapist. The findings lend credence to the therapeutic use of play, as the universal language of children, to bridge the gap in linguistic differences between therapists and children. Practitioners are cautioned to understand and use these results in the context of the training and supervision procedures followed for ethical practice and to ensure that monolingual, non-Latino counselors are culturally competent and responsive to the participating children's needs. These findings suggest that for this population of children, ongoing supervision delivered by a bilingual professional counselor trained in CCPT may be an especially important component to the successful delivery of CCPT by a monolingual counselor.

Ideally, mental health services for Spanish-speaking children should be provided by bilingual counselors trained to deliver culturally responsive services to this population. Unfortunately, there is a shortage of bilingual counselors, particularly those trained to work with young Latina/o children. The present study findings offer a promising solution to the gap in services for this population and suggest that bilingual counselors trained in CCPT could maximize their efforts by training and supervising monolingual counselors and thus provide Latina/o children with greater accessibility to the services they need.

Conclusion

As an ethnic group, Latina/o children are highly represented in primary school grades, representing 25% of the total enrollment in the United States (Snyder & Dillow, 2015). It has been also documented that Latina/o children face diverse challenges that place them at risk to develop behavioral problems. Without early intervention, childhood behavior problems tend to be stable over the child's lifetime and are associated with long-term consequences including a variety of mental health disorders, youth violence, and delinquency (Turney & Kao, 2012; Vazsonyi & Chen, 2010). Yet, Latina/o children and families have been historically underserved in the mental healthcare system due to systemic and cultural barriers (Avila & Bramlett, 2013; Ojeda et al., 2011; Snowden & McClellan, 2013). Particularly for Spanish-speaking Latina/o families, language represents a significant barrier to accessing counseling services due to the lack of trained bilingual and culturally responsive professionals (Castaño et al., 2007; McCaffrey & Moody, 2015).

The present study indicates that CCPT delivered by both bilingual and monolingual counselors trained and supervised in culturally-responsive attitudes and procedures offers a viable solution to the shortage of developmentally responsive mental health services for Latina/o children. More specifically, results suggest that play might help to bridge the gap when linguistic barriers exist between Spanish-speaking Latina/o children and English-speaking play therapists. However, such practice should be examined following the strictest ethical guidelines. Ongoing supervision by a bilingual/bicultural counselor professional is imperative. Future research should include larger sample sizes and maintain Latina/o cultural values, as well as attend to linguistic and ethnic variables separately.

This study was funded by the National Latina/o Psychological Association's Cynthia de las Fuentes Dissertation Grant, the Association for Humanistic Counseling's Make-A-Difference Grant, the Texas Association for Play Therapy's Dan E. Homeyer Research Grant, and the University of North Texas Center for Play Therapy.

APPENDIX E

INFORMED CONSENT FORMS

University of North Texas Institutional Review Board

Informed Consent Form

Before agreeing to your child's participation in this research study, it is important that you read and understand the following explanation of the purpose, benefits and risks of the study and how it will be conducted.

Title of Study: Child-Centered Play Therapy (CCPT) for Young Spanish-speaking Latino children: Effects on Behavioral Problems and Social Emotional Development.

Principal Investigator: Dr. Sue Bratton, Professor at the University of North Texas (UNT) Department of Counseling and Director of the Center for Play Therapy; co-PI: Dr. Peggy Ceballos, University of North Texas (UNT) Department of Counseling.

Purpose of the Study: You are being asked to allow your child to participate in a research study which examines the effects of school-based play therapy services and reading mentoring. The purpose of the study is to help Spanish-speaking young Latino children who have behavior difficulties such as aggression, fighting, attention problems, hyperactivity, anxiety, rule-breaking, etc. to reduce their behavior problems. Experts in child development suggest that children who have less behavioral problems at school do better academically.

Study Procedures: Your child will be asked to participate in approximately 20 individual play therapy or reading mentoring sessions. Play therapy sessions will be delivered by either a Latina/o Spanish speaking play therapist or by a non-Latina/o English-speaking play therapist. Reading mentoring sessions will be delivered by bilingual mentors. Both, play therapy and reading mentoring sessions will take about 30 minutes, two times each week. All sessions will take place during regular school hours at a time determined by the teacher. Sessions will be video-recorded or tape-recorded to provide supervision to the counselors in order to make sure your child is receiving the best services possible. Teachers and you will be asked to complete a brief assessment regarding your child's classroom and home behaviors three times during the study to help assess if the services your child is receiving is helping your child. You may choose to withdraw your child from the study at any time.

Play therapy:
In play therapy, a type of counseling with children through play and toys, a counselor who has advanced training in play therapy will take your child to the playroom at school which is equipped with a variety of developmentally appropriate toys and materials such as arts/craft supplies, clay, games, toy people and animals, cars and trucks, dolls, puppets, dress-up/pretend clothes, and a play kitchen area.

Using play and toys in counseling help children who are having problems at school is based on the belief that children communicate best through play, while adults generally communicate through words. Preschool-age children think at a very concrete level, thus it is easier for them to use the toy figures and other materials to show the counselor what they are thinking and feeling. Trying to explain how you are feeling and why you feel that way can be hard even for an adult—especially when you are upset! This is especially true for children.

Reading mentoring:
In the reading mentoring program, a master's student will work with your child for 30 minutes twice each week. Mentors provide a time when children can choose to read books that are specially chosen for pre-school children or the children may choose to complete coloring pages. Having a special adult to read to

APPROVED BY THE UNT IRB

DATE: 1/29/16 - 1/28/17
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them and color with them can help children increase their interest in reading and feel special. Children receiving reading mentoring will receive play therapy sessions after the study has been completed, if the parents so choose.

Foreseeable Risks: The potential risks involved in this study are minimal. As with any counseling intervention, children may become more aware of emotional difficulties. In the event a child has a difficult time adjusting to emotional insight or it appears the child needs more intense services than reading mentoring, the parent will be contacted and a referral will be made to a local counseling center.

Benefits to the Subjects or Others: We expect the project to benefit your child by allowing him or her an opportunity to learn self-control and socially acceptable behaviors which can then be transferred to the classroom and home.

Procedures for Maintaining Confidentiality of Research Records: Your child's name will be removed from all identifying materials related to this research and replaced with a random code number. Consent forms will be stored in a location separate from coded materials. All research records including video recordings will be kept in a locked cabinet in the researcher's office, and be accessible only to the researchers. Research records will be kept for a period of 3 years following the conclusion of this study. At that time, all records will be properly destroyed. The confidentiality of your child's individual information will be maintained in any professional publications or presentations regarding this study.

Questions about the Study: If you have any questions about the study, you may contact *Dr. Sue Bratton, Dr. Peggy Ceballos, or Mr. Gustavo Barcenas,* UNT Department of Counseling, at telephone number 940-565-3864.

Review for the Protection of Participants: This research study has been reviewed and approved by the UNT Institutional Review Board (IRB). The UNT IRB can be contacted at (940) 565-4643 with any questions regarding the rights of research subjects.

APPROVED BY THE UNT IRB
DATE: 1/29/16- 1/28/17

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

- Dr. Sue Bratton, or Dr. Peggy Ceballos, or the designated research assistant, Gustavo Bárcenas, has explained the study to you and your questions have been answered. You have been informed of the possible benefits and the potential risks and/or discomforts of the study.
- You understand that you do not have to allow your child to take part in this study, and your refusal to allow your child to participate or your decision to withdraw him/her from the study will involve no penalty or loss of rights or benefits. The study personnel may choose to stop your child's participation at any time.
- Your decision to allow your child to participate or to withdraw from the study will not have a negative effect on your child's grades or standing in their classroom.
- You understand why the study is being conducted and how it will be performed.
- You understand your rights as the parent/guardian of a research participant and you voluntarily consent to your child's participation in this study.
- You have been told you will receive a copy of this form.

__________________Y / N   __________________Y/N   __________________Y/N
Cell phone - ok to leave msg   Home phone - ok to leave msg   Work phone - ok to leave msg

____
Email address

____
Name of Child

____
Printed Name of Parent or Guardian

____________________________   ____________
Signature of Parent or Guardian   Date

For the Principal Investigator or Designee: I certify that I have reviewed the contents of this form with the parent or guardian signing above. I have explained the possible benefits and the potential risks and/or discomforts of the study. It is my opinion that the parent or guardian understood the explanation.

________________________________   ____________
Signature of Principal Investigator   Date

APPROVED BY THE UNT IRB
DATE: 1/29/16 - 1/28/17

University of North Texas Institutional Review Board

Teacher Informed Consent Form

Before agreeing to your child's participation in this research study, it is important that you read and understand the following explanation of the purpose, benefits and risks of the study and how it will be conducted.

Title of Study: Child-Centered Play Therapy (CCPT) for Young Spanish-speaking Latino children: Effects on Behavioral Problems.

Principal Investigator: Sue Bratton, Ph.D., Licensed Professional Counselor - Supervisor (LPC-S), Registered Play Therapist and Supervisor (RPT-S), University of North Texas, Department of Counseling & Higher Education; co-PI: Dr. Peggy Ceballos, University of North Texas (UNT) Department of Counseling.

Purpose of the Study: You are being asked to participate in a research study which examines the effects of school-based play therapy services and reading mentoring. The purpose of the study is to help Spanish-speaking young Latino children who have behavior difficulties such as aggression, fighting, attention problems, hyperactivity, anxiety, rule-breaking, etc. to reduce their behavior problems. Experts in child development suggest that children who have less behavioral problems at school do better academically.

Study Procedures: After parents provide permission for their child's participation in this study, each participating child will participate in approximately 20 individual play therapy or reading mentoring sessions. Play therapy sessions will be delivered by either a Latina/o Spanish speaking play therapist or by a non-Latina/o English-speaking play therapist. Reading mentoring sessions will be delivered by bilingual mentors. Both, play therapy and reading mentoring sessions will take about 30 minutes, two times each week. All sessions will take place during regular school hours at a time determined by you and the student investigator. You will be asked to complete a brief assessment regarding your student's classroom behaviors three times during the study: prior to the study's beginning, midpoint (approximately after 5 weeks of the beginning of the study), and after the end of the study. It will take approximately 15 minutes to complete the assessment each time for a total of approximately 45 minutes of your time over the course of the study (2015-2016 academic school year).

Play therapy:

In play therapy, a type of counseling with children through play and toys, a counselor who has advanced training in play therapy will take your child to the playroom at school which is equipped with a variety of developmentally appropriate toys and materials such as arts/craft supplies, clay, games, toy people and animals, cars and trucks, dolls, puppets, dress-up/pretend clothes, and a play kitchen area.

Using play and toys in counseling help children who are having problems at school is based on the belief that children communicate best through play, while adults generally communicate through words. Preschool-age children think at a very concrete level, thus it is easier for them to use the toy figures and other materials to show the counselor what they are thinking and feeling. Trying to explain how you are feeling and why you feel that way can be hard even for an adult—especially when you are upset! This is especially true for children.

Reading mentoring:

In the reading mentoring program, a master's student will work with your student for 30 minutes twice each week. Mentors provide a time when children can choose to read books that are specially chosen for

APPROVED BY THE UNT IRB
DATE: 1/29/16 - 1/28/19

pre-school children or the children may choose to complete coloring pages. Having a special adult to read to them and color with them can help children increase their interest in reading and feel special. Children who receive reading mentoring will receive play therapy sessions after the study has been completed, if parents so choose.

Foreseeable Risks: The potential risks involved in this study are minimal. As with any counseling intervention, children may become more aware of emotional difficulties. In the event a child has a difficult time adjusting to emotional insight or it appears the child needs more intense services, the parent will be contacted and a referral will be made to a local counseling center.

Benefits to the Subjects or Others: We expect the project to benefit your student by allowing him or her an opportunity to learn self-control and socially acceptable behaviors which can then be transferred to the classroom and home.

Procedures for Maintaining Confidentiality of Research Records: Your student's name will be removed from all identifying materials related to this research and replaced with a random code number. Consent forms will be stored in a location separate from coded materials. All research records will be kept in a locked cabinet in the researcher's office, and be accessible only to the researchers. Research records will be kept for a period of 3 years following the conclusion of this study. At that time, all records will be properly destroyed. The confidentiality of your student's individual information will be maintained in any professional publications or presentations regarding this study.

Questions about the Study: If you have any questions about the study, you may contact *Dr. Sue Bratton, Dr. Peggy Ceballos, or Mr. Gustavo Barcenas* UNT Department of Counseling, at telephone number 940-565-3864.

Review for the Protection of Participants: This research study has been reviewed and approved by the UNT Institutional Review Board (IRB). The UNT IRB can be contacted at (940) 565-4643 with any questions regarding the rights of research subjects.

APPROVED BY THE UNT IRB
DATE: 1/29/16 - 1/28/17

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

- Dr. Sue Bratton, Dr. Peggy Ceballos or the designated research assistant, Gustavo Bárcenas, has explained the study to you and your questions have been answered. You have been informed of the possible benefits and the potential risks and/or discomforts of the study.
- You understand that you do not have to take part in this study, and your refusal to participate or your decision to withdraw will involve no penalty or loss of rights or benefits. The study personnel may choose to stop your participation at any time.
- You understand why the study is being conducted and how it will be performed.
- You understand your rights as a research participant and you voluntarily consent to participate in this study.
- You have been told you will receive a copy of this form.

____

Printed Name of Participant (Teacher)

______________________________ ____________________

Signature of Participant (Teacher) Date

For the Principal Investigator or Designee: I certify that I have reviewed the contents of this form with the parent or guardian signing above. I have explained the possible benefits and the potential risks and/or discomforts of the study. It is my opinion that the parent or guardian understood the explanation.

______________________________ ____________________

Signature of Principal Investigator Date

APPROVED BY THE UNT IRB
DATE: 1/29/16 - 1/28/17

UNIVERSITY OF NORTH TEXAS INSTITUTIONAL REVIEW BOARD

FORMA DE CONSENTIMIENTO INFORMADO

Antes de que usted decida la participación de su hija(o) en esta investigación, es muy importante que lea y entienda las siguientes explicaciones sobre los objetivos, beneficios y riesgos del estudio, así como la forma en que este se llevara a cabo.

Titulo de la investigación: Terapia de juego centrada en el niño para niños Latinos de habla Hispana: Efectos en problemas de comportamiento y el desarrollo socio-emocional.

Investigador Principal: Dr. Sue Bratton, Profesora de la University of North Texas (UNT) Department of Counseling and Director of the Center for Play Therapy; co-PI: Dr. Peggy Ceballos, University of North Texas (UNT) Department of Counseling.

Objetivo de la investigación: Se le solicita su consentimiento para permitirle a su niña(o) participar en un estudio que tiene por objetivo examinar los efectos de los servicios de terapia de juego en las escuelas y de tutoría en lectura. El propósito de este estudio es ayudar a niños de habla hispana que presentan dificultades en su comportamiento, tales como agresión, peleas constantes, problemas de atención, hiperactividad, ansiedad, rompimiento de normas y reglas, a reducir o disminuir dichos problemas. Expertos en el área de desarrollo infantil sugieren que los niños con menos problemas de comportamiento en la escuela obtienen un mejor aprovechamiento académico.

Procedimiento de la investigación: Se requerirá que su niño participe de manera individual en 20 sesiones de terapia de juego o de tutoría en lectura. Las sesiones de terapia de juego se llevaran a cabo por un terapeuta de juego Latino bilingüe o por una terapeuta de juego que no es Latino y que habla Ingles. Las sesiones de tutoría en lectura serán llevadas a cabo por tutores bilingües. Las sesiones de terapia de juego y de tutoría en lectura tendrán una duración de 30 minutos aproximadamente, dos veces por semana. Todas las sesiones se llevaran a cabo durante el tiempo regular de escuela de su niña(o) en días y horas que sean acordados por su maestra(o). Las sesiones serán video grabadas o audio grabadas, esto con la finalidad de proveer supervisión al consejero/counselor y tutor para asegurarnos de que su niña(o) reciba el mejor servicio posible. Tanto a usted como a la maestra(o) de su hija(o) se les pedirá que contesten un breve cuestionario referente al comportamiento de su niña(o) dentro del salón de clases. Este cuestionario será llenado por usted y el maestro tres veces a lo largo del estudio con el objetivo de evaluar si el servicio que su niña(o) recibe esta siendo de ayuda. Usted tiene la opción de retirar a su niña(o) del estudio en cualquier momento que así lo decida.

Terapia de juego

En la terapia de juego, un tipo de consejería/counseling con niños que utiliza el juego y juguetes, un consejero/counselor quien tiene entrenamiento avanzado en terapia de juego estará con su hija(o) en un cuarto de juego ubicado dentro de la escuela. Este cuarto de juego esta equipado con una gran variedad de juguetes y materiales apropiados para el nivel de desarrollo del niño tales como plastilina, juegos, materiales para arte, figuras humanas de juguete y animales, carros y camiones, muñecas, títeres, disfraces y un área para jugar a la comidita, que incluye una cocina pequeña de juguete.

El uso del juego y juguetes en consejería/counseling ayuda a los niños que están teniendo dificultades en la escuela, esto se basa en la idea de que el mejor medio de comunicación de los niños es el juego, mientras que los adultos generalmente se comunican mediante palabras. Los niños de edad pre-escolar tiene un nivel de pensamiento muy concreto, por lo tanto es mucho mas sencillo para ellos el utilizar figuras de juguete y otros materiales para expresar lo que piensan y sienten al consejero/counselor. El tratar de explicar como se están sintiendo y el por que se sienten de esa forma, puede ser algo muy difícil, incluso para un adulto – ¡especialmente cuando estas molesto! Esto es particularmente muy cierto para los niños.

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1/29/16- 1/28/17

Tutoría en lectura
En este programa de asesoría, el tutor, un estudiante de maestría, trabajara con su niño por 30 minutos, dos veces por semana. Los tutores brindan al niño un tiempo en donde él puede escoger leer libros, los cuales están especialmente seleccionados para niños de edad pre-escolar o escoger colorear en dichos libros. El hecho de tener a alguien especial, un adulto que lea y coloree con el niño puede ayudarle a incrementar sus intereses en la lectura y sentirse especial. Los niños en el programa de tutoría en lectura recibirán servicios de terapia de juego una vez que el estudio haya concluido, si es que así lo desea usted.

Riesgos previsibles: Los riesgos potenciales en la participación de este estudio son minimos. De la misma forma que en cualquier forma de consejería/counseling, los niños pueden llegar a ser más conscientes de ciertas dificultades emocionales. En el caso de que un niño tenga dificultad para ajustarse emocionalmente a su ambiente o que parezca que el niño necesite servicios mas especializados que la tutoría en lectura, se contactara de inmediato a los padres y el niño será referido a un centro de atención local.

Beneficios de los participantes u otros: Se espera que el proyecto beneficie a su niño al brindarle la oportunidad para aprender auto-control y comportamientos socialmente aceptables, lo cuales pueden ser posteriormente usados en el salón de clase.

Procedimientos para el mantenimiento de la confidencialidad de la investigación: El nombre de su niña(o) será eliminado de cualquier material de identificación relacionado con este estudio y remplazado por un número de código especial que se le asignara aleatoriamente. Las hojas de consentimiento informado serán guardadas en un lugar diferente al de los materiales con código especial. Todos los archivos, incluyendo las grabaciones serán guardados en un archivero cerrado con llave el cual se encontrara en la oficina del investigador, quien será el único que tendrá acceso a ellos. Los archivos de este estudio serán guardados por un periodo de tres años después de haber concluido el proyecto. Una vez pasado ese tiempo, todos los archivos serán destruidos de manera correcta. La confidencialidad sobre la información de identificación personal de su niña(o) será guardada de manera confidencial en caso de cualquier publicación o presentación académica profesional referente a esta investigación.

Preguntas a cerca de la investigación: En caso de cualquier pregunta referente a este estudio, siéntase en la libertad de contactar a la Dra. Sue Bratton, la Dra. Peggy Ceballos, o a Gustavo Barcenas en el Departamento de Counseling de la UNT en el teléfono: (940) 565-3864.

Revisión para la protección de los participantes:
Este estudio de investigación ha sido revisado y aprobado por el Comité de Revisión Institucional (IRB, por sus siglas en Ingles). La oficina de IRB en la UNT puede ser contactada en el teléfono: (940) 565-4643.

APPROVED BY THE UNT IRB
DATE: 1/29/16 - 1/28/17

Los derechos de los participantes de la investigación:
Su firma en la parte inferior indica que usted ha leído o le han leído todo lo mencionado arriba y que confirma todo lo siguiente:

- La Dra. Sue Bratton, la Dra. Peggy Ceballos o su asistente de investigación, Gustavo Bárcenas, le han explicado en que consiste el estudio y todas sus preguntas han sido respondidas. Se le ha informado también sobre los posibles beneficios y los riesgos potenciales y/o incomodidades de este estudio.
- Usted entiende que no esta obligado a permitir que su niño forme parte de esta investigación y que su negación a participar o su decisión de retirar al niño del estudio no conllevará a ninguna penalización o perdida de los derechos o los beneficios. También entiende que la investigadora puede decidir interrumpir la participación de su niña(o) en cualquier momento.
- Su decisión de retirar o permitir a su niña(o) participar en este estudio no tendrá ningún efecto negativo en las calificaciones de su niña(o).
- Usted entiende los propósitos de esta investigación y la forma en que se llevara a cabo.
- Usted entiende sus derechos como el padre/tutor del participante de la investigación y acepta voluntariamente que su hijo(a) participe en este estudio.
- Se le ha dicho que recibirá una copia de esta forma.

____________________ S/N
Celular - pueden dejar mensaje

____________________ S/N
Tel. de casa - pueden dejar mensaje

____________________ S/N
Tel. de trabajo - pueden dejar mensaje

____
Correo electrónico

____
Nombre del niño

____
Nombre del Padre o Tutor

____
Firma del Padre o Tutor

____
Fecha

Para la Investigadora o asistente del estudio:
Certifico que he revisado el contenido de esta forma con el padre o tutor quien firma arriba. He explicado los posibles beneficios y posibles riesgos e incomodidades de esta investigación. Es mi opinión que el padre o tutor entienda esta explicación.

____
Firma del Investigador Principal

____
Fecha

3

1/29/16 - 1/28/17
QAA

Research and Economic Development
THE OFFICE OF RESEARCH INTEGRITY AND COMPLIANCE

January 29, 2016

Dr. Sue Bratton
Department of Counseling
Center of Play Therapy
University of North Texas

Re: Human Subjects Application No. 15-532

Dear Dr. Bratton:

As permitted by federal law and regulations governing the use of human subjects in research projects (45 CFR 46), the UNT Institutional Review Board has reviewed your proposed project titled "Child-Centered Play Therapy (CCPT) for Young Spanish-Speaking Latino Children: Effects on Behavioral Problems and Social Emotional Development." The risks inherent in this research are minimal, and the potential benefits to the subject outweigh those risks. The submitted protocol is hereby approved for the use of human subjects in this study. **Federal Policy 45 CFR 46.109(e) stipulates that IRB approval is for one year only, January 29, 2016 to January 28, 2017.**

Enclosed are the consent documents with stamped IRB approval. Please copy and **use this form only** for your study subjects.

It is your responsibility according to U.S. Department of Health and Human Services regulations to submit annual and terminal progress reports to the IRB for this project. The IRB must also review this project prior to any modifications. **If continuing review is not granted before January 28, 2017, IRB approval of this research expires on that date.**

Please contact Jordan Harmon, Research Compliance Analyst II at 940-565-4258, if you wish to make changes or need additional information.

Sincerely,

Chad Trulson, Ph.D.
Professor
Chair, Institutional Review Board

CT: jh

UNIVERSITY OF NORTH TEXAS
1155 Union Circle #310979 Denton, Texas 76203-5017
940.369.4643 940.369.7486 fax www.research.unt.edu

UNIVERSITY OF NORTH TEXAS
A green light to greatness.

THE OFFICE OF RESEARCH INTEGRITY AND COMPLIANCE

February 9, 2017

Dr. Sue Bratton
Student Investigator: Gustavo Barcenas
Department of Counseling & Higher Education
University of North Texas

RE: Human Subjects Application No. 15-532

Dear Dr. Bratton:

The UNT Institutional Review Board has reviewed and approved the extension you requested to your project titled "Child-Centered Play Therapy for Young Spanish-Speaking Latino Children: Effects on Behavioral Problems and Social Emotional Development." Your extension period is for one year, **February 9, 2017 through February 8, 2018. Federal policy 45 CFR 46.109(e) stipulates that IRB approval is for one year only.**

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

The UNT IRB must re-review this project prior to any modifications you make in the approved project. It is your responsibility according to U.S. Department of Health and Human Services regulations to submit annual and terminal progress reports to the IRB for this project. Please mark your calendar accordingly.

Please contact The Office of Research Integrity and Compliance, 940-565-4643, if you need additional information.

Sincerely,

Chad Trulson, Ph.D.
Professor
Chair, Institutional Review Board

CT/jm

1155 Union Circle, #310979 | Denton, Texas 76203-5017 | TEL: 940.369.4643 | FAX: 940.565.4277
TTY: 940.369.8652 | http://research.unt.edu

APPENDIX F

DENTON INDEPENDENT SCHOOL DISTRICT APPROVAL

Susannah O'Bara, Area Superintendent ■ 1307 N. Locust Street, Denton TX 76201
Phone: 940-369-0032 FAX: 940-369-4983

January 20, 2016

Dr. Sue Bratton and Gustavo Barcenas
425 Welch St.
Denton, TX 76203

Dr. Bratton and Mr. Barcenas:

I have reviewed and approved your research proposal, "Child-centered play therapy for young Spanish-speaking Latino children: Effects on behavioral problems". This will be done at Ann Windle School for Young Children, Gonzalez School for Young Children, Rivera Elementary School, and Hodge Elementary School. Best wishes with your research.

Sincerely,

Susannah O'Bara

Susannah O'Bara
Area Superintendent
Denton ISD

RECEIVED 12-1-2015

DENTON INDEPENDENT SCHOOL DISTRICT
RESEARCH PROPOSAL

I. General Information

Date 11/19/2015

Researcher(s) Name Sue Bratton and Gustavo Barcenas

Address 425 S. Welch St. City Denton, TX Zip 76203

Email Sue.Bratton@unt.edu Phone# 940.565.3864

Level of research: ~~Doctoral~~ Masters Other

Preferred campus research location (s) Ann Windle School for Young Children, Gonzalez School for Young Children, Rivera Elementary School, Evers Park Elementary School, and Hodge Elementary School

Numbers involved: Classroom teachers 30 Students 60 Level Pre-K and Kindergarten

Beginning date January 11, 2016 Ending date May 6, 2017

II. Research Procedures and Needs: Provide a one or two-page summary of proposed research, which includes:

A. Purpose of the research
B. Research procedures (include description of tests or surveys to be used, information to be obtained from the district, or any special procedures or equipment needed or to be used).
C. Time requirements (specify class time, out-of-class time for students and teacher/administrator time required).
D. Financial requirements (specify any costs the district is expected to cover).

III. Feedback to the District:

Anyone conducting research in the Denton ISD is required to submit to the district a summary of all results obtained in the research. The departmental chairman will be notified when this requirement is not met. Doctoral students doing a dissertation should provide a copy of the dissertation to the Denton ISD.

IV. University Approval (Signature required)

Major professor(s) Sue C. Bratton Signature Sue C. Bratton
Type or print name

Department Department of Counseling University University of North Texas Phone 940-565-4461

V. Number of copies: One copy of this request must be prepared for the Division of Academic Programs to be submitted along with Proposal.

VI. Use of Data

Use of the data for publication must receive prior approval from the District. In all instances the anonymity of the district, its employees and its students *must* be maintained.

(Approved)	Disapproved	[signature] Dr. David Hicks, Area Supt.	12-7-15 Date
Approved	Disapproved	Dr. Mike Mattingly, Asst. Supt.	Date
Approved	Disapproved	Amy Lawrence, Counseling Services	Date
Approved	Disapproved	Ray Lagleder, Information Technology	Date
(Approved)	Disapproved	Roshaunda Thomas by phone & email Principal Signature	1-11-2016 Date
(approved)		Felicia Sprayberry by email	1-14-2016

Revised: April 2015

12-1-2015

DENTON INDEPENDENT SCHOOL DISTRICT
RESEARCH PROPOSAL

I. General Information

Date 11/19/2015

Researcher(s) Name Sue Bratton and Gustavo Barcenas

Address 425 S. Welch St. City Denton, TX Zip 76203

Email Sue.Bratton@unt.edu Phone# 940.565.3864

Level of research: ~~Doctoral~~ Masters Other

Preferred campus research location (s) Ann Windle School for Young Children, Gonzalez School for Young Children, Rivera Elementary School, Evers Park Elementary School, and Hodge Elementary School

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Department Department of Counseling University University of North Texas Phone 940-565-4461

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(Approved)	Disapproved	[signature] Dr. David Hicks, Area Supt.	12-7-15 Date
Approved	Disapproved	Dr. Mike Mattingly, Asst. Supt.	Date
Approved	Disapproved	Amy Lawrence, Counseling Services	Date
Approved	Disapproved	Ray Lagleder, Information Technology	Date
(Approved)	Disapproved	Angela Hellman Principal Signature	1-14-16 Date

Revised: April 2015

12-1-2015

DENTON INDEPENDENT SCHOOL DISTRICT
RESEARCH PROPOSAL

I. General Information

Date 11/19/2015

Researcher(s) Name Sue Bratton and Gustavo Barcenas

Address 425 S. Welch St. City Denton, TX Zip 76203

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Department Department of Counseling University University of North Texas Phone 940-565-4461

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(Approved)	Disapproved	[signature] Dr. David Hicks, Area Supt.	12-7-15 Date
Approved	Disapproved	Dr. Mike Mattingly, Asst. Supt.	Date
Approved	Disapproved	Amy Lawrence, Counseling Services	Date
Approved	Disapproved	Ray Lagleder, Information Technology	Date
(Approved)	Disapproved	[signature] Principal Signature	1-19-16 Date

Revised: April 2015

12-1-2015

DENTON INDEPENDENT SCHOOL DISTRICT
RESEARCH PROPOSAL

I. General Information

Date 11/19/2015

Researcher(s) Name Sue Bratton and Gustavo Barcenas

Address 425 S. Welch St. City Denton, TX Zip 76203

Email Sue.Bratton@unt.edu Phone# 940.565.3864

Level of research: ~~Doctoral~~ Masters Other

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Major professor(s) Sue C. Bratton Signature Sue C. Bratton
Type or print name

Department Department of Counseling University University of North Texas Phone 940-565-4461

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(Approved)	Disapproved	[signature] Dr. David Hicks, Area Supt.	12-7-15 Date
Approved	Disapproved	Dr. Mike Mattingly, Asst. Supt.	Date
Approved	Disapproved	Amy Lawrence, Counseling Services	Date
Approved	Disapproved	Ray Lagleder, Information Technology	Date
Approved	(Disapproved)	Linda Tucker - by email Principal Signature	1-20-2016 Date

Revised: April 2015

COMPREHENSIVE REFERENCE LIST

Achenbach, T. M., & Rescorla, L. A. (2000). *Manual for the ASEBA school-age forms & profiles.* Burlington, VT: University of Vermont, Research Center for Children, Youth, & Families.

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Allan, J. (1997). Jungian play psychotherapy. In K. J. O'Connor & L. M. Braverman (Eds.), *Play therapy theory and practice: A comparative presentation* (pp. 100-130). New York, NY: Wiley.

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