CHILD-CENTERED PLAY THERAPY WITH CHILDREN AFFECTED BY ADVERSE CHILDHOOD EXPERIENCES: A SINGLE CASE DESIGN

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Child centered play therapy (CCPT) is a therapeutic intervention that provides the environment for children to work through and heal from difficult experiences through expression of play and therapeutic relationship. It has been demonstrated effective with multiple types of disruptive behaviors. I conducted single-case research to explore CCPT's influence on children who had four or more adverse childhood experiences (ACEs) and provided analysis of data collected from one assessment administered weekly and one assessment at pre-, mid-, and post-intervention: the Strength and Difficulties Questionnaire and the Trauma Symptoms Checklist for Young Children. The two participants (one 8-year-old White American male and one 9-year-old White American female) demonstrated significant improvement in total difficulties and prosocial behaviors. The study revealed potential therapeutic benefits for utilizing CCPT with children who had four or more ACEs. Encompassed in discussion of study results are implications for practice, suggestions for future research, and limitations.

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CHILD-CENTERED PLAY THERAPY WITH CHILDREN AFFECTED BY ADVERSE CHILDHOOD EXPERIENCES: A SINGLE CASE DESIGN

Introduction

Adverse childhood experiences (ACEs) can be defined as traumatic and stressful experiences occurring in childhood (Murphy et al., 2014). Categories for ACEs include physical abuse, sexual abuse, emotional abuse, emotional neglect, physical neglect, mental illness, substance abuse, separation/ divorce, domestic violence, incarceration, and living in foster care (Felitti et al., 1998; Wade et al., 2016). The commonality between all of the categories is a self-report of feeling maltreated or living in household dysfunction during childhood. The Center for Disease Control and Prevention (CDC; n.d.) reported over 50% of adults in the United States have reported experiencing at least one ACE while 15% have reported experiencing four or more ACEs. Adverse experiences occurring in childhood have been found to have profound influence on the health and well-being of children and adults (Felitti et al., 1998; Wade et al., 2016; Clarkson Freeman, 2014). Resulting and complex trauma is a common outcome and response to the experiencing of adverse experiences (SAMHSA, n.d). Although various mental health interventions have been proposed to address the symptoms resultant from ACEs and childhood trauma, there is still little evidence to support positive treatment outcomes for children who have experienced ACEs. Child-centered play therapy (CCPT) fosters connections and relationships in a safe therapeutic environment lending to the potential of CCPT being an effective intervention with children who have experienced multiple ACEs.

Adverse experiences occurring in childhood have been found to have profound influence on the health and well-being of adults (Felitti et al., 1998; Wade et al., 2016). ACEs have long-term effects on physical and mental health, addictive behaviors, criminal activities, and adult

relationships. As a result of ACEs, adults may have a higher risk for health symptoms that lead to death and a shortened lifespan as well as fatigue and lack of energy which impacts the perceived quality of life. Felitti et al (1998) found a strong relationship between people who experienced four or more ACEs and increased risk factors leading to death. Monnat and Chandler (2015) concluded there was an increase in physical health consequences when certain ACEs were present, such as the links between physical abuse and increased likelihood of diabetes, heart attacks, self-rated health concerns, and functional limitations. Overall, an increased number of ACEs is associated with poorer health outcomes in adulthood (Mersky, Topitzes, & Reynolds, 2013). Research provides ample evidence that when children experience adverse experiences, there is a profound impact on physical health concerns in adulthood.

In addition to physical health consequences, researchers discovered a relationship between the experience of ACEs and negative consequences for mental health. Subsequent mental health issues such as post-traumatic stress, depression, anxiety, hopelessness, stress, and even suicidal behavior appear to be linked to a person's ACEs. Felitti et al (1998**)** found 50.7% of adults who experienced four or more ACEs reported having two or more recent weeks of depressed mood and 18.3% of adults who had 4 or more ACEs reported attempting suicide. Adolescents who have experienced ACES are also at an increased risk of suicide attempts (Perez, Jennings, Piquero, & Baglivo, 2016). Haatainen et al. (2003) compared the experience of hopelessness to the number of ACEs experienced by men and women, finding the higher the number of ACEs, the more likely they were to experience severe hopelessness (Haatainen et al., 2003). Generally, affective disorders as well as depressive and anxiety disorders in adulthood are likely to be correlated with adverse experiences in childhood (Spinhoven et al., 2010). Grasso, Dierkhising, Branson, Ford, and Lee (2015) found that if children had multiple types of

ACEs during any time of childhood, early childhood, middle childhood, or adolescence, the participants were affected developmentally and had a persistent amount of stress into adolescence and adulthood. The combination of ACEs and poverty also appears to place adults at high risk. Wade et al. (2016) correlated the number of ACEs and socio economic status with mental health risk factors in adults in order to determine the effects of ACEs and poverty on mental health discovering while ACEs had an impact on mental illness, the combination of ACEs and low SES increased the probability of suffering from a mental illness.

In addition to physical and mental health consequences, ACEs appear to be linked to later substance abuse and criminal activity. Substance abuse issues are highly correlated with increased number of ACEs (Felitti et al., 1998) which has been shown to be a consistent finding across cultures (Brockie et al., 2015; Giordano, Ohlsson, Kendler, Sundquist, & Sundquist, 2014). Regarding criminal activity, researchers have linked juvenile offenders and increased number of ACEs (Baglivio & Epps, 2016). Hahn Fox, Perez, Cass, Baglivio, and Epps (2015) found the number of ACEs experienced by serious, violent, and chronic offenders was statistically significantly higher than offenders who had one violation suggesting that identification of ACEs could be one indicator in determining youth who are at a higher risk of becoming a serious, violent, and chronic offender.

There has been little research done on the impact of ACEs on interpersonal and familial relationships and relational behaviors. The research that has been conducted thus far focuses on the correlation of ACEs with risky behavior and stress within the parenting relationship. These preliminary studies allow researchers to hypothesize the impact ACEs might have on across relationships. Steele et al. (2016) found that mothers who reported experiencing four or more ACEs reported a higher amount of parenting stress than mothers who did not experience four or

more ACEs. Narayan et al. (2017) found that if a parent suffered maltreatment as a child, they were more likely to mistreat their own children. Murphy et al. (2014) found that a majority of women studied who experienced ACEs also reported unresolved attachment regarding past trauma. Overall, the research results indicate that people who have experienced multiple ACEs are more likely to have difficulty participating in healthy adult relationships.

While research has been conducted on the effects of ACEs in adulthood, there are substantially fewer studies exploring the effects of ACEs during childhood. Burke, Hellman, Scott, Weems, and Carrion (2011) found children who experienced four or more ACEs had a significantly higher probability of having learning and behavior problems. Utilizing the National Survey of Child and Adolescent Well-Being (NSCAW) and the Child Behavior Checklist (CBCL; Achenbach, 1991), Clarkson Freeman (2014) examined the prevalence and relationship between ACEs and internalizing, externalizing, and total problems for 2,830 children six years of age and younger. Overall, children who had four or more ACEs were more likely to exhibit problematic behaviors than children who did not experience ACEs (Clarkson Freeman, 2014). Escueta, Whetten, Osterman, and O'Donnell (2014) examined the psychosocial well-being and cognitive development of orphaned and abandoned children who experienced ACEs in five low income countries. The found exposure to potentially traumatic events was determined to be a predictor of emotional difficulties. Although research on ACEs while participants are still in childhood is limited, there is evidence to suggest that children exhibit the deleterious consequences of ACEs during and immediately following adverse events.

Child-Centered Play Therapy

Virginia Axline (1947) created nondirective or child-centered play therapy based on the person-centered theory developed by Carl Rogers. Utilizing the core conditions of person-

centered theory; congruence, empathic understanding, and unconditional positive regard (UPR), Axline created a space for children to be heard and understood. Responses were provided with therapeutic intention of allowing children to be in the lead with relationship as the facilitator of change. Landreth (2012) proposed children do not communicate the same way as adults and therefore should be given the opportunity to make sense of their world in the way they communicate. The language of the child is play and therefore toys are the words (Landreth, 2012). In order to facilitate a wide vocabulary of play, he specified a list of materials which allow the child to utilize the toys in a therapeutic manner. Toys take on the meaning the child deems necessary, and the variety of toys open up the communication. Because children's language development is still developing, toys are used as the primary method for communication. While the toys are important, the safety of relationship between child and therapist allows communication to occur (Landreth, 2012). Child-centered play therapists hold the belief children innately have the capacity within them to work through and make sense of maladaptive behaviors when provided with the necessary environment (Landreth, 2012).

Relationships between therapists and children are crucial for healing to occur in therapy. CCPT therapists provide the core conditions of person-centered theory; congruence, empathic understanding, and UPR to create a therapeutic relationship with children (Landreth, 2012). Children hold the self-actualizing ability within them to change and grow, and given a safe environment, children are able to reach their full potential (Ray, 2011). While children guide and lead the play, therapists actively engage in forming and maintaining the relationship (Landreth, 2012). Through the therapeutic relationship, children become self-accepting and establish a deeper understanding of themselves which fosters the ability in children to change and grow in the ways they need (Ray, 2011).

The CCPT and ACE Connection

As children grow and develop, influences from caregivers have the potential to disconnect them from their natural organismic valuing process. Although the organismic valuing process still remains, children begin to rely more on external messages from caregivers and become less attuned to their organismic valuing process, placing higher emphasis on what others value (Turner, 2012). Children's self-structure changes to integrate the way they view themselves and their actual experiences (Wilkins, 2010). Children strive to be protected, nurtured, and cared for by others. Due to the need of being positively regarded by others, children may begin to rely on external locus of control and create conditions of worth. Conditions of worth are messages created to earn love or acceptance from others by conforming to demands, expectations, and positive evaluations from others (Wilkins, 2010). Children may begin to have beliefs of only being accepted when their conditions of worth are met. Children become incongruent because they no longer take in all experiences through their organismic valuing process, instead experiences are taken in through the filter of a rigid self-perception influenced by the values of others (Wilkins, 2010).

Children who experienced ACEs may develop extremely negative and abusive self-regard, which can become the focus of their self-concepts and influence their decisions and attitudes toward themselves (Power, 2012). Children who experience ongoing adverse and traumatic experiences likely live in a world of fear (Hawkins, 2014). While typical self-structures are fluid and allow for new experiences to help shape the way children view experiences (Rogers, 1951), self-structures of children who have ongoing adverse or traumatic experiences are rigid (Wilkins, 2010). The rigidity of self-structure occurs because their

conditions of worth continue to contribute to their negative self-regard. Children's understanding of the world and reality might be altered and viewed through a more negative lens. Ongoing confirmation of negativity serves the purpose of maintaining the rigidity of the self-structure. The utilization of negative behaviors insure that others will treat them in ways matching their current self-concept (Clarkson Freeman, 2014).

Children who have experienced multiple or ongoing ACEs need experiences that contradict the traumatic experiences that have influenced their rigid self-structure. Although CCPT can be a lengthy process, the consistent attendance of clients is likely to lead to healing. As a child slowly perceives and integrates the therapist attitudinal conditions, he or she is able to form a new self-structure. When counselors are free of expectations while unconditionally positively regarding clients, children are able to grow and develop (Rogers, 1957). Although the self-actualizing tendency may have been halted, it is still a dynamic force inside of a child. By experiencing UPR and empathic understanding, a child can begin to integrate new experiences and establish a more fluid self-structure (Ray, 2011). The fluidity of self-structure will provide them with abilities to accept more positive experiences without rejecting them fully.

Although CCPT research has not been conducted on ACEs as a singular construct, historical and recent research on CCPT supports the use of intervention with children with individual ACEs. Intervention research has been conducted on the individual ACEs of sexual abuse, witnessing domestic violence, and refugee trauma. Kot, Landreth, and Giordano (1998) utilized intensive CCPT with children who witnessed domestic violence. The experimental group demonstrated a statistically significant increase in self-concept and a statistically significant reduction of externalizing and total behaviors. Scott, Burlingame, Starling, Porter, and Lilly (2003) conducted 7 to 13 CCPT sessions with 26 three to nine-year-olds who were sexually

abused finding that while the child self-report results showed progress, the parent reports did not show significant changes. Scott et al. hypothesized children began to feel different before external changes were observable by parents. Children who experienced play therapy were provided with an environment where they felt positively regarded; therefore, the participants were able to view themselves in a more positive way. Schottelkorb, Doumas, and Garcia (2012) compared the effectiveness of CCPT to trauma-focused cognitive behavioral therapy (TF-CBT), which was an already established evidence-based intervention. Schottelkorb et al. established CCPT had a statistically significant impact with children who suffered from refugee trauma. CCPT research was also conducted with children who lived in poverty. Although poverty is not considered an ACE, Wade et al. (2016) demonstrated that living in poverty was correlated to experiencing ACEs. Bratton et al. (2013) examined the effectiveness of CCPT with 54 children enrolled at a low-income preschool, finding the CCPT group had a statistically significant decrease of disruptive behaviors, aggression, and attention problems. Bratton et al. demonstrated the effectiveness of using CCPT to reduce problem behaviors of children in lower socioeconomic preschools. CCPT has been shown to be effective with each individual ACEs, refugee trauma, and low income environments lending to the hypothesis that CCPT may be effective with children who experienced multiple ACEs.

Purpose of Study

The purpose of this study was to investigate the impact of CCPT on children who have experienced four or more ACEs. Specifically, I examined the effectiveness of CCPT on the child's emotional, interpersonal, and problem behaviors. Single-case design was implemented and data was collected throughout baseline, intervention, and follow-up phases for two children, Justin and Megan, participating in CCPT. The guiding research question for this study was what

is the impact of CCPT on emotional symptoms, conduct problems, hyperactivity and inattention, peer relationship problems, prosocial behavior, and posttraumatic stress of children who experienced four or more ACEs?

Method

Participants

Research participants included two children recruited from a university-based counseling clinic that served community clients located in the southwest United States. The clinic is an instructional and training based clinic that serves clients across the lifespan. The majority of clients (60%) are children under the age of 12. Child clients served through the clinic typically come from families of low socioeconomic status and low educational attainment. Participants for the current study met the following inclusion criteria: 1) Between ages 4 to 9 years old; 2) Score of 4 or higher on the Adverse Childhood Experiences Checklist; and 3) Not participating in other forms of counseling over the course of the study. Four participants were initially identified for participation. However, two of the participants who were also siblings were dropped from the study due to home disruption during the course of the study resulting in completion of the study by two participants. Individual information for each participant is listed below. Pseudonyms were used to help maintain confidentiality.

Participant 1

Justin is an 8-year-old White American male who resided with his biological mother, sister, and maternal grandmother. Background information was reported by Justin's mother. Justin qualified for the study due to his exposure to eight categories of ACEs including emotional abuse, emotional neglect, physical neglect, domestic violence, household substance abuse, household mental illness, parental separation, and incarcerated household member.

Prior to divorce between Justin's mother and father, Justin's mother reported Justin witnessed domestic violence between his father and mother. On one occasion, his father choked his mother in front of him. After the divorce and while living with his father, Justin's father swore at him and was verbally aggressive toward his mother and sister in Justin's presence. Justin's mother reported that his father frequently verbally denigrated his mother when talking to Justin on the phone. Justin's father abused methamphetamine and alcohol. He was incarcerated multiple times for drugs and violence against Justin's mother and her property. Additionally, Justin's father regularly drove under the influence while Justin was in the car. Justin's father had a history of depression and was openly suicidal in Justin's presence. Justin also verbalized negative thoughts about his self-worth and felt responsible for mediating between his parents. At intake for participation in the current study, Justin's mother reported that Justin verbalized wanting to live with his father despite his fears and often blamed his mother for his father's behavior. Justin's mother reported that Justin had difficulty regulating emotions and cried and screamed at school. She was often asked to pick him up from school due to his difficulty.

Participant 2

Megan is a 9-year-old White American female who resided with her biological father, step-mother, and multiple siblings who were step-siblings or half-biological siblings. Background information was reported by Megan's father and step-mother. Megan qualified for the study due to her exposure of eight categories of ACEs including sexual abuse, emotional neglect, physical neglect, domestic violence, household substance abuse, household mental illness, parental separation, and incarcerated household member.

Megan's biological mother and father were separated when she was an infant. Her biological mother accused her father of sexually abusing Megan resulting in invasive medical

examinations. However, there were no findings that Megan's biological father was physically abusive. Megan's father and stepmother reported that as a young child, Megan witnessed her mother being physically abused by her mother's boyfriend. Her biological mother's boyfriend was incarcerated on multiple occasions. During custodian visits with her mother, Megan was often unsupervised and found with dirty clothes and diapers when picked up by her father. Megan's biological mother died from a drug overdose when Megan was three years old. Megan's father and step-mother reported both being diagnosed with depression and anxiety and her biological mother was diagnosed with bipolar disorder prior to her death. At intake for the present study, Megan's father reported that Megan frequently expressed low self-worth and lack of belonging in her family.

Instrumentation

Adverse Childhood Experiences (ACEs) Checklist

The original ACE Checklist (Felitti et al., 1998) is a 10-item checklist that assesses adults for the past experiences of ACEs. The total number of ACEs checked provides participants with their ACE numbers. Felitti et al. (1998) introduced the original ACEs adult checklist, which included items related to physical abuse, sexual abuse, emotional abuse, emotional neglect, physical neglect, mental illness, substance abuse, separation/ divorce, domestic violence, and incarceration. Wade et al. (2016) modified the adult checklist to incorporate extended ACEs, which included witnessing violence, felt discrimination, lack of neighborhood safety, feeling bullied, and living in foster care. The original checklists were designed for adults to answer about their childhoods. For the purposes of the present study, the ACE Checklist was modified for language in order to use present tense language for parents to complete items regarding their children. For example, the original ACE checklist (Felitti et al., 1998) asked, "Did you live with

anyone who was a problem drinker or alcoholic or who used street drugs?" The question was rewritten to state, "Has your child lived with anyone who is/ was a problem drinker, or alcoholic or had a problem with street drugs or prescription drugs?" The ACE Checklist (Cronholm et al., 2015) included the original 10 ACEs (Felitti et al., 1998) and extended ACEs identified by Wade et al. (2016). For clarity purposes, wording chosen for the study was derived from both checklists. All of the original ACEs were included and I extended the checklist to include placement in foster care resulting in the ACE Checklist – modified.

Strengths and Difficulties Questionnaire (SDQ)

Strengths and Difficulties Questionnaire (SDQ: Goodman, 2001) is a 25-item assessment completed by parents/caregivers and used to identify behavioral problems and interpersonal strengths of children four to seventeen years of age. The SDQ Total Difficulties score is a composite of four subscales including Emotional Symptoms, Conduct Problems, Hyperactivity and Attentional Difficulties, and Peer Relationship Problems. The Total Difficulties score can range from 0 – 40. An additional fifth subscale indicates Prosocial Behavior. Higher total difficulties scores have been correlated to greater psychopathology (Goodman & Goodman, 2009). Normative data for the parent questionnaire was obtained on 10,298 children aged 5 to 15 living in urban, suburban, and rural areas; consisting of 50% female and 50% male participants. The sample respondents included biological parents, adoptive parents, step-parents, and grandparents. Goodman (2001) reported internal consistency reliability coefficients for scales ranging from .41 to .87, with .82 for the total parent score. Factor analyses support the five-factor solution. The reported mean test-retest reliability for the SDQ is r =.72 while the mean internal consistency is α = .71 (NCTSN, n.d.). For the current study, the SDQ total score was used as the weekly measurement of behaviors for the participants.

The Trauma Symptom Checklist for Young Children (TSCYC)

The Trauma Symptoms Checklist (TSCYC; Briere, 2005) is an assessment used to evaluate posttraumatic stress and consists of 90 questions and eight subscales including: Anxiety, Depression, Anger/ Aggression, Posttraumatic Stress-Intrusion, Posttraumatic Stress-Avoidance, Posttraumatic Stress-Arousal, Dissociation, Sexual Concerns. The subscales result in an overall Posttraumatic Stress score (Briere, 2005). Normative data for the parent questionnaire was obtained on 219 children with a mean age of 7.1 years including 62% females and 38% males. The racial composition was 38% Non-Hispanic Caucasian, 25% Black/ African American, and 28% Hispanic. The norming sample included children who had been exposed to abuse and were recruited from child advocacy centers, child abuse programs, or child trauma centers. Internal consistency alphas were reported as ranging from .73 to .86. The test-retest reliability for the TSCYC correlation coefficients ranged from .68 to .96 with a median $r = .88$ (Briere, 2005). For the purposes of the current study, the TSCYC total score was used a descriptive measurement of change from pre to post test across the duration of the study.

Procedures

The researcher gained human subjects approval by the University of North Texas Institutional Review Board (IRB) prior to beginning the study. Additionally, parents received and signed informed consent for participants prior to beginning the study. I utilized a single case experimental design for measurement of treatment effectiveness with a reversal/withdrawal ABA design. In order to recruit participants, I examined intake documentation of children ages four to nine who presented to the clinic for services. Upon determination of the children having a strong probability of experienced ACEs based on intake caretaker report, I contacted the caregivers to provide an overview of the study and inquire about interest in participation. If parents indicated

interest, I set up parent interviews in which I gained background information, consent to participate, and determined eligibility through the use of the ACEs checklist-modified. Of 6 children identified as potential participants, 4 met criteria of reporting four or more ACEs. For those 4 children, parents/guardians completed the initial TSCYC and SDQ. Parents continued to complete the SDQ weekly for a minimum of three weeks to establish a baseline during which time the participants received no treatment. Over the course of the study, two of the participants were removed from the study due to disruption in the home environment. For both participants completing the study, consistent baseline was established at six weeks. Once a consistent baseline was established, the treatment phase began.

During the treatment phase, participants participated in 24 play therapy sessions held bi-weekly for 45 minutes each. Occasionally, participants only engaged in one play therapy session due to participant or play therapist illness. The participants did not engage in play therapy for two weeks due to holiday vacations. Parents continued to complete the SDQ weekly. At the 12-session midpoint and following the 24th session, parents/guardians completed the TSCYC. After completion of the 24th session, final interviews were conducted with the caregivers to gather information about caregivers' and children's experiences of CCPT. Following the 24th session, the SDQ was completed weekly for four weeks during the follow-up phase during which parents/guardians and children did not receive services.

Description of CCPT Intervention

I facilitated the CCPT intervention with both children. I am an advanced doctoral student in a CACREP-accredited counselor education doctoral program and have completed two and a half years of doctoral work in counseling, 23 hours of graduate-level coursework in play therapy, and had 5 years of experience utilizing child-centered play therapy. Additionally, I am a licensed

professional counselor intern and certified school counselor. I participated in weekly supervision of play therapy with a doctoral level faculty member who is a licensed professional counselor supervisor and a registered play therapist supervisor.

Each child was scheduled to receive 45 minutes of individual CCPT twice a week for 12 weeks. In order to ensure treatment adherence, the Child-Centered Play Therapy - Research Integrity Checklist (CCPT-RIC; Ray, Purswell, Haas, & Aldrete, in press) was used to review one session per week for each child. A rater trained in CCPT-RIC procedures viewed 15 minutes of each session and rated using the Child-Centered Play Therapy Research Integrity Checklist. Threshold for fidelity adherence is met when ratings fall at 80% or higher on adherence to protocol (Ray et al., 2017). For the current study, fidelity adherence was 96%.

For play therapy sessions, the playroom was equipped according to Ray's (2011) *Child Centered Play Therapy Manual*. Each room used was equipped with a video camera to provide the opportunity to check for fidelity. The rooms varied in size but were equipped with toys and materials recommended by Landreth (2012).

CCPT therapists provide the therapist attitudinal conditions of person-centered theory including congruence, empathic understanding, and UPR to create a therapeutic relationship with children (Landreth, 2012). In the CCPT protocol, Ray (2011) established eight categories of therapeutic verbal responses: (a) tracking behavior; (b) reflecting content; (c) reflecting feeling; (d) facilitating decision making, returning responsibility; (e) facilitating creativity, spontaneity; (f) esteem building, encouraging; (g) facilitating relationship; and (h) limit-setting. The study utilized therapeutic verbal responses and nonverbal body language to embody the attitudinal conditions.

Parent Consultation

Typically, regular and consistent parent consultations are a part of CCPT implementation. In order to ensure consistency with CCPT, parent consultations were conducted for thirty minutes biweekly, in addition to the CCPT sessions. Parent consultations were conducted following every four play therapy sessions and were held at a separate time from play sessions. Schottelkorb, Swan, and Ogawa (2015) created a child-centered parent consultation model that was utilized to maintain consistency for the therapist. The five components of the parent consultation model are: 1) creating and maintaining the therapeutic relationship with parents; 2) demonstrating an awareness and understanding by listening and responding; 3) honoring parents as the experts of their children; 4) providing pertinent knowledge; and 5) teaching therapeutic skills. Parent consultations followed the five components of the model in order to provide parents with information about their child and the therapeutic process while teaching skills deemed necessary to help facilitate the child-parent relationship. Schottelkorb, Swan, and Ogawa (2015) suggested a session format in order to ensure the five components are met. The first parent consultation session focused on the building of the relationship and gathering a deeper understanding of the child. Each subsequent session continued to build the relationship, gaining and providing understanding of the child; and teaching therapeutic techniques relevant to each individual. Final parent consultation sessions consisted of the parents and therapist reporting progress and changes witnessed throughout the process (Schottelkorb, Swan, & Ogawa, 2015).

Data Analysis

Using weekly data gathered from the SDQ, I used visual data analysis to examine predictable baseline patterns, data within each phase, data between each phase, and integration of data between all phases (Ray, 2015). Following the standards from What Works Clearinghouse

on Single Case Design studies (Kratochwill et al., 2013), I analyzed and reported the following: 1) the level of each phase which is the mean of each phase; 2) the trend which is the slope of data between each phase; 3) the variability which is the difference between the trend and individual data points; 4) the immediacy of effect which measures how quickly there was an effect with the intervention; 5) the consideration of overlap which compares how much one phase overlaps with another one; and 6) the consistency of data patterns across the phases (Ray, 2015). In order to find the strength of the relationship between variables, I calculated effect size using Nonoverlap of All Pairs (NAP; Parker & Vannest, 2009) and interpreted according to the following criteria: 0-.65 weak effect size, .66-.92 medium effect size, and .93-1.0 strong effect size (Parker & Vannest, 2009). Data from the TSCYC was used descriptively to provide further information of change over duration of the study.

Results

After using scoring software to score each assessment, I graphed each participant's scores from the SDQ on separate graphs. The SDQ included the following seven subscales: Emotional Symptoms (ES), Conduct Problems (CP), Hyperactivity and Attentional Difficulties (HAD), Peer Relationship Problems (PRP), Prosocial Behavior (PB), and Total Difficulties. After utilizing visual analysis, I calculated effect sizes for Total Difficulties using the Nonoverlap of All Pairs (NAP) statistic.

Participant 1: Justin

Justin participated in 6 weeks of a non-intervention baseline phase, 13 weeks of intervention phase where he participated in 24 play therapy sessions, and 4 weeks of a non-intervention follow-up phase. Table 1 provides the means and standard deviations for each subscale in each phase of the study. For five subscales, Emotional Symptoms, Conduct

Problems, Hyperactivity and Attentional Difficulties, Peer Relationship Problems, and Total Difficulties, means continually decreased across all phases of the study demonstrating improvement. The means of Prosocial Behavior increased across all phases demonstrating improvement. Figure 1 provides a graphical representation of all data.

Justin's mother completed an SDQ each week that generated one score for each of the subscales. I separately evaluated each subscale by assessing the level, trend, variability, immediacy of effect, and overlapping data. In addition to visual analysis, I calculated the NAP for Total Difficulties.

Emotional Symptoms

Level analysis of graph indicated a decrease from a mean of 7.83 in the baseline phase to 2 in the treatment phase followed by another decrease to .25 in the follow-up phase. Trend analysis revealed a downward trend across the baseline and treatment phase of the study with a large correlation (R^2=.77), indicating a large relationship between play therapy phase and Justin's decrease in emotional symptomology. Analysis of variability between conditions revealed moderate variability between phases with standard deviations (SD) of .75 in the baseline phase, 3.32 in the intervention phase, and .5 in the follow-up phase. The decrease was not immediate, as the data did not visibly decrease until the third data point of the intervention phase. Additionally, there was overlapping data between these two phases. The mean of the last three data points in the baseline (M=8) was similar to the mean of the first three data points in the intervention phase (M=7.33).

Conduct Problems

Level analysis of graph indicated a decrease from a mean of 4.33 in the baseline phase to 1.77 in the treatment phase followed by another decrease to .5 in the follow-up phase. Trend

analysis revealed a downward trend across the baseline and treatment phase of the study with a large correlation (R^2=.77), indicating a large relationship between play therapy phase and Justin's decrease in conduct problems. Analysis of variability between conditions revealed moderate variability between phases with standard deviations (SD) of .52 in the baseline phase, 1.17 in the intervention phase, and .58 in the follow-up phase. The decrease was not immediate, as the data did not visibly decrease until the third data point of the intervention phase. Additionally, there was overlapping data between these two phases. The mean of the last three data points in the baseline (M=4) was the same as the mean of the first two data points in the intervention phase (M=4).

Hyperactivity and Inattention

Level analysis of graph indicated a decrease from a mean of 9.67 in the baseline phase to 5.78 in the treatment phase followed by another decrease to 2.25 in the follow-up phase. Trend analysis revealed a downward trend across the baseline and treatment phase of the study with a large correlation (R^2=.62), indicating a large relationship between play therapy phase and Justin's decrease in hyperactive and inattentive behaviors. Analysis of variability between conditions revealed moderate variability between phases with standard deviations (SD) of .52 in the baseline phase, 1.89 in the intervention phase, and 2.25 in the follow-up phase. The decrease was not immediate, as the data did not visibly decrease until the third data point of the intervention phase. Additionally, there was overlapping data between these two phases. The mean of the last three data points in the baseline (M=10) was the same as the mean of the first two data points in the intervention phase (M=10).

Peer Problems

Level analysis of graph indicated a decrease from a mean of 4.5 in the baseline phase to

2.08 in the treatment phase followed by another decrease to 0 in the follow-up phase. Trend analysis revealed a downward trend across the baseline and treatment phase of the study with a large correlation (R^2=.75), indicating a large relationship between play therapy phase and Justin's decrease in difficulty with peers. Analysis of variability between conditions revealed moderate variability between phases with standard deviations (SD) of .84 in the baseline phase, 1.66 in the intervention phase, and 0 in the follow-up phase. The decrease was not immediate, as the data did not visibly decrease until the third data point of the intervention phase. Additionally, there was overlapping data between these two phases. The mean of the last three data points in the baseline (M=5) was similar to the mean of the first three data points in the intervention phase (M=4.33).

Prosocial Behavior

Level analysis of graph indicated an increase from a mean of 5.42 in the baseline phase to 7.23 in the treatment phase followed by another increase to 9.5 in the follow-up phase. Trend analysis revealed an upward trend across the baseline and treatment phase of the study with a large correlation (R^2=.52), indicating a large relationship between play therapy phase and Justin's increase in prosocial behaviors. Analysis of variability between conditions revealed moderate variability between phases with stand deviations (SD) of .79 in the baseline phase, 1.48 in the intervention phase, and 1 in the follow-up phase. The increase was not immediate, as the data did not visibly increase until the third data point of the intervention phase. Additionally, there was overlapping data between these two phases. The mean of the last three data points in the baseline (M=5) was similar to the mean of the first three data points in the intervention phase (M=5.67).

Total Difficulties

Level analysis of graph indicated a decrease from a mean of 26.5 in the baseline phase to 11.69 in the treatment phase followed by another decrease to 3 in the follow-up phase. Trend analysis revealed a downward trend across the baseline and treatment phase of the study with a large correlation (R^2=.78), indicating a large relationship between play therapy phase and Justin's decrease in overall difficulties. Analysis of variability between conditions revealed large variability between phases with standard deviations (SD) of 1.22 in the baseline phase, 7.66 in the intervention phase, and .82 in the follow-up phase. The decrease was not immediate, as the data did not visibly decrease until the third data point of the intervention phase. Additionally, there was overlapping data between these two phases. The mean of the last three data points in the baseline (M=27.33) was similar to the mean of the first two data points in the intervention phase (M=28). In addition to visual analysis, I calculated the NAP statistic to examine the degree of the treatment's effectiveness. The NAP effect size comparing the baseline phase data and the intervention phase data was a medium effect size of .87, whereas effect size calculation of the baseline phase data compared to the follow-up phase data was a strong effect size of 1 (Parker & Vannest, 2009).

Post-Traumatic Stress

The TSCYC was completed by Justin's mother prior to the baseline, at the twelfth intervention session, and at the twenty-fourth session. The Posttraumatic Stress T-scores were 98 prior to the intervention, 48 at the twelfth session of the treatment phase, and 46 at the twenty-fourth session. The Post-traumatic Stress scores decreased over the time of the study with substantial improvement reported after 12 sessions.

Follow-Up Parent Interview

Upon completion of the intervention phase, Justin's mother participated in a follow-up interview. She reported Justin demonstrated less anger and was more carefree than when the study began. He was no longer displaying sadness at school or home and he was verbalizing his feelings and opinions. He no longer erupted in tears and anger, instead he spoke up and shared what he was thinking and feeling. Justin's meltdowns at school stopped and his teachers reported he was no longer displaying problem behaviors. Justin's mother reported he was helpful and kind at home and more readily used his manners. In regards to peer relationships, she reported Justin had better relationships with peers and he was able to problem solve when he was upset. Justin's mother reported positive changes to their parent-child relationship. She previously felt that Justin hated her and blamed her for the divorce, yet at the final interview, she reported feeling reconnected to him. Additionally, Justin's mother reported that he had demonstrated nurturing behaviors toward her. Overall, she reported Justin looked forward to coming to play therapy during the intervention phase.

Participant 2: Megan

Megan participated in 6 weeks of a non-intervention baseline phase, 12 weeks of intervention phase where she participated in 24 play therapy sessions, and 4 weeks of a non-intervention follow-up phase. Table 2 provides the means and standard deviations for each subscale in each phase of the study. For two subscales, Emotional Symptoms and Hyperactivity and Attentional Difficulties means continually decreased across all phases of the study demonstrating improvement. For Conduct Problems, the means remained the same during the baseline and intervention phases and decreased during the follow-up phase. For Peer Relationship Problems and Total Difficulties, the means increased between the baseline and

intervention phases and decreased during the follow-up phase. The means of Prosocial Behavior decreased between the baseline and intervention phases and increased during the follow-up phase. Figure 2 provides a graphical representation of all data.

Megan's stepmother completed an SDQ each week that generated one score for each of the subscales. I separately evaluated each subscale by assessing the level, trend, variability, immediacy of effect, and overlapping data.

Emotional Symptoms

Level analysis of graph indicated a decrease from a mean of.83 in the baseline phase to .75 in the treatment phase followed by another decrease to 0 in the follow-up phase. Although the initial scores were in the normal range, trend analysis revealed a slight downward trend across the baseline and treatment phase of the study with a small correlation (R^2=.13), indicating a weak relationship between play therapy phase and Megan's decrease in emotional symptomology. Analysis of variability between conditions revealed moderate variability between phases with standard deviations (SD) of .41 in the baseline phase, .86 in the intervention phase, and 0 in the follow-up phase. Due to initial scores falling in the very low range, there was overlapping data between phases. The scores across phases were not in the problematic range.

Conduct Problems

Level analysis of graph indicated a consistency of means between the baseline and treatment phase with means of 4.83 followed by a decrease to 2.25 in the follow-up phase. Trend analysis revealed a downward trend across the baseline and treatment phase of the study with a small correlation (R^2=.04), indicating a weak relationship between play therapy phase and Megan's decrease in conduct problems. Analysis of variability between conditions revealed moderate variability between phases with standard deviations (SD) of .75 in the baseline phase,

1.33 in the intervention phase, and .96 in the follow-up phase. The increase was not immediate, as the data did not visibly decrease until the seventeenth data point of the intervention phase. Additionally, there was overlapping data between these two phases. The mean of the last three data points in the baseline (M=5.33) was the same as the mean of the first three data points in the intervention phase (M=5.33).

Hyperactivity and Inattention

Level analysis of graph indicated a decrease from a mean of 8.83 in the baseline phase to 8.25 in the treatment phase followed by another decrease to 5.25 in the follow-up phase. Trend analysis revealed a downward trend across the baseline and treatment phase of the study with a medium correlation (R^2=.22), indicating a relationship between play therapy phase and Megan's decrease in hyperactive and inattentive behaviors. Analysis of variability between conditions revealed moderate variability between phases with standard deviations (SD) of .98 in the baseline phase, 2.01 in the intervention phase, and .5 in the follow-up phase. The decrease was not immediate, as the data did not visibly decrease until the seventeenth data point of the intervention phase. Additionally, there was overlapping data between these two phases. The mean of the last three data points in the baseline (M=9) was similar to the mean of the first three data points in the intervention phase (M=10).

Peer Problems

Figure 13 presents the data levels and trend for Peer Problems across phases of the study. Level analysis of graph indicated an increase from a mean of 1 in the baseline phase to 2.5 in the treatment phase followed by a decrease to 1.75 in the follow-up phase. Trend analysis revealed an upward trend across the baseline and treatment phase of the study with a small correlation (R^2=.06), indicating an inverse relationship between play therapy phase and Megan's decrease in

difficulty with peers. Analysis of variability between conditions revealed moderate variability between phases with standard deviations (SD) of .63 in the baseline phase, 1 in the intervention phase, and .95 in the follow-up phase. Initial scores were in the normal range with low variability indicating peer problems were not an issue of concern. Subsequent scores remained in the normal range across all phases.

Prosocial Behavior

Level analysis of graph indicated a decrease from a mean of 8.5 in the baseline phase to 7.83 in the treatment phase followed by an increase to 9.5 in the follow-up phase. Trend analysis revealed an upward trend across the baseline and treatment phase of the study with a negligible correlation (R^2=.004), indicating little to no relationship between play therapy phase and Megan's increase in prosocial behaviors. Analysis of variability between conditions revealed moderate variability between phases with standard deviations (SD) of .55 in the baseline phase, 1.93 in the intervention phase, and .58 in the follow-up phase. Improvement was not immediate, as the data did not visibly decrease until the seventeenth data point of the intervention phase. Additionally, there was overlapping data between these two phases. The mean of the last three data points in the baseline (M=8.33) was similar to the mean of the of the first three data points in the intervention phase (M=7.67) and overlapped with subsequent data points in intervention phase.

Total Difficulties

Level analysis of graph indicated an increase from a mean of 15.5 in the baseline phase to 16.18 in the treatment phase followed by a decrease to 9.25 in the follow-up phase. Trend analysis revealed a consistent trend across the baseline and treatment phase of the study with a small correlation (R^2=.03), indicating a weak relationship between play therapy phase and

Megan's decrease in overall difficulties. Analysis of variability between conditions revealed variability between phases with standard deviations (SD) of 1.64 in the baseline phase, 3.59 in the intervention phase, and 1.71 in the follow-up phase. The decrease was not immediate, as the data did not visibly decrease until the seventeenth data point of the intervention phase. Additionally, there was overlapping data between these two phases. The mean of the last three data points in the baseline (M=15.67) was smaller than the mean of the of the first three data points in the intervention phase (M=19). In addition to visual analysis, I calculated the NAP statistic to examine the degree of the treatment's effectiveness. The NAP effect size comparing the baseline phase data and the intervention phase data was a weak effect size of -.35 in the negative direction, whereas effect size calculation of the baseline phase data compared to the follow-up phase data was a large effect size of 1.

Post-Traumatic Stress

The TSCYC was completed by Megan's stepmother prior to the baseline, at the twelfth intervention session, and at the twenty-fourth session. The Posttraumatic Stress T-scores were 78 prior to the intervention, 76 at the twelfth session of the treatment phase, and 50 at the twenty-fourth session. The Post-traumatic Stress scores decreased over the time of the study with most substantial improvement occurring from play therapy phase to follow-up.

Follow-Up Parent Interview

Upon completion of the intervention phase, Megan's father and stepmother participated in a follow-up interview. They reported that following participation in CCPT, Megan appeared happier and that she bounced backed from disappointments when things did not go as planned more quickly. She discusses her feelings with them and accepts responsibilities for mistakes. They reported Megan had a greater attention span and a better ability to stay focused at home

and school. Megan was less impulsive and she started thinking before acting. Megan became more selective with her peer choices; therefore, she had a better relationship with friends. Megan discontinued physically reacting when she was upset and she demonstrated remorse when she was upset. They reported that Megan had become more affectionate with her stepmother, whereas prior to the study she was only affectionate with her father. They reported they have a deeper stronger relationship and connection with Megan. Although they reported in the final interview that they initially had mixed feelings about seeking counseling, they reported it was a positive experience. They reported that once Megan began feeling heard in the therapeutic relationship, she tried calmer ways of receiving attention at home. Through parent consultations, they discovered Megan's desire for relationships and physical touch and discontinued removing relational activities as consequences. Megan's father reported seeing gradual changes throughout the study, however her stepmother reported that she was unaware of the gradual changes but recognized the drastic changes toward the end.

Summary of Results

Both Justin and Megan demonstrated lack of improvement during the baseline phase of no treatment. Justin's scores demonstrated a rapid improvement in which he was positively responsive to play therapy intervention within six sessions. Megan's scores demonstrated delayed improvement that became noticeably pronounced following 19 play therapy sessions.

Discussion

The purpose of this study was to examine the effectiveness of facilitating CCPT with children who had four or more ACEs. Each of the participants in the study had eight ACEs which was well over the criteria requirements for the study. Both participants demonstrated clinical levels in some or all of the subscales from the SDQ as well as high levels of

posttraumatic stress at the initiation of study. Through the duration of the study, both participants significantly decreased in all areas of concern and were not clinical in any area at the end of the follow-up phase. Although the improvements occurred at different times of the intervention phase, both children had lasting changing once the initial change was reported. Through the play therapy experience, both participants were able to begin self-actualizing which allowed them to build self-acceptance and self-confidence. Justin demonstrated a rapid decrease in symptomology across subscales within the intervention phase and continued throughout the follow-up phase. Megan's decrease in symptomology occurred for clinically-scored subscales further into the intervention phase and continued throughout the follow-up phase. While both participants decreased problematic behaviors and increased prosocial behaviors, the time in which the change occurred was different for participants.

Process of CCPT for Children with ACEs

Manifestation of change and growth is a slow process (Landreth, 2012). Children who lived through difficult situations typically present with intensified emotions, mostly negative and no longer tied to reality of the moment but filtered through past experiences. When they enter therapy their emotions are heightened, indiscriminate, and easily aroused (Moustakas, 1953). Through qualitative research, Moustakas (1953) identified four stages of change during the therapeutic process which lead toward improved functioning. As children receive faith, acceptance, and respect, relationships between therapists and children are strengthened and children begin to move through the stages (Moustakas, 1953). Although there are significant shifts, parents and caregivers may not be immediately aware of the changes outside of the playroom.

In the first stage, children diffuse negative feelings and express them throughout their play. Typically, children no longer tie their negative emotions and frustrations to the people who originally aroused those emotions. Children's emotions might be magnified, generalized, and easily evoked. Children are often frightened, angry, or immature without focusing their emotions on any one person or experience. In Justin's case, his first stage of play occurred immediately upon entering play therapy. During his first stage of play, he demonstrated fear toward many toys in the room. Justin picked up toys and verbalized how scary they were to him. When he began using the army men, he verbalized the fear one team had toward the other. During the first stage, Justin's mother described him as inconsolable when he was upset at school and home. When Justin was upset he reacted by throwing objects or hiding while screaming or crying. Justin had difficulty putting words to his feelings even once he was calm. In Megan's case, the first stage occurred after the initial exploratory sessions. Megan had an overall negative affect during the first stage of play. Her body language and facial expressions demonstrated negative feeling throughout her play regardless of the play. Megan's father and stepmother reported that when Megan was upset she would hit her siblings or scream and yell at her stepmother. When they attempted to engage Megan in conversations about her feelings, she would disengage from the conversations.

During the second stage, children express negative emotions more directly and typically express emotions toward particular people or experiences. While in the second stage, children may focus aggressions on family members or therapists by attacking, denouncing, or threatening them during play. During Justin's second stage, the negative play continued but it appeared more focused. In play with army men, he created fighting scenes where one team was weaker and unable to defend themselves. He maintained focus during play and utilized the army men

throughout entire sessions. During the second stage, his mother reported that Justin's negative emotions began to feel more proportionate to the situations occurring and he was verbalizing his negative emotions more clearly. During Megan's second stage, her affect began to vary. She had negative affect during times when she was quieter and focused. Megan's father and stepmother reported Megan was continuing to display anger toward her stepmother and siblings, however the intensity had increased toward her stepmother.

Throughout the third stage, children no longer have completely negative emotions. They begin to fluctuate between negative and ambivalent emotions during their play. Intensity of ambivalent emotions may be high in the beginning of the third stage but the intensity might lessen toward the end of the third stage. During the third stage, Justin wavered back and forth between negative emotions and ambivalence. Justin created ways for soldiers to be safe and also created new ways for them to be attacked. During the third stage, Justin's mother reported that Justin was communicating his frustrations with words and seemed calmer at home and school. During the third stage of play, Megan began to show more fluctuation in her affect. She had moments when she conveyed looks of anger but more often she seemed relaxed. She was still not displaying positive emotions, but she appeared ambivalent. Her father reported that Megan would avoid her stepmother while finding him to hug. Her stepmother reported feeling disconnected from Megan and left out from her affection.

In the final stage, positive feelings begin to emerge. Children may see themselves and their relationships more realistically. Positive and negative emotions become separated, more consistent, and realistic (Moustakas, 1953). During the fourth and final stage, Justin began to integrate positive and negative emotions. Justin began to integrate laughter into his play. He created situations where people were hurt and then he took care of them or found a way for them

to get better. As the stage progressed, Justin moved away from the army men and other negative play and began playing games he created in the playroom with the therapist. Justin's mother reported that Justin was verbalizing his love and anger toward his parents in a very calm way. Justin's mother also reported that all behavior problems had ceased to occur. She said he demonstrated strong care toward others and he was a joy to be around. During the fourth stage of play, Megan's affect became evidently positive. Like Justin, Megan began to display happiness through authentic laughter. Although she still had moments where she appeared angry, the majority of the time she appeared positive. As Megan entered the fourth stage, her outward changes became apparent to her stepmother and father. When Megan became upset, she requested a hug from her stepmother. As Megan began seeking affection from her stepmother, their relationship began to grow closer. Megan's stepmother and father reported that all of Megan's behaviors concerns were no longer present. They verbalized that she was no longer a child of concern.

When the conditions that created the maladjustment are still present, healing may take longer (Axline, 1947). Therapeutic relationships provide the environment for healing, but when children are still subjected to relationships which facilitated their conditions of worth, discovering their self-worth may take longer (Axline, 1947). Therefore, if children still reside in the environment where the ACEs occurred, their maladjusted behaviors may remain persistent compared to potential for change in a stable, nurturing environment.

In Justin's case, he still had contact with his father, but he no longer resided in the same house. Therefore, the majority of the ACEs were occurring less frequently or less present. Justin was not exposed as often to the ongoing adverse conditions he had previously experienced. Justin's progress was identified by his mother quickly after the intervention phase began.

Because many of the adverse experiences were less present, when Justin received the core conditions his self-structure was able to adapt more quickly. His movement toward self-actualization as evidenced through desire to connect to others became apparent to his mother and she observed his self-confidence change and grow.

In Megan's case, she continued to live in an environment where some of the adverse experiences were still present. Throughout the first half of the study, Megan experienced being yelled at and ignored by her caregivers. Megan verbalized her feelings of being unwanted from her family. Therefore, the healing nature of the therapeutic relationship took longer than if those factors had been removed. As Megan strived to self-actualize during her play sessions, she was met with messages of being unwanted at home. Therefore, her self-structure remained rigid for a large portion of the session. As Megan's self-structure became more flexible, in spite of her environment, she began to demonstrate care and kindness toward her family. Megan's healing relationship with her stepmother led to alleviating some of the ACEs that were still occurring which allowed her to continue to self-actualize. Megan's efforts to connect with her stepmother appeared to initiate her stepmother's ability to reciprocate affection and acceptance.

Implications for Practice

Results of this single case research design provide implications for clinicians who are working with children who have experienced multiple ACEs. CCPT is a promising intervention modality for working with children who have experienced multiple or ongoing ACEs. Rogers (1957) stated there are six necessary and sufficient conditions that had to be met for to healing occur. Six necessary and sufficient therapeutic conditions include: 1) psychological contact between two people; 2) incongruence from the client; 3) a congruent therapist; 4) UPR for the client is conveyed by the therapist; 5) therapist experiences empathic understanding for the

client; and 6) the client receives the congruence, UPR, and empathic understanding communicated by the therapist (Rogers, 1957). When the six necessary and sufficient conditions are present in the therapeutic process, healing transpires (Rogers, 1957). Although providing core conditions, therapist congruence, UPR, and empathic understanding, are important to healing, all six necessary and sufficient conditions must be met for healing to occur (Wilkins, 2010).

Although CCPT can be a lengthy process, the consistent attendance of clients is likely to lead to healing. As children slowly perceive and integrate the core conditions, they are able to form a new self-structure. When counselors hold few expectations of child clients while unconditionally positively regarding them, children are able to grow and develop (Rogers, 1957). Although their self-actualizing tendency may have been halted, it is still a positive force inside of them. By having the six necessary and sufficient conditions met, children can begin to integrate new experiences and establish a more fluid self-structure (Ray, 2011).

Children who have experienced multiple or ongoing ACEs might have sporadic healing experiences (Power, 2012). Children may appear to be healing when negative behaviors reoccur. Although their healing may not be a linear process, children are working through their difficulties in their own ways (Landreth, 2012). In addition, this study supported the practice of working with parents through consultation as a way to impact the child's systemic environment and encourage therapeutic progress. Yet, it also appeared that when parents were resistant to change, CCPT was effective in helping the child develop resources to provide for the parent's needs, as in the case of Megan and her stepmother, thereby affecting the parent child relationship in a positive way.

Children who have experienced ACEs may still be exposed to the same ACEs while in play therapy. Children who have endured ongoing or multiple ACEs, have had a difficult childhood prior to entering play therapy (Clarkson Freeman, 2014). The adversities faced by children who experienced ACEs differ based on individuals (Clarkson Freeman, 2014). Due to the varying nature of the experiences, it is difficult to predict how children will present during play therapy. Sessions with children exposed to ACEs may differ greatly.

Overall, CCPT appears to be a promising intervention for children who have experienced multiple or ongoing ACEs. When implementing CCPT, it is important to consider that number of sessions with children might vary and healing might occur quickly or gradually. Although parents may not report sudden changes, small changes may be occurring.

Implications for Research

This pilot study provided information for future research with children who have experienced four or more ACEs. Following this study another SCRD is suggested with a multiple baseline design with three or more participants. By recreating this study, using the guidelines from What Works Clearinghouse (Kratochwill et. Al, 2010), researchers can assist in building the evidence-based literature for children who experienced ACEs.

In addition to another SCRD, a correlation study should be conducted to continue to discover how ACEs impact children. While there are a few studies examining the correlations between ACEs and children's behaviors, a study should be conducted to increase researchers understanding of which assessment measures are more indicative of the problematic symptomology resulting from ACEs.

Another research topic of interest would be to investigate parent variables and the impact they have on therapeutic progress as well as the number and types of ACEs children experience.

In particular, researchers might look at parents' perceived stress, attachment, and mental health concerns. The types and numbers of parent ACEs could also be correlated with the types and numbers of the children's ACEs.

A randomized controlled trial could be the following step in research. Comparisons between children who have experienced four or more ACEs receiving the CCPT intervention and children who have experienced four or more ACEs not receiving the intervention will provide researchers a further understanding of the effects of CCPT with children who have experienced four or more ACEs.

When researchers begin recruitment for any of the suggested studies, they should recruit more participants than needed. Due to the nature of ACEs, attrition is likely to occur at a higher rate than with other studies. In addition to attrition, recruitment is difficult with this population due to the nature of the questions used to determine eligibility. Recruitment processes should begin well in advance and participants should be entered into the studies at different times.

Limitations

There are a few limitations to the study. Single case design has minimal external validity which limits the ability to generalize the findings to the general population. Although both participants demonstrated changes within the study, it is difficult to generalize these findings to all children who have experienced ACEs due to the individual nature of single-case design.

Disruptions in the home environment may have impacted the way in which participants were rated by their parents. Having one rater per participant may have inhibited the researchers from gaining a deeper understanding of the effectiveness of CCPT. In order to have gained more insight, the researcher could have utilized more raters per child or incorporated an observation measure.

Due to caregivers' report regarding the occurrence of ACEs rather than the children who have experienced them, not all of the ACEs may have been reported. Reports are based on the parents' views of the child's experiences and due to changes in home environments, parents may not have a full understanding of the depth of the ACEs. When answering the questions parents may not fully grasp how their children are experiencing the environments.

Conclusion

ACEs have been shown to have negative effects throughout the lifespan beginning in childhood after the ACEs have occurred (Argawal, 2015). This study demonstrated positive impact utilizing CCPT with two children who had experienced four or more ACEs. While each child's healing occurred at different points, both children demonstrated significant changes in symptomology. The process of CCPT with participants who experienced ACEs appeared to support previous research related to stages of play therapy, moving from diffused negative reactions in the playroom to an integrated expression of self with positive emotions. The relationship between child and play therapist seemed to provide a reparative experience for children whose primary relationships have been made vulnerable by ACEs. Although more research is necessary, CCPT seems to demonstrate promise as an intervention for children who have experienced multiple or ongoing ACEs.

Table 1

Means and Standard Deviations for Justin's SDQ Scores

Subscale	Baseline		Intervention		Follow-Up	
	M	SD	M	SD	M	SD
Emotional Symptoms	7.83	.75	2	3.32	.25	.5
Conduct Problems	4.33	.52	1.77	1.17	.5	.58
Hyperactivity/Attention Difficulties	9.67	.52	5.78	1.89	2.25	1.26
Peer Relationship Problems	4.5	.84	2.08	1.66	0	0
Prosocial Behavior	5.44	.79	7.23	1.48	9.5	1

Total Difficulties	26.5	1.22	11.69	7.60	3	.82

Table 2

Means and Standard Deviations for Megan's SDQ Scores

Subscale	Baseline		Intervention		Follow-Up	
	M	SD	M	SD	M	SD
Emotional Symptoms	.83	.41	.75	.86	0	0
Conduct Problems	4.83	.75	4.83	1.33	2.25	.96
Hyperactivity/Attention Difficulties	8.83	.98	8.25	2.01	5.25	.5
Peer Relationship Problems	1	.63	2.5	1	1.75	.95
Prosocial Behavior	8.5	.55	7.83	1.93	9.5	.58
Total Difficulties	15.5	1.64	16.18	3.59	9.25	1.71

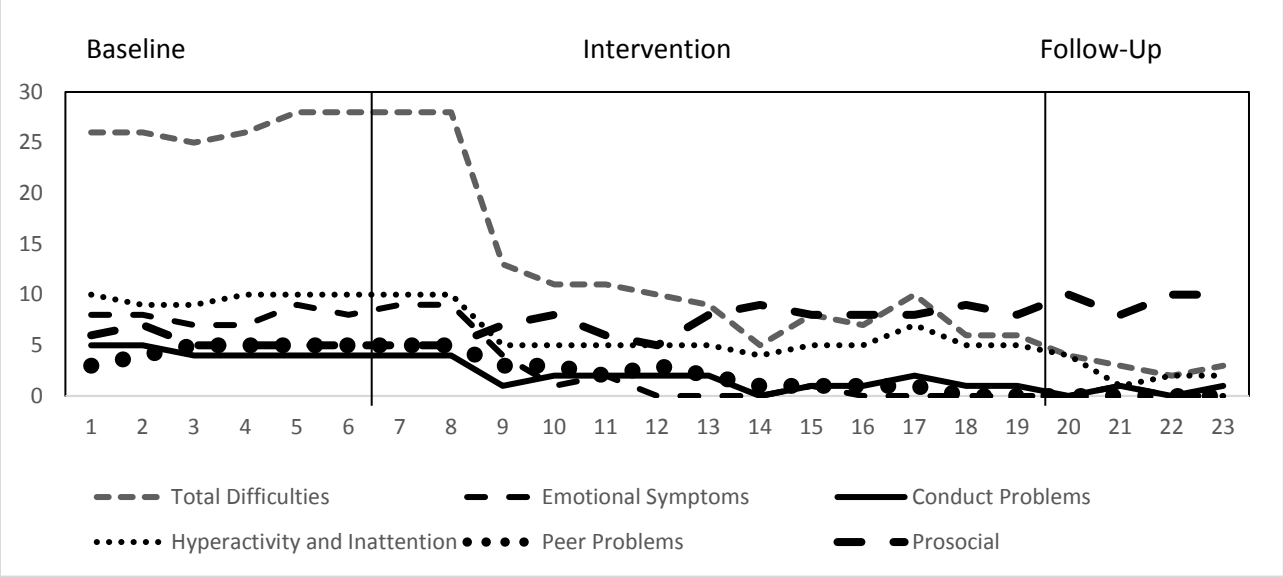

Figure 1. Justin's SDQ scores during baseline, intervention, and follow-up phases

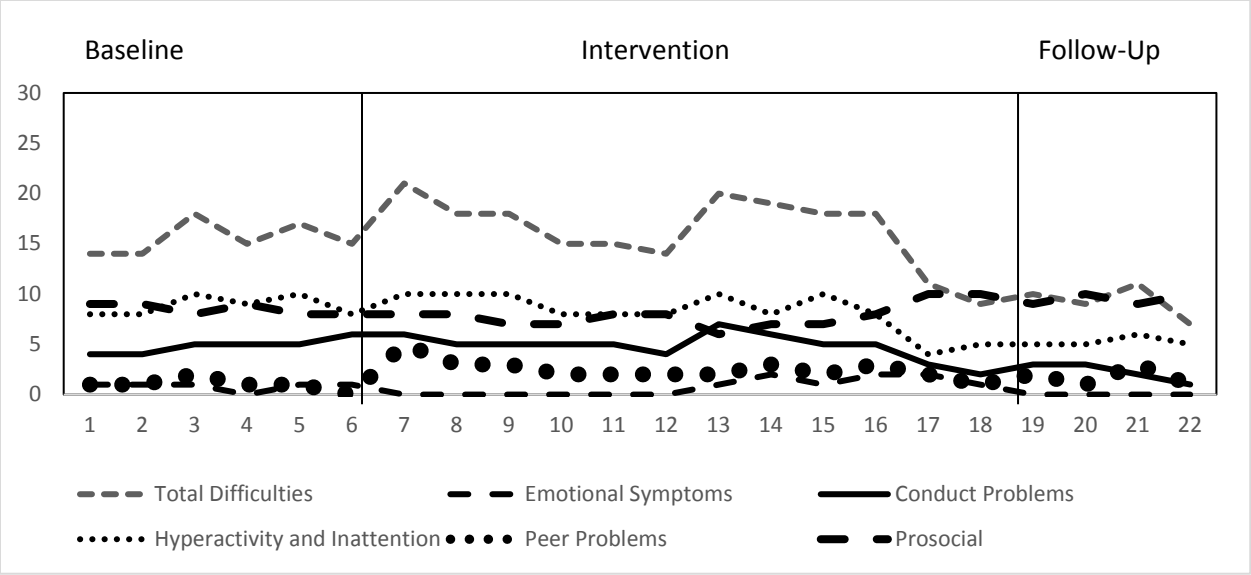

Figure 2. Megan's SDQ scores during baseline, intervention, and follow-up phases

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APPENDIX A

EXTENDED REVIEW OF THE LITERATURE

Adverse childhood experiences (ACEs) can be defined as traumatic and stressful experiences occurring in childhood (Murphy et al., 2014). Categories for ACEs include physical abuse, sexual abuse, emotional abuse, emotional neglect, physical neglect, mental illness, substance abuse, separation/ divorce, domestic violence, incarceration, and living in foster care (Felitti et al., 1998; Wade et al., 2016). The Center for Disease Control and Prevention (CDC; n.d.) reported over 50% of the adult United States population have reported experiencing at least one ACE while 15% have reported experiencing four or more ACEs. Adverse experiences occurring in childhood have been found to have profound influence on the health and well-being of children and adults (Felitti et al., 1998; Wade et al., 2016; Clarkson Freeman, 2014). Resulting and complex trauma is a common outcome and response to the experiencing of adverse experiences (SAMHSA, n.d). Although various mental health interventions have been proposed to address the symptoms resultant from ACEs and childhood trauma, there is still little evidence to support positive treatment outcomes for children who have experienced ACEs. Child-centered play therapy (CCPT) fosters connections and relationships in a safe therapeutic environment lending to the potential of CCPT being an effective intervention with children who have experienced multiple ACEs.

Overview of ACEs

There are 10 categories of ACEs originally cited in the ACE Checklist (Cronholm et al., 2015) but the commonality between all of the categories is a self-report of feeling maltreated or living in household dysfunction during childhood. The experiences are considered adverse because they are difficult circumstances that are unhealthy. In order to have a better understanding of each of the ACEs' categories, items from the ACE Checklist specify characteristics of each category. Physical abuse is the act of an adult living in the household

hitting, slapping, pushing, grabbing, leaving marks, or physically injuring the child. In the context of ACEs, physical abuse is present if an incident has occurred once or more than once (Felitti et al., 1998; Wade et al., 2016). The sexual abuse category of ACE is characterized as present when a person at least five years older than a child has touched or fondled a child sexually, had the child touch or fondle the older person sexually, attempted to have sexual intercourse either oral, vaginal, or anal, or had sexual intercourse either orally, vaginally, or anally. As in the case of physical abuse, one occurrence of sexual abuse is considered an ACE (Felitti et al., 1998; Wade et al., 2016). Emotional abuse is when an adult living in the household has sworn at the child, insulted the child, or acted in a way that made the child feel like being physically hurt was a possibility. Unlike the physical and sexual abuse categories, emotional abuse would need to occur often in order to be considered an ACE (Felitti et al., 1998; Wade et al., 2016).

The emotional neglect category is the person's report of not feeling special, important, or loved. Emotional neglect must be reported as occurring often in order to be considered an ACE (Felitti et al., 1998; Wade et al., 2016). Physical neglect occurs when a person reports that during childhood, he or she felt there was not enough to eat, had to wear clothes that were dirty, did not feel protected, or perceived the caregivers were too drunk or high to take care of the child or get the child medical care if necessary (Felitti et al., 1998; Wade et al., 2016). The mental illness category is defined by report of living with an adult who was depressed, mentally ill, had suicidal ideations, or attempted suicide (Felitti et al., 1998; Wade et al., 2016).

The substance abuse category of ACE includes report of living with anyone who had a drinking problem (e.g., drinking too much, alcoholic, etc), used streets drugs, or abused prescription medications (Felitti et al., 1998; Wade et al., 2016). Parental separation/ divorce

items include report of separation or divorce of the child's caregivers (Felitti et al., 1998; Wade et al., 2016). Domestic violence is marked as present when a person reports that she or he observed a caregiver slapped, kicked, punched, beaten up, hit or cut with an object. One or more domestic violence incidents denotes presence of an ACE in this category (Felitti et al., 1998; Wade et al., 2016). Incarceration is defined as report of anyone living in the child's household that has served time in prison, jail, or other correctional facilities for any length of time (Felitti et al., 1998; Wade et al., 2016). The presence of one ACE is of critical concern to child development. Multiple occurrences indicate that children may be experiencing grave and complex trauma. Each adverse experience has negative implications and only recently have researchers begun to consider what consequences manifest when multiple ACEs occur in childhood.

History and Prevalence of ACEs

ACEs became a topic of interest based on the research of Felitti (Stevens, 2012) who inadvertently discovered the link between early childhood experiences and adult physical health. Dr. Felitti was the chief physician at an obesity clinic specializing in helping people who were severely obese. Discontinuation of treatment was common among patients which contributed to a low retention rate (50%). Puzzled by the number of patients who discontinued, Felitti began to examine the discontinued patients' files. He was unable to find a clear explanation for the reason patients left before they were ready. Felitti held interviews with the patients who dropped out of the program. The initial interviews did not have any significant findings until Felitti made a mistake. In one interview, instead of his typical question regarding age of ongoing sexual activity, he inadvertently asked of her weight at the time of her first sexual experience. The woman's reply startled him because she only weighed 40 pounds the first time she had sex. She

reported that her father had sexually abused her when she was four-years old. Had Felitti not misspoken, he might not have correlated sexual abuse with obesity problems. After making this discovery, Felitti incorporated questions about sexual abuse and sexual violence into the questions he asked his patients. He noticed a trend that many of the patients had encountered sexual abuse or assault prior to their weight gain. His profound discovery led him to inquire about more experiences that had possibilities of having adverse effects on adult health (Stevens, 2012).

Once Felitti determined that ACEs seemed to have a detrimental effect on adult health, he began researching the correlation between the adverse experiences that occurred during childhood and the number of negative health effects occurring in adulthood. Working with Kaiser Permanente, Felitti developed the first ACE study (Stevens, 2012). Felitti et al. (1998) used a survey questionnaire to discover the number of ACEs adults had experienced during childhood. The survey was sent to 13,494 adults through a large health maintenance organization (HMO) with 9,508 responding to the survey. After removing surveys that were incomplete, there were 8,056 participants. Of the people who responded to the survey, 49.5% reported experiencing zero ACEs, 24.9% reported experiencing one ACE, 12.5% reported experiencing two ACEs, 6.9% reported experiencing three ACEs, and 6.2% reported experiencing 4 or more ACEs. 4,197 of the respondents were women and 3,859 of the respondents were men. Women experienced a higher percentage of ACEs than men with 8.5% of women reported experiencing 4 or more ACEs whereas 3.9% of men reported experiencing 4 or more ACEs (Felitti et al., 1998).

Because early research on ACEs was limited due to samples from participants in the middle class socio-economic level, Wade et al. (2016) embarked on exploration of populations from varied economic backgrounds. He surveyed 1,784 adults ages 18-97, with a variety of

socio-economic statuses (SES) living in the urban area of Philadelphia. The survey addressed ACEs including: emotional abuse, physical abuse, sexual abuse, physical neglect, emotional neglect, household substance abuse, household mental illness, domestic violence, and incarcerated care provider. Wade et al. extended the inclusion of ACEs to witnessing violence, felt discrimination, lack of neighborhood safety, feeling bullied, and living in foster care in order to provide a more extensive view of adverse experiences. Of the participants surveyed 32.5% reported experiencing zero ACEs, 20.5% reported experiencing one ACE, 15.1% reported experiencing two ACEs, 12.2% reported experiencing three ACEs, and 19.7% reported experiencing 4 or more ACEs. Of the participants surveyed, 41.2% reported experiencing zero extended ACEs, 30.0% reported experiencing one extended ACE, 18.7% reported experiencing two extended ACEs, and 10.0% reported experiencing three or more extended ACEs. In examining the correlation between SES level and ACEs, Wade et al. discovered that the lower the SES level of the participants, the higher the number of original ACEs and extended ACEs the participants experienced. Researchers also found that the people who were at a lower SES level had more difficulties than people at a higher SES level with the same number of ACEs. Finally, the team discovered that the original ACEs typically occurred in early childhood whereas the extended ACEs typically occurred in later childhood and adolescence. When comparing Felitti et al.'s (1998) findings to Wade et al.'s (2016), differences indicated that poverty was directly correlated to an increase in reported ACEs.

Long-Term Effects of ACEs

Adverse experiences occurring in childhood have been found to have profound influence on the health and well-being of adults (Felitti et al., 1998; Wade et al., 2016). Studies were conducted to observe the correlation between the number of ACEs experienced in childhood and

the negative effects throughout the lifespan. Research has concluded that ACEs have long-term effects on physical and mental health, addictive behaviors, criminal activities, and adult relationships. Figure A.1 depicts the relationship between adverse experiences in childhood and later physical, behavioral, and emotional consequences as conceptualized by Centers for Disease Control and Prevention (CDC; n.d.).

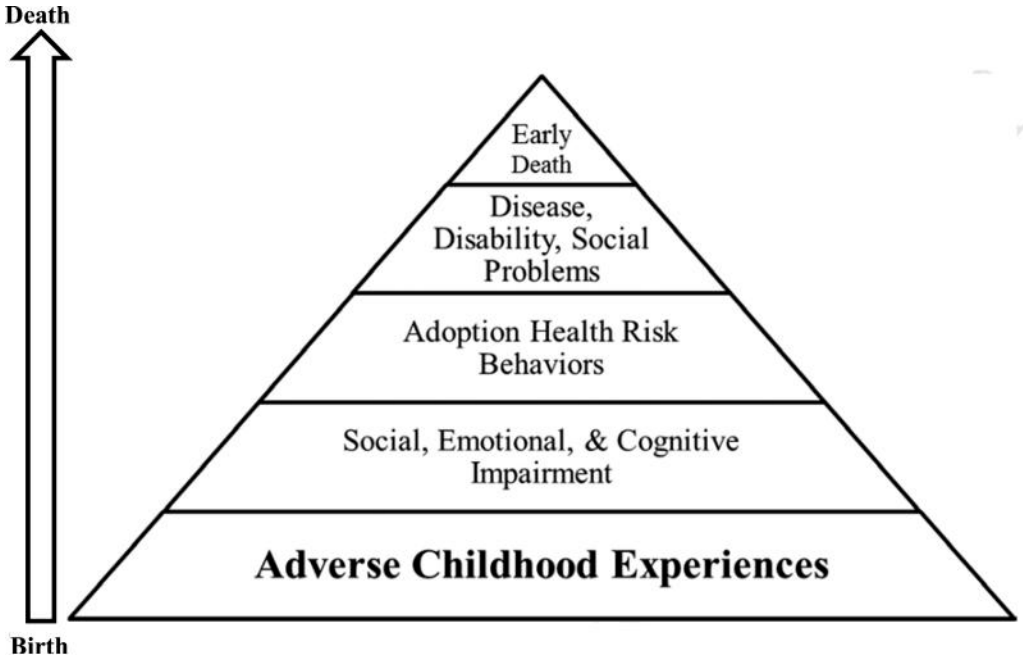

Figure A.1. Adverse childhood experiences pyramid. Center for Disease Control and Prevention (n.d.)

Physical health effects. Multiple ACE occurrences have negative impacts on physical health in adults. As a result of ACEs, adults may have a higher risk for health symptoms that lead to death and a shortened lifespan as well as fatigue and lack of energy which impacts the perceived quality of life. By understanding the consequences and impacts of ACEs on physical health, researchers are able to identify risk factors early in order to provide appropriate interventions.

Felitti et al (1998) utilized the survey questionnaire as part of Kaiser Permanente's Health Appraisal Center's study to examine the relationship between the number of ACEs experienced

during childhood and risk factors in adults. The researchers found a strong relationship between people who experienced four or more ACEs and increased risk factors leading to death. Of the people who experienced four or more ACEs, 12% were considered severely obese, whereas only 5.4% of the people who did not experience ACEs were considered severely obese. Of the people who experienced four or more ACEs, 26.6% reported not getting leisure-time physical activity, whereas 18.4% of people who did experience ACEs reported a lack of leisure-time physical activity. The researchers suggested that lack of physical activity and severe obesity could lead to an early death, thereby connecting the occurrence of ACEs with shorter lifespan (Felitti et al., 1998).

Monnat and Chandler (2015) examined the effect ACEs had on long-term physical health. Utilizing the Behavioral Risk Factor Surveillance System, the researchers examined data collected from 2009 to 2012 from 52,250 adults who were ages 18-64. Using the data, the researchers examined correlations between ACEs and four categories of adult physical health: heart attacks, diabetes, self-rated health concerns, and functional limitations. Respondents who experienced physical abuse were 23% more likely to be diagnosed with diabetes, while those who experienced sexual abuse had 36% more likelihood, and those who experienced domestic violence had 22% more likelihood than those who did not experience ACEs. If someone had endured physical abuse, the likelihood for a heart attack increased by 24% and if there was parental divorce it increased by 25%. Findings from Monnat and Chandler showed there was an increase in physical health consequences when certain ACEs were present, such the links between physical abuse and increased likelihood of diabetes, heart attacks, self-rated health concerns, and functional limitations. Alternately, the correlations between verbal abuse and physical consequences were limited to self-rated health concerns and functional limitations.

Monnat and Chandler concluded by correlating individual ACEs with risk categories, medical professionals could begin to predict the health outcomes of adults who had ACEs.

Mersky, Topitzes, and Reynolds (2013) used the Chicago Longitudinal Study (CLS) to analyze the association of ACEs and poor health-related outcomes in adulthood. Participants of CLS were mostly African American (93%) with a small number of Latina/o participants (7%), all born into underprivileged, urban dwelling families. The CLS included 1,142 participants who responded to an adult survey between the ages of 22 and 24. While 79.5% of the sample experienced at least one ACE, 48.9% of the sample experienced multiple ACEs. Researchers found an increased number of ACEs associated with poorer health in adulthood.

Mostoufi et al. (2013) explored the relationship between ACEs and health perceptions of adults using 90 pairs of adult female twins to further examine the shared familial factors. Using the ACEs survey and a health survey to examine correlations between ACEs and health concerns, Mostoufi et al found a positive correlation between ACEs scores and health concerns for the twin pairs. In exploring the effects of ACEs beyond physical and sexual abuse, researchers found that health concerns continued to be highly correlated. However, the inclusion of physical and sexual abuse into ACEs was additionally correlated with vitality scores indicating physical and sexual abuse had an impact on the energy level of the participants. Each pair of twins scored similarly indicating the effects of ACEs may be attributed more to the effects of the household dysfunction rather than to the individual's perception.

Correlations were discovered between ACEs and physical health symptoms of adults which indicated that the higher number of ACEs people experienced, the more likely they were to experience negative health effects as adults. Research provides ample evidence that when children experience adverse experiences, there is a profound impact on physical health concerns

in adulthood. Ultimately, the cumulative effect of ACEs was found to increase the probability of risk factors that lead to of a shorter lifespan and death.

Mental health effects**.** In researching the long-term effects of ACEs, researchers discovered a relationship between the experience of ACEs and negative consequences for mental health. Subsequent mental health issues such as post-traumatic stress, depression, anxiety, hopelessness, stress, and even suicidal behavior appear to be linked to a person's ACEs. By understanding the impact of ACEs on mental health, clinicians are gaining a better understanding of how experiences in childhood have prolonged mental health effects.

Feliti et al (1998**)** found 50.7% of people who experienced four or more ACEs reported having two or more weeks of depressed mood within a year of the survey, whereas 14.2% of people who did not experience ACEs reported having two or more weeks of depressed mood within a year of the survey. Additionally, 18.3% of people who had 4 or more ACEs reported attempting suicide, whereas 1.2% of people who did not experience ACEs reported suicide attempts (Felitti et al., 1998).

Continuing with the Kaiser Permanete's Health Appraisal Center's ongoing research, Anda et al. (2006) examined the correlation between the number of ACEs and a variety of changes in brain structure and function and stress-responsive neurobiological systems in adulthood. To analyze changes in brain structure and stress-responsive neurobiological systems the researchers investigated current adult mental health disturbances, substance abuse, impaired memory of childhood, sexuality, perceived stress, anger control, and risk of intimate partner violence. They hypothesized that if the brain structure and function had changed, it would impact affect responses. When Anda et al. compared affective responses to the number of ACEs, the ACEs score had a statistically significant graded relationship to each individual category as well

as an overall affective disturbances score. The highest correlation between ACEs and affective scores occurred when participants had four or more ACEs. Anda et al. concluded that the higher the ACEs score, there was an increased likelihood of changes in the brain structure that impacted affective responses (Anda et al., 2006).

Wade et al. (2016) correlated the number of ACEs and socio economic status with mental health risk factors in adults in order to determine the effects of ACEs and poverty on mental health. If participants had a low socio-economic status (SES) and four or more ACEs, they were nine times more likely to have a mental illness , which included any mental health diagnosis or two or more weeks of depressed or hopeless moods. If the participants had a higher SES status and four or more ACEs, they were four times as likely to have mental illness than someone with a higher SES status and four or more reported ACEs. The authors discovered while ACEs had an impact on mental illness, the combination of ACEs and low SES increased the probability of suffering from a mental illness (Wade et al., 2016).

Using the Beck Hopelessness Scale (Beck, Weismann, Lester, & Trexler, 1974), Haatainen et al. (2003) compared the experience of hopelessness to the number of ACEs experienced by men and women. This research team theorized that more ACEs experienced in childhood would positively correlate with the amount of hopelessness experienced in adulthood. Using a sample of 1598 participants comprised of 43% men and 57% women the researchers compared the level of hopelessness to the number of ACEs reported. A total of 65.4% of men and 62.7% of women reported no hopelessness, 25.5% of men and 30.2% of women reported mild hopelessness, 7.9% of men and 5.9% of women reported moderate hopelessness, and 1.3% of men and 1.2% of women reported severe hopelessness. Uniquely, when compared to other ACEs studies, male participants in the Haatainen et al. study reported more overall ACEs than

female participants. There were 16% of men and 26% of women who reported zero ACES, 59% of men and 52% of women who reported one to two ACEs, 18% of men and 16% women who reported three to four ACEs, and 7% of men and 6% of women who reported five to six ACEs. More men than women reported physical punishment, while more women than men reported sexual abuse. For both men and women, the higher the number of ACEs they had the more likely they were to experience severe hopelessness (Haatainen et al., 2003).

Nurius, Green, Logan-Greene, and Borja (2015) suggested that exposure to ACEs and high levels of stress result in complications with psychological well-being. The participants were chosen from the 2010 Behavioral Risk Factor Surveillance System (BRFSS). The sample consisted of 13,593 people, 60% were females and 40% were males. Results indicated that higher number of reported ACEs were correlated with a lower well-being score. Additionally, researchers found that as participants' ACE scores went up, the number of absent work days increased. Nurius et al. concluded that the report of ACEs and stress levels are related to lower levels of psychological well-being and work productivity.

Stumbo, Yarborough, Paulson, & Green (2015) examined the impact of adverse childhood and adult experiences on the recovery of serious mental illness. Using a mixed methods format the researchers interviewed and administered questionnaires to 177 participants diagnosed with bipolar disorder, affective psychosis, schizophrenia, or schizoaffective disorder. Of the participants, 91 participants experienced ACEs while 82% had adult exposures. The cumulative lifetime exposure was 94% of the participants. If the adverse experiences occurred during adulthood, the participants were more likely to have a psychiatric disorder combined with a difficulty recovering than if the adverse experiences occurred during childhood (Stumbo et al., 2015).

Perez, Jennings, Piquero, and Baglivo (2016) examined at the relationship between ACEs and adolescent suicide attempts. Utilizing the Florida Department of Juvenile Justice database, the researchers calculated the number of ACEs, between zero to nine and correlated that number with suicide attempts and risk factors that lead to suicide; impulsivity, aggression, school difficulties, and substance abuse. The higher number of ACEs directly and significantly correlated to the adolescents' impulsivity, aggression, school difficulties, and substance abuse. Because most of the juveniles were in constrained environments, the average number of suicide attempts was lower than the national average, However, the researchers discovered the higher the number of ACEs the participants experienced, the higher the likelihood they had to attempt suicide. Participants who experienced nine ACEs were 24% more likely to attempt suicide than those who experienced zero ACEs. Increased ACEs were highly correlated with suicide risk factors and suicide attempts.

Brockie, Dana-Sacco, Wallen, Wilcox, and Campbell (2015) examined the relationship of ACEs to PTSD, depression, poly-drug use, and suicide attempts among 288 Native Americans who were 15-24 and on a remote plains reservation. The researchers focused on six ACEs of emotional abuse, physical abuse, sexual abuse, physical neglect, emotional neglect, and witness to intimate partner violence. For participants over the age of 19, they included historical loss symptoms and perceived discrimination to their list of possible ACEs. Through an anonymous web-based questionnaire, the researchers analyzed the number of ACEs compared to the risk behaviors of PTSD symptoms, depression, poly-drug use, and suicide attempts. The researchers reported that 78% of the sample reported at least one ACE while 37% reported at three to six ACEs. When participants reported three to six ACEs, the likelihood of PTSD symptoms increased by 55%, depression increased by 57%, poly-drug use increased by 51%, and lifetime

suicide attempt increased by 37%. The researchers found an increase in symptomology when there was an increase in ACEs. They concluded if children were exposed to multiple ACEs, they had an increased chance of mental illness and drug use (Brockie et al., 2015).

Spinhoven et al. (2010) researched as to whether childhood adversities or negative life events occurring throughout the life span were present for people who had anxiety and depressive disorders. Childhood adversities were defined as emotional neglect, psychological abuse, physical abuse, and/or sexual abuse occurring before the age of 16, whereas negative life events were defined as personal serious illness, personal injury, death of a close friend or relative, unemployment, major financial loss, and/or loss of important relationships occurring at any time throughout the lifespan. They discovered there was a strong relationship between affective disorders, depressive and anxiety disorders, and childhood adversities. However, they found the significant relationship between negative life events and affective disorders to exist to a lesser extent. The authors speculated that childhood adversities had a stronger relationship with affective disorders because they typically occurred throughout childhood and the negative life experiences were typically one-time events (Spinhoven et al., 2010).

Grasso, Dierkhising, Branson, Ford, and Lee (2015) focused on a sample of adolescents who had at least one confirmed trauma. They examined the age the ACEs occurred to discover the effect on development during adolescence. Grasso et al. found that if children had multiple types of ACEs during any time of childhood, early childhood, middle childhood, or adolescence, the participants were affected developmentally and had a persistent amount of stress into adolescence and adulthood (Grasso et al., 2015).

Multiple occurrences of ACEs increased the presence of mental health symptomology among adults and adolescents. The experience of ACEs contributed to difficulty attaching to

others, mental illness, feelings of hopelessness, behaviors correlated with suicide, suicide attempts, and developmental delays. The research established that people were more likely to experience mental health difficulties as adults and adolescents if they had multiple adverse experiences as children.

Substance use. The Substance Abuse and Mental Health Services Administration's (SAMSHA) national survey (2015) reported drug and alcohol use continues to be a major health concern across the U.S. population (SAMHSA, n.d.). ACE researchers have theorized and explored the connection between presence of ACEs and later drug and alcohol abuse. There appears to be evidence to support the influence of adverse experiences in childhood on later use of illicit and legal substances.

Felitti et al. (1998) examined the correlation between drug use and ACEs to confirm if participants who had experienced ACEs had a higher likelihood for drug use. They discovered 16.5% of people who experienced four or more ACEs reported currently smoking, which was close to 10% higher than people who reported not experiencing ACEs. Of the participants who experienced four or more ACEs, 16.1% reported they identify as alcoholics, whereas only 2.9% of people who did not experience ACEs reported identifying as alcoholics. Of people who experienced four or more ACEs, 28.4% reported using illicit drugs, whereas 6.4% of people who did not experience ACEs reported using illicit drugs. Of people who experienced four or more ACEs, 3.4% reported injecting drugs, whereas .3% of people who did not experience ACEs reported injecting drugs. Felitti et al. (1998) concluded that people who had a higher number of ACEs were more likely to use and abuse drugs.

Giordano, Ohlsson, Kendler, Sundquist, and Sundquist (2014) examined the relationship of ACEs and subsequent drug use disorders in the Swedish adolescent and young adult

population ages 15-24. The researchers used the terms ACEs and second-hand childhood stressors to describe the same events. Giordano et al. found that experiencing any ACEs doubled the risk of having a drug use disorder. Additionally, they reported that male participants were twice as likely to try drugs than female participants.

In addition to exploring the relationship between ACEs and mental health, Brockie et al. (2015) examined the relationship of ACEs to poly-drug use among 288 Native Americans. The researchers reported that if the participants experienced three to six ACEs, drug use increased by 51% compared to those who experienced between zero to two ACEs. Brockie et al. concluded presence of the correlation between the use of drugs and multiple occurrences of ACEs.

The correlations found in the studies between drug use and multiple ACEs demonstrated that people who experienced multiple ACEs had a higher probability of using and abusing drugs. As the number of ACEs increased the use of illicit drugs and alcohol became more prevalent. Due to the relationship between drug and alcohol abuse and significant physical health consequences, there seems to be a salient need to acknowledge ACEs as a mediating factor in substance use.

Criminal activity. Once researchers began to understand the impact of ACEs on physical and mental health, they began to hypothesize that an increase of ACEs could also negatively impact behavior considered criminal. Considering the relationship between ACEs and multiple negative consequences, criminal activity appears as another concern. Recent research has focused on juvenile offenders and the correlation of the number of ACEs they experienced prior to participating in criminal activity.

Hahn Fox, Perez, Cass, Baglivio, and Epps (2015) examined the relationship between ACEs and serious, violent, and chronic juvenile offenders. Juvenile offenders who are referred to

as serious, violent, and chronic are the offenders who have made the most violent offenses. Because screening tools have not been created to find children at risk of becoming serious, violent, and chronic offenders, the researchers examined the correlation between ACEs and the offenders to determine if ACEs are sources of influence. The researchers found that the number of ACEs experienced by serious, violent, and chronic offenders was statistically significantly higher than offenders who had one violation suggesting that the ACEs questionnaire could be one indicator in determining youth who are at a higher risk of becoming a serious, violent, and chronic offender (Hahn Fox et al., 2015).

Baglivio and Epps (2016) examined the interrelatedness of ACEs among high-risk juvenile offenders. When surveyed, 100% of the juvenile offenders reported at least one ACE. Of the youth that experienced one ACE, 67.5% of them reported four or more ACEs and 24.5% of them were exposed to six or more ACEs. They compared male and female youth having six or more ACEs and 29.5 % of female youth had six or more ACEs whereas 14% of male youth had six or more ACEs. Baglivio and Epps concluded a strong correlation between high-risk juvenile offenders and the experiences of ACEs.

Adolescents who participated in criminal activities had a higher probability of having experienced ACEs during childhood. The high correlation between ACEs and juvenile offenders demonstrates the effect ACEs might have on adolescents. Research indicates a need for intervention with children who have experienced ACEs in order to prevent their participation in criminal activity.

Relationships**.** There has been little research done on the impact of ACEs on interpersonal and familial relationships and relational behaviors. The research that has been conducted thus far focuses on the correlation of ACEs with risky behavior and stress with a parenting relationship.

These preliminary studies allow researchers to hypothesize the impact ACEs might have on all relationships.

Felitti et al. (1998) investigated at-risk behaviors that could potentially impact relationships and the way people viewed relationships and correlated the behaviors with the number of ACEs they experienced. Of people who experienced four or more ACEs, 6.8% reported having intercourse with 50 or more partners, whereas of people who did not experience ACEs 3.0% reported having intercourse with 50 or more partners. Of people who experienced four or more ACEs 16.7% reported having a sexually transmitted disease, whereas 5.6% of people who did not experience ACEs reported having a sexually transmitted disease. People who experienced four or more ACES had an increase of sexual risk factors when compared to people who had not experienced ACEs.

Steele et al. (2016) used a sample of mothers from both clinical and community settings to compare mothers who have experienced four or more ACEs to parenting stress. In the clinical sample, 79% of the participants experienced four or more ACEs and 70% experienced clinical levels of parenting stress as measured by the Parenting Stress Index (Abidin, 1995). In the community sample, 25% of the participants experienced four or more ACEs and 14% experienced clinical levels of parenting stress. The authors found that mothers who reported experiencing four or more ACEs reported a higher amount of parenting stress than mothers who did not experience four or more ACEs. The authors hypothesized that mothers who experienced ACEs had difficulty attaching with their children which impacted their perceptions and experiences of parenting stress.

Narayan et al. (2017) examined intergeneration continuity of ACEs, the passing down of ACEs from parents to their children in homeless families. Using an interview approach, parents

were asked about their own ACEs as well as the ACEs their child experienced. The teachers of the children rated the children's socioemotional development using the Strength and Difficulties Questionnaire. The researchers found that the higher numbers of parental ACEs were predictors of the children's ACEs. The higher levels of parental maltreatment ACEs significantly predicted the exposure children had to maltreatment. The researchers also found that the total number of ACEs children experienced did not significantly predict more socioemotional problems. However, if the children had exposure to maltreatment, the prediction of higher socioemotional concerns was significant. The authors concluded that if a parent suffered maltreatment as a child, they were more likely to mistreat their own children.

Murphy et al. (2014) researched the correlation between ACEs and adult attachment in a sample of 75 adult women. The women were from clinical and community settings. In the clinical setting 83% of the women reported four or more ACEs compared to 27% of women in the community setting. The women who showed the most struggles with attachment had four or more ACEs or witnessed their mothers being treated violently during childhood. The ACE that had the lowest effect on attachment was household mental illness. The researchers found that a majority of women who experienced ACEs also reported unresolved attachment regarding past trauma (Murphy et al., 2014).

Researchers highlighted the negative effect ACEs might have on relationships. ACEs impeded attachment abilities with parents which increased the likelihood of their children also experiencing ACEs. ACEs also increased the probability of participating in relationship behaviors labeled as dangerous which could impede the ability to be involved in healthy relationships. Overall, the research results indicate that people who have experienced multiple

ACEs might have difficulty participating in healthy adult relationships. However, there appear to be a limited number of studies exploring the impact of ACEs on familial relationships.

Longitudinal studies. The majority of ACE research is dependent on adult self-report in an attempt to explore the effects of childhood experiences. However, two prominent studies (Flaherty et al., 2009; Thompson et al. 2015) followed the trajectories of ACE effects across childhood and adulthood. Researchers utilized the Consortium for Longitudinal Studies of Child Abuse and Neglect (LONGSCAN) database, researchers conducted longitudinal studies to examine the effects ACEs had on individuals throughout childhood and on young adults. The studies utilized caregiver and self-reports to gain a deeper understanding of the effects of ACEs.

Flaherty et al. (2009) examined the correlation between ACEs and self-reported health concerns with participants who were 12-years-old. Using the LONGSCAN database, researchers examined the caregiver-reported and self-reported health of 12-year-olds. Participants and their caregivers were enrolled in the study from the time the children were four or six years of age. When the children turned 8-years-old, the caregivers were interviewed and surveyed regarding the children's experiences of ACEs during the first six years of their lives. When the participants were 12-years-old, the participants and their caregivers were interviewed regarding new occurrences of ACEs and the parents' and children's perceptions of the children's current health. Unlike adult-reported studies, this study did not find associations between health concerns at age 12 and ACEs that occurred in the first six years of life. Flaherty et al. found that if five or more ACEs occurred in the second six years of life, participants reported a higher number of health concerns. The authors hypothesized that the health concerns would occur later in life for children who experienced ACEs before the age of 6 and that children who experienced ACES closer to the age of 12 had more immediate health effects (Flaherty et al., 2009).

Thompson et al. (2015) examined the correlation between ACEs and self-reported health concerns with participants who were 18. Using the LONGSCAN database, researchers examined the self-reported health of 18-year-olds. The caregivers were interviewed and asked questions regarding ACEs every other year and at the age of 18 the participants were asked questions about their health. The study began with 1,354 participants but due to attrition and premature ending of funding, complete data was only available for 912 participants. Thompson et al. assessed the health outcome of 18-year-olds in three categories: health worry, medical care, and overall health rating. Of the 912 participants, 802 had exposure to ACEs at the ages of 6, 12, 14, 16, and 18. Participants who experienced chronic ACEs were likely to worry more about their health, need or receive medical attention, and have more overall health problems. The researchers noted that the chronic exposure to ACEs seemed to appear more influential than early or limited exposure to ACEs. In agreement with previous adult reported studies, Thompson et al. concluded that frequently occurring ACEs had an effect on the self-reported health of 18-year-olds.

Overall, findings from these two longitudinal studies demonstrated that the effect of ACEs that occurred only in the first six years of life did not have a strong impact on perceived physical health of adolescents and young adults. However, if the ACEs occurred throughout childhood or closer to when the survey was administered, the impact of the perceived health was higher. Although they did not research older adults, they hypothesized their perceived health score would begin to demonstrate a stronger correlation as the participants aged.

Impact of ACEs During Childhood

While research has been conducted on the effects of ACEs in adulthood, it is important to consider the impact ACEs have during childhood. Although adverse experiences occur during

childhood, there are substantially fewer studies done demonstrating the effects. Each of the following studies provide a focused view of the effects ACEs have on children.

Burke, Hellman, Scott, Weems, and Carrion (2011) examined past medical charts of 701 pediatric subjects to compare the number of reported ACEs to learning and behavior problems in the pediatric population. File reviews revealed 3% of children who experienced zero ACEs, 21% of children who experienced one to three ACEs, and 51% of children who experienced four of more ACEs had reported learning and behavior problems. Children who experienced four or more ACEs had a significantly higher probability of having learning and behavior problems. (Burke et al., 2011).

Although studies have examined the impact of ACEs on older children, currently only one study examined the social emotional impact on children six and younger. Utilizing the National Survey of Child and Adolescent Well-Being (NSCAW) and the Child Behavior Checklist (CBCL; Achenbach, 1991), Clarkson Freeman (2014) examined the prevalence and relationship between ACEs and internalizing, externalizing, and total problems for 2,830 children six years of age and younger. Clarkson Freeman correlated individual ACE categories and CBCL internalizing, externalizing, and total problems subscales to determine how children responded to effects of adverse experiences. Children who did not experience physical abuse were more likely to exhibit externalizing behaviors compared to children who experienced physical abuse. Children who experienced sexual abuse had significantly higher externalizing and total problem scores compared to their internalizing scores. Children who experienced neglect were significantly more likely to have elevated scores across all three scales. Children who lived in a household where a caregiver had a reported mental illness were significantly more likely to score higher on the total problems scale. Children who lived in a home where domestic

violence had occurred were more likely to have a higher score for externalizing problems. Children whose caregivers reported having a criminal history had higher externalizing problems. No significant relationship was reported between the CBCL subscales and caregivers reporting a history of drug abuse. Children raised in married homes were more likely to experience four or more ACEs, whereas children raised in single family homes were more likely to experience two ACEs. Clarkson Freeman examined the correlations and frequency of occurrences of ACE categories among participants. Physical and psychological abuse were the highest reported maltreatment ACEs among participants. Participants were significantly more likely to have experienced other ACEs if physical or psychological abuse were reported. Overall, children who experienced four or more ACEs were 4.87 times more likely to experience internalizing problems, 3.75 times more likely to experience externalizing problems, and 3.6 times more likely to experience total problems. Overall, children who had four or more ACEs were more likely to exhibit problematic behaviors than children who did not experience ACEs (Clarkson Freeman, 2014).

Escueta, Whetten, Osterman, and O'Donnell (2014) examined the psychosocial well-being and cognitive development of orphaned and abandoned children who experienced ACEs in five low income countries. This ongoing longitudinal study began following children ages 6 to 12 living in institutional or community-based settings. Utilizing three years of data, Escueta et al. applied random sampling to identify a sample of 1,480 children who were orphaned or abandoned. Cognitive and learning assessments were administered to determine cognitive development of each participant and the Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997) was administered to examine the psychosocial well-being. Exposure to potentially traumatic events was determined to be an important predictor of emotional

difficulties. Escueta et al. determined that participants with lower cognitive functioning had a significantly stronger correlation with reported behavioral difficulties (Escueta et al., 2014).

Children who experienced multiple ACEs had increased reported emotional difficulties and difficulties. While studies have demonstrated the negative effects of ACEs that occur later in life, adverse effects were also found with children. This body of research established the need for interventions for children who had adverse experiences during childhood.

Trauma and ACEs

Literature supports a strong conceptual relationship between ACEs and trauma (Grasso et al, 2015). SAMHSA (n.d.) connected ACEs to trauma by labeling each adverse experience as an individual traumatic event. Trauma occurs as a result of experiencing adverse or traumatic experiences (SAMHSA, n.d.). The National Child Traumatic Stress Network (NCTSN, n.d.) explains that children are innately in fear of experiencing dangerous situations that are outside of their control. Dangerous experiences can become traumatic when children feel threatened with serious injury or death. The physical and sexual violation of child's body falls within the description of a traumatic experience. Additionally, children witnessing threats to others can be equally as traumatic as experiencing the threats themselves (NCTSN, n.d.).

Cumulative traumatic experiences occur when people experience more than one traumatic event. Cumulative traumatic experiences that occur in childhood may have the same outcomes as ACEs (NCTSN, n.d.). Cumulative trauma categories are similar to ACEs but lack the concrete detail of ACEs categories. Cumulative trauma is an abstract concept without specific parameters or criteria whereas ACEs are comprised of actual events and researched by viewing the effects of multiple occurrences of ACEs. Cumulative trauma research demonstrates the effect select ACEs have on the experiences on children.

Categories of traumatic experiences for children are explained by NCTSN (n.d). Community violence is predatory violence or an act of personal violence between people who are not related to the child. Community violence includes acts of rape, shootings, stabbings, or beating. Community violence occurs in the home community or school community and could lead to fears of being harmed around the community or school (NCTSN, n.d.). Pediatric medical traumatic stress occurs when children or family members undergo a treatment or medical procedure that appears invasive and frightening. Medical trauma could translate into fear of doctors and hospitals (NCTSN, n.d.). Natural disasters include natural incidents that cause damage requiring local, state, or federal agencies to assist. Trauma from natural disasters may increase the fear of those occurrences having a personal impact (NCTSN, n.d.). Terrorism includes a violent act used to intimidate or coerce governments. Similar to natural disasters, trauma occurring as a result of terrorism may increase the fear of being personally harmed (NCTSN, n.d.). Refugee trauma comes from living in a region where exposure to violence is common resulting in being forcefully displaced. Children affected from refugee trauma often mimic the symptoms common among war veterans (NCTSN, n.d.). Traumatic grief involves the loss of someone close and could be sudden or expected. Traumatic grief interferes with children's abilities to go through the natural grieving process (NCTSN, n.d.).

Neglect occurs when an adult caregiver does not provide care a child of that age requires. Neglect can mean poor supervision, withholding food, being without shelter, not providing clothing, or withholding necessary medical and educational services (NCTSN, n.d.). Physical abuse is the act of physically causing harm or attempting to cause harm. Physical abuse may be one single act or an accumulation of violent acts upon the child (NCTSN, n.d.). Sexual abuse occurs when someone older than the child acts in a sexual way toward the child. Sexual abuse

includes sexual kissing, intercourse, touching, fondling of genitals, genital exposure, verbal pressure to have sex, or sexual exploitation (NCTSN, n.d.). Domestic violence encompasses actual or threatened physical or sexual violence as well as emotional abuse between intimate partners (NCTSN, n.d.).

In contrast to individual trauma categories as described above, complex trauma encompasses multiple forms of trauma. Complex trauma is the exposure to prolonged or multiple traumatic events, which occur simultaneously or sequentially, having negative effects on development (NCTSN, n.d). Child maltreatment associated with complex trauma includes: psychological maltreatment, neglect, physical abuse, sexual abuse, and domestic violence. Complex trauma usually begins in early childhood, ages 0 to 6, and occurs from primary caregivers of the child (NCTSN, n.d.). D'Andrea, Ford, Stolbach, Spinazzola, and van der Kolk (2012) refer to traumatic experiences in complex trauma as interpersonal trauma because each occurrence happens within the child-caregiver relationship. Exposure to complex trauma contributes to physical dysregulation which lessens the ability to detect or respond to feelings of danger. Dysregulation can lead to subsequent traumatic experiences in adolescence and adulthood (D'Andrea et al., 2012; NCTSN, n.d.).

Both complex/ interpersonal trauma and ACEs occur during childhood but there are some minor differences in definition. Complex trauma typically begins before the age of six and ACEs can occur at anytime before the age of 18. When a combination of more than one occurrence of psychological maltreatment, neglect, physical abuse, sexual abuse, or domestic violence ACEs begin before the age of six, it can be defined as complex/ interpersonal trauma. However, specific criteria for the number of occurrences to be considered complex has not been defined

whereas ACE categories have been defined and the effects of multiple ACEs on children and adults have been extensively researched.

Research on trauma follows a similar trajectory to research on outcomes related to ACEs. Appleyard, Egeland, van Dulmen, and Sroufe (2005) determined cumulative risk factors occurring in early and middle childhood were correlated with internalizing and externalizing behaviors. Hodges et al. (2013) established that cumulative traumatic events were associated with complex psychological symptomology assessed by child-reported and caregiver-reported assessments. Wright, Fagan, and Pichevsky (2013) concluded that accumulation of exposure to violence was a statistically significant predictor of future alcohol and marijuana use. Tasca et al. (2013) hypothesized that by having at least one occurrence of trauma, the probability of having an eating disorder was exponentially increased. Similar to ACE research conclusions, trauma research indicates a need for early intervention to prevent negative consequences over a person's lifetime.

Evidence-Based Trauma Interventions

Although complex trauma does not have as concise criteria as ACEs, complex trauma is more widely recognized by mental health professionals and correlates to ACEs. Criteria for complex trauma lacks the clear definitions ACEs offer; however, ACEs currently lack evidence-based interventions. Complex trauma is a cumulative exposure to traumatic events, and the evidence based interventions appeared to focus on the whole person rather than a singular traumatic event.

SAMHSA identifies two treatments as evidence-based for complex trauma. Child First is an in home treatment which works with children ages 0 to 6 and their families to help remove the occurrences of abuse and neglect. In order to impact the caregiver-child relationship, Child First

professionals provide services to caregivers to enhance their ability to provide sensitive nurturing parenting. The Child First program strives to: (a) provides parents guidance in understanding normal development; (b) teaches understanding of children's unique abilities; (c) facilitates an understanding of the impact trauma has on children's development and behaviors; (d) teaches therapeutic skills to parents to promote children's understanding of feelings and actions; (e) facilitates age appropriate responses to behavioral challenges; and (f) provides insight to parents about the impact their upbringing and experiences has on the relationship with their children. The 12-month program utilizes weekly visits to the home in order to engage in teaching and providing of services (SAMHSA, n.d.).

The other evidence-based complex trauma intervention recognized by SAMHSA intervention is trauma-focused cognitive behavioral therapy (TF-CBT). TF-CBT is conducted with children 3 to 18 years of age. One stipulation of TF-CBT is current caregivers must not have participated in the trauma causing behavior. The therapist who is trained and certified in TF-CBT works with the non-offending caregivers and children to establish goals and teach skills and techniques. TF-CBT therapists integrate trauma interventions, cognitive principles, behavioral principles, interpersonal skills training, and family therapy to facilitate healing for the whole family. When TF-CBT therapy begins, therapists facilitate therapy with parents and children separately. Once the therapist deems readiness for both parents and children family sessions are integrated into the treatment plans. TF-CBT therapists aim to provide parents and children an atmosphere to practice skills allowing for effective parent-child communication about abuse and related topics (SAMHSA, n.d.).

To date, intervention studies specific to children or adults who experienced ACEs have not been published. However, researchers have recognized the need for evidence based

interventions and proposed possible ways of facilitating healing for children who experienced ACEs. Although intervention research has not been conducted, Purewal et al. (2016) and Murphy et al. (2015) recognize the need for therapeutic interventions that foster development and positive relationships.

Purewal et al. (2016) proposed utilizing a team approach to working with children who experienced ACEs and developed a rationale for screening for ACEs in primary care pediatric settings. Screening for ACEs in childhood promotes healthy development and helps to prevent poor health outcomes throughout the lifespan. By identifying ACEs, health providers are able to place more emphasis on interacting with the children, caregivers, and educators in order to foster positive development and prevent the ACEs for having lasting impact on brain development (Purewal et al., 2016).

Although intervention studies for children who have experienced multiple ACEs have not been conducted, Murphy et al. (2015) proposed utilizing group attachment-based intervention (GABI) for families who reported ACEs. They hypothesized GABI has the potential be effective with families who have infants and toddlers. GABI is designed to teach families how to think about thoughts and feelings of another person, emotionally attune to family members, manage feeling states, recognize feelings and emotions, and understand family trauma history. GABI is delivered in a group format and the providers are trained to be nurturing, sensitive, and responsive. Research has not been conducted to show the effectiveness; however, Murphy et al. suggested the reparative nature of GABI would positively effect the population due to attachment disruptions within families who have experienced ACEs.

The current evidence-based trauma interventions for children, adolescents, and adults do not include research for ACEs. Matching treatment to number and type of ACEs appears absent

from the literature. Research on trauma intervention highlights the importance of education and and skill-building but fails to emphasize the importance of self-expression and self-directed nature of healing. Considering that research on the presence and negative effects of ACEs spans almost 20 years and current trauma-informed interventions focus on educational components, intervention outcome research to address the needs and developmental levels of children who have experienced ACEs seems necessary and overdue.

Child-Centered Play Therapy

Virginia Axline (1947) created nondirective or child-centered play therapy based on the person-centered theory developed by Carl Rogers. Utilizing the core conditions of person-centered theory; congruence, empathic understanding, and unconditional positive regard, Axline created a space for children to be heard and understood. Responses were provided with therapeutic intention of allowing children to be in the lead with relationship as the facilitator of change. Garry Landreth (2012) continued the development and understanding of child-centered play therapy. Landreth proposed children do not communicate the same way as adults and therefore should be given the opportunity to make sense of their world in the way they communicate. The language of the the child is play and therefore toys are the words (Landreth, 2012). In order to facilitate a wide vocabulary of play, he created specific toy lists which allowed the child to utilize the toys in a therapeutic manner. Toys take on the meaning the child deems necessary, and the variety of toys open up the communication. Because children's language development is still developing, toys are used as the primary method for communication. Children utilize play as their primary method of communication which makes the use of verbal language less necessary. While the toys are important, the safety of relationship between child and therapist allows communication to occur (Landreth, 2012). Child-centered play therapists

hold the belief children innately have the capacity within them to work through and make sense of maladaptive behaviors when provided with the necessary environment (Landreth, 2012).

Relationships between therapists and children are crucial for healing to occur in therapy. CCPT therapists provide the core conditions of person-centered theory; congruence, empathic understanding, and unconditional positive regard to create a therapeutic relationship with children (Landreth, 2012). Children hold the self-actualizing ability within them to change and grow, and given the safe environment, children are able to reach their full potential (Ray, 2011). While children guide and lead the play, therapists actively engage in the forming and maintaining the relationship (Landreth, 2012). Through the therapeutic relationship, children become self-accepting and establish a deeper understanding of themselves which fosters the ability in children to change and grow in the ways they need (Ray, 2011).

Theoretical Implications of CCPT for Children Who Have Experienced ACES

Infants are born with an organismic valuing process which provides the ability to detect whether something is good or safe (Wilkins, 2010). Infants are naturally attuned to their organismic valuing processes; therefore, they are automatically attuned to recognizing safety and danger (Wilkins, 2010). According to person-centered theory, infants self-structures are fully congruent and flexible. Self-structure is an organized formation of opinions of the self that are admitted into awareness (Turner, 2012). Infants are born with natural tendencies to move toward the positive. New information is taken into their awareness and they are able to judge whether something is enhancing to the organism. Their self-actualizing tendencies continue to move them in positive directions.

As children grow and develop, influences from others pull them away from their natural organismic valuing process. Although it still remains, they become less attuned to their

organismic valuing process, placing higher emphasis on what others value (Turner, 2012). As children's organisms develop they continue to have an innate tendency to move toward the positive (Rogers, 1951). Self-actualizing tendencies lead to the striving toward fully actualizing and understanding of self. If the right conditions are met, the self-actualizing tendency within each child propels the child toward positive self-enhancing ways of being. Yet, through interactions with others, conditions of worth are created. Children begin to hold beliefs of only being accepted when certain conditions placed by others are met. Self-structure begins to change forming the self-concept; the way they view themselves and actual experiences and the ways in which experiences actually occur (Wilkins, 2010). Whereas infants take in experiences wholly, children begin to take in their experiences through a new understanding of themselves that has been created through their conditions of worth (Bohart, 2013). Children become incongruent because they no longer take in all experiences as actual experiences, instead they are taken in through the way they see themselves (Wilkins, 2010).

When trauma occurs in adulthood, adults typically have a previous self-structure that allows them to recognize the changes in structure (Turner, 2012). However, when multiple traumatic or adverse experiences occur during childhood, there is a potential for a breakdown of the self-structure (Hawkins, 2014). Although children are the center of a continually changing world of experience (Rogers, 1951), children who experienced ACEs may not have a continually changing world. Their world of experience is built around fear and harm and is continually reinforced by those around them. Children who experienced ACEs may have actual experiences and self-concepts that align which look like congruence. Experiences are taken in exactly as they occur. Children who experience ongoing adverse and traumatic experiences live in a world of fear (Hawkins, 2014). While typical self-structures are fluid and allow for new experiences to

help shape the way children view experiences (Rogers, 1951), self-structures of children who have ongoing adverse or traumatic experiences are likely to be rigid. Negative ways in which they view themselves will align with the actual ways they are treated. Understanding of the world and the reality they are confronted by will be viewed through a more negative lens. Although their organisms seek to actualize (Rogers, 1951), actualization is halted by their fears. Negative behaviors are used to confirm the rigid self-structure. Emotions accompany behaviors needed for enhancement of the organism (Rogers, 1951); however, the emotions may be less obvious with children who had traumatic and adverse experiences. In order to stay fully consistent with their concepts of self, children only let in experiences that confirm their existing self-structures (Wilkins,2010).

Children who had multiple or ongoing adverse and traumatic experiences are likely to have a rigid self-structures, and may appear younger or older than their developmental age. Through enduring long-term negativity, children adapt their behaviors in order to have their needs met. Behaviors insure that others will treat them in the ways they are accustomed to and that match their experiences (Clarkson Freeman, 2014). Ongoing confirmation of negativity continues to serve the purpose of maintaining the rigidity of the self-structure.

Children who have experienced multiple or ongoing ACEs are in need of experiences that contradict the traumatic experiences that have influenced their self structures. When receiving ongoing new experiences, children are faced with the dilemma of allowing them into their self-structures which weakens rigidity, therefore causing a state of incongruence. Child-centered play therapy provides the conditions necessary to allow children to receive new experiences to facilitate their healing.

Rogers (1957) stated there are six necessary and sufficient conditions that had to be met for to healing occur. These therapeutic conditions are: 1) psychological contact between two people; 2) incongruence from the client; 3) a congruent therapist; 4) unconditional positive regard for the client is conveyed by the therapist; 5) therapist experiences empathic understanding for the client; and 6) the client receives the congruence, unconditional positive regard, and empathic understanding communicated by the therapist (Rogers, 1957). When the six necessary and sufficient conditions are present in the therapeutic process, healing transpires (Rogers, 1957). As counselors, it is easy to mistakenly believe that the six necessary and sufficient conditions are being met based on counselors' views of providing the therapist attitudinal conditions of congruence, empathic understanding, and unconditional positive regard. Although providing therapist attitudinal conditions are important to healing, all six necessary and sufficient conditions must be met for healing to occur (Wilkins, 2010).

When children who experienced traumatic and adverse experiences enter a therapeutic setting, they may have difficulty experiencing psychological contact. Because psychological contact is required for healing to occur, it is important that it is made within the therapeutic relationship. Van Werde and Prouty (2013) proposed the use of pre-therapy with adults who were unable to establish contact. Contact reflections are concrete in nature and succinctly focus on what people are doing, saying, or feeling (Van Werde & Prouty, 2013). Pre-therapy contact reflections resemble tracking, reflecting content, and reflecting feeling skills utilized in CCPT (Landreth, 2011). Therefore, if children are unable to make psychological contact, focusing on tracking, reflecting content, and reflecting feeling will provide the space necessary for the child and therapist to develop or restore contact while the therapist conveys unconditional positive regard and empathy (Van Werde & Prouty, 2013).

When children who have experienced adverse and traumatic experiences first enter therapy their self-structures may be rigid, The act of therapy will eventually cause a state of incongruence. Rogers (1951) proposed that when experiences occur they are either integrated into the perception of self, ignored because they do not fit the current self-structure, or denied or given distorted meaning because the experience is not consistent with the current self-structure. Therefore, core conditions may be rejected or given a distorted meaning for children to protect and preserve their self-structures.

Patience from the therapist throughout the process is of the utmost importance. Recovering from adverse or traumatic experiences can be a long process due to the experiences children have endured. Once the six necessary and sufficient conditions have been met, children must still face the incongruencies created from therapy. The process of healing from adverse or traumatic experiences can take a long period of time, therefore the therapist should understand the lengthy process and remain patient throughout therapy.

Although CCPT can be a lengthy process, the consistent attendance of clients is likely to lead to healing. As a child slowly perceives and integrates the therapist attitudinal conditions, he or she is able to form a new self-structure. When counselors are free of expectations while unconditionally positively regarding clients, children are able to grow and develop (Rogers, 1957). Although their self-actualizing tendency may have been halted, it is still a dynamic force inside of them. By having the six necessary and sufficient conditions met, a child can begin to integrate new experiences and establish a more fluid self-structure (Ray, 2011). The fluidity of self-structure will provide them with abilities to accept more positive experiences without rejecting them fully.

Summary of Child-Centered Play Therapy Research

Meta-analytic reviews were conducted to provide a broader understanding of the effectiveness of play therapy. Bratton, Ray, Rhine, and Jones (2005) conducted a meta-analytic review of play therapy interventions. They reviewed 93 treatment-control play therapy interventions and found a large mean effect size of .80. Nondirective humanistic play therapy was reported to be an effective intervention with children who suffered from emotional and behavioral difficulties (Bratton et al., 2005). Lin and Bratton (2015) conducted a meta-analytic review of 52 treatment-control studies utilizing CCPT approaches. They reported an overall moderate effect of .47, finding children who received play therapy had a better outcome than children who received a different treatment or did not receive treatment (Lin & Bratton, 2015). Ray, Armstrong, Balkin, and Jayne (2015) conducted a meta-analytic review of 23 CCPT treatment-control studies conducted in the schools. A moderate effect size was reported with statistically significant differences between the treatment and control groups (Ray et al., 2015). The three meta-analyses demonstrated significant changes for the participants who received CCPT interventions; reporting children who received play therapy were more likely to demonstrate improvement when compared to control groups.

Child-Centered Play Therapy and ACEs

CCPT intervention research has not investigated the combination of ACEs as a whole. However, intervention research has been conducted on the individual ACEs of sexual abuse, witnessing domestic violence, and refugee trauma. CCPT research was also conducted with children who lived in poverty. Although poverty is not considered an ACE, Wade et al. (2016) demonstrated that living in poverty was correlated to experiencing ACEs; therefore, an intervention study with poverty has been included.

Witnessing domestic violence is a singular category of ACEs household dysfunction. Kot, Landreth, and Giordano (1998) utilized intensive CCPT with children who witnessed domestic violence. Experimental and control groups of children who lived in domestic violence shelters were compared. The experimental group participated in 12 sessions of play therapy over the span of 12 days to three weeks and the control group did not receive intervention. Pre and post assessments were administered to children and their caregivers. The children's self-concept was evaluated using the Joseph Preschool and Primary Self-Concept Scale (JSCS; Joseph, 1979) and internalizing, externalizing, and total behaviors were measured with the Child Behavior Checklist (CBCL; Achenbach, 1991). The experimental group demonstrated a statistically significant increase in self-concept and a statistically significant reduction of externalizing and total behaviors on the CBCL. The control group had an increase in internalizing, externalizing, and total behaviors. The statistically significant increase in self-concept and reduction in behaviors demonstrated the effectiveness of CCPT with children who witnessed domestic violence. Kot et al. hypothesized the therapeutic relationship provided the opportunity for children to find meaning and in turn decrease problem behaviors. The decrease of problem behaviors allowed the mothers to build a closer relationship with their children; therefore, continuing the decrease of problem behaviors.

Sexual abuse is considered a singular ACE with only one occurrence necessary to deem it an ACE. Scott, Burlingame, Starling, Porter, and Lilly (2003) conducted 7 to 13 CCPT sessions with 26 three to nine-year-olds who were sexually abused. The researchers utilized pre and post parent and child reports to understand the effects of CCPT with children who experienced sexual abuse. While the child self-report results showed progress, the parent reports did not show significant changes. Scott et al. hypothesized children began to feel different before

external changes were observable by parents. Children who experienced play therapy were provided with an environment where they felt positively regarded; therefore, the participants were able to view themselves in a more positive way.

Schottelkorb, Doumas, and Garcia (2012) compared the effectiveness of CCPT to trauma-focused cognitive behavioral therapy (TF-CBT) which was an already established evidence-based intervention. Currently this is the only study that utilized CCPT to label the experiences as traumatic. Traumatized refugee children were randomly assigned to either CCPT or TF-CBT. The traumatic symptoms were evaluated at the beginning and end of the interventions using a parent and child reports. CCPT was administered for 12 weeks with the children participating in two thirty-minute sessions per week and included six 15-minute parent consultations.TF-CBT was administered for 9 weeks with the children participating in two thirty-minute sessions per week. Both groups demonstrated a statistically significant decrease on severity rating on both the child and parent assessments. Schottelkorb et al. established CCPT had a statistically significant impact with children who suffered from refugee trauma.

Bratton et al. (2013) examined the effectiveness of CCPT with 54 children enrolled at a low-income preschool. The researchers used block randomization to assign the participants to one of two groups, CCPT or reading mentoring (RM). Both groups received the interventions for 30 minutes twice a week. All children received at least 16 sessions. Unaware of the group assignments, teachers filled out the Caregiver-Teacher Report Form (C-TRF; Achenbach, 1997) at pre, middle, and post time increments. The CCPT group had a statistically significant decrease of disruptive behaviors compared to the RM group. A post hoc analysis of the CCPT group demonstrated a statistically significant decrease in aggression and attention problems. Bratton et

al. demonstrated the effectiveness of using CCPT to reduce problem behaviors of children in lower socioeconomic preschools.

CCPT has demonstrated effectiveness across multiple populations. While research has not been conducted with children who experienced multiple ACEs, research has been conducted with children who experienced one ACE or were in environments where ACEs were likely to occur. CCPT was effective with each individual ACE, refugee trauma, and low income environments lending to the hypothesis that CCPT may be effective with children who experienced multiple ACEs.

Conclusion

There have been a multitude of studies examining the ramifications of ACEs in adults. Correlations were found between ACEs and at-risk behaviors in adults. As the number of ACEs increased, the correlations to at-risk behaviors became stronger. Increases in mental and physical health symptoms occurred with people who experienced multiple ACEs. When children experienced multiple ACEs there was an increased chance of severe ramifications in adulthood.

Fewer studies have been conducted examining the implications of ACEs for children and adolescents. Mental and physical health problems were prevalent in children who experienced a high number of ACEs. Clarkson-Freeman (2014) indicated social emotional problems occur during and after the experience of multiple ACEs. As ACEs occur early and endure over long-term, the likelihood of childhood problems increases. However, if the problems do not occur immediately, it is hypothesized adverse effects will manifest later in life.

Studies on the impact of intervention on the social and emotional concerns of children who experience multiple ACEs have not been conducted. Research studies have demonstrated CCPT as being effective with individual ACEs and refugee trauma. Marie-Mitchell et al. (2016)

stated there was a need for early intervention with children who experienced ACEs while Murphy et al. (2015) proposed a need for an intervention that fosters connection and attachment. In CCPT the therapists' utilization of the core conditions fosters connections and relationships in a safe therapeutic environment. Therefore, CCPT has potential of being an effective intervention with children who have experienced multiple ACEs.

APPENDIX B

EXTENDED METHODOLOGY

The purpose of this study was to investigate the impact of Child-Centered Play Therapy (CCPT) on children who have experienced four or more Adverse Childhood Experiences. Specifically, the researcher examined the effectiveness of CCPT on the child's level of emotional symptoms, conduct problems, hyperactivity and inattention, peer relationship problems, post traumatic stress, and prosocial behavior. The researcher used experimental single-case design. The proposed methodology is outlined below including: research questions, selection of participants, instrumentation, treatment procedures, data collection, and data analysis.

Research Question

What is the impact of Child-Centered Play Therapy (CCPT) on emotional symptoms, conduct problems, hyperactivity and inattention, peer relationship problems, prosocial behavior, and posttraumatic stress of children who experienced four or more Adverse Childhood Experiences (ACEs)?

Operational Definitions

Adverse Childhood Experiences (ACEs)

Adverse childhood experiences (ACEs) are stressful or traumatic events, including abuse and neglect. They may also include household dysfunction such as witnessing domestic violence or growing up with family members who have substance use disorders (SAMHSA, n.d.). ACEs are strongly related to the development and prevalence of a wide range of health problems throughout a person's lifespan, including those associated with substance misuse. For the purposes of this study, ACEs were defined by the Adverse Childhood Experiences Checklist (Felitti, 1998; modified version).

Child-Centered Play Therapy (CCPT)

Landreth (2012) defined CCPT as "a dynamic interpersonal relationship between a child (or person of any age) and therapist trained in play therapy procedures to provide selected play materials and facilitates the development of a safe relationship for the child (or any person of age) to fully express and explore self (feelings, thoughts, experiences, and behaviors) through play, the child's natural medium of communication, for optimal growth and development" (p. 11). For the purposes of this study, the CCPT manual (Ray, 2011) was used to operationalize CCPT.

Emotional Symptoms

In accordance with the Strengths and Difficulties Questionnaire (SDQ), Goodman, Lamping, and Ploubidis (2010) described emotional symptoms as somatic complaints, worrying, perception of unhappiness, clinginess, fears, and preferring being solitary (Goodman et al., 2010). For the purposes of this study, emotional symptoms were operationalized by the Emotional Symptoms subscale score on the SDQ.

Conduct Problems

In accordance with the SDQ, Goodman et al. (2010) described conduct problems as having a temper, being disobedient, fighting, lying, and stealing (Goodman et al., 2010). For the purposes of this study, conduct problems were operationalized by the Conduct Problems subscale score on the SDQ.

Hyperactivity/Inattention

In accordance with the SDQ, Goodman et al. (2010) described hyperactivity and inattention problems as being restless or fidgety, fighting, lying, and stealing (Goodman et al.,

2010). For the purposes of this study, hyperactivity/ inattention symptoms were operationalized by the Hyperactivity/Inattention subscale score on the SDQ.

Peer Relationship Problems

In accordance with the SDQ, Goodman et al. (2010) described peer relationship problems as not being a good friend, being bullied, preferring to be alone, and preferring adult interactions. (Goodman et al., 2010). For the purposes of this study, peer relationship problems were operationalized by the Peer Relationship Problems subscale score on the SDQ.

Prosocial Behavior

In accordance with the SDQ, Goodman et al. (2010) described prosocial behavior as being considerate, sharing with others, caring about others, kind to children, and helping out (Goodman et al., 2010). For the purposes of this study, prosocial behavior was operationalized by the Prosocial Behavior subscale score on the SDQ

Posttraumatic Stress

Posttraumatic stress is the presence of significant emotional stress or disorganized behavior following the witnessing/experiencing of a trauma (Briere, 2005). For the purposes of this study, posttraumatic stress was operationalized by the Posttraumatic Stress subscale score on the Trauma Symptoms Checklist for Young Children (TSCYC).

Participants

Research participants included two children recruited from a university-based counseling clinic that served community clients located in the southwest United States. The clinic is an instructional and training based clinic that serves clients across the lifespan. The majority of clients (60%) are children under the age of 12. Child clients served through the clinic typically come from families of low socioeconomic status and low educational attainment. Participants for

the current study met the following inclusion criteria: 1) Between ages 4 to 9 years old; 2) Score of 4 or higher on the *Adverse Childhood Experiences Checklist*; and 3) Not participating in other forms of counseling over the course of the study. Four participants were initially identified for participation. However, two of the participants who were also siblings were dropped from the study due to home disruption during the course of the study resulting in completion of the study by two participants. Individual information for each participant is listed below. Pseudonyms were used to help maintain confidentiality.

Participant 1

Justin was an 8-year-old White American male who resided with his biological mother, sister, and maternal grandmother. Background information was reported by Justin's mother. Justin qualified for the study due to his exposure to eight categories of ACEs including emotional abuse, emotional neglect, physical neglect, domestic violence, household substance abuse, household mental illness, parental separation, and incarcerated household member.

Prior to divorce between Justin's mother and father, Justin witnessed domestic violence between his father and mother. On one occasion, his father choked his mother in front of him. After the divorce and while living with his father, Justin's father swore at him and was verbally aggressive toward his mother and sister in Justin's presence. Justin's mother reported that his father frequently verbally denigrated his mother when talking to Justin on the phone. Justin's father abused methamphetamine and alcohol. He was incarcerated multiple times for drugs and violence against Justin's mother and her property. Additionally, Justin's father regularly drove under the influence while Justin was in the car. Justin's father had a history of depression and was openly suicidal in Justin's presence. Justin also verbalized negative thoughts about his self-worth and felt responsible for mediating between his parents. At intake for participation in the

current study, Justin's mother reported that Justin verbalized wanting to live with his father despite his fears and often blamed his mother for his father's behavior. Justin's mother reported that Justin had difficulty regulating emotions and cried and screamed at school. She was often asked to pick him up from school due to his difficulty.

Participant 2

Megan was a 9-year-old White American female who resided with her biological father, step-mother, and multiple siblings who were step-siblings or half-biological siblings. Background information was reported by Megan's father and step-mother. Megan qualified for the study due to her exposure of eight categories of ACEs including sexual abuse, emotional neglect, physical neglect, domestic violence, household substance abuse, household mental illness, parental separation, and incarcerated household member.

Megan's biological mother and father were separated when she was an infant. Her biological mother accused her father of sexually abusing Megan resulting in invasive medical examinations. However, there were no findings that Megan's biological father was physically abusive. As a young child, Megan witnessed her mother being physically abused by her mother's boyfriend. Her biological mother's boyfriend was incarcerated on multiple occasions. During custodian visits with her mother, Megan was often unsupervised and found with dirty clothes and diapers when picked up by her father. Megan's biological mother died from a drug overdose when Megan was three years old. Megan's father and step-mother reported both being diagnosed with depression and anxiety and her biological mother was diagnosed with bipolar disorder prior to her death. At intake for the present study, Megan's father reported that Megan frequently expressed low self-worth and lack of belonging in her family.

Instrumentation

Adverse Childhood Experiences (ACEs) Checklist

The original ACE Checklist (Felitti et al., 1998) is a 10-item checklist that assesses adults for the past experiences of ACEs. The total number of ACEs checked provides participants with their ACE numbers. Felitti et al. (1998) introduced the original ACEs adult checklist, which included items related to physical abuse, sexual abuse, emotional abuse, emotional neglect, physical neglect, mental illness, substance abuse, separation/ divorce, domestic violence, and incarceration. Wade et al. (2016) modified the adult checklist to incorporate extended ACEs, which included witnessing violence, felt discrimination, lack of neighborhood safety, feeling bullied, and living in foster care. The original checklists were designed for adults to answer about their childhoods. For the purposes of the present study, the ACE Checklist was modified for language in order to use present tense language for parents to complete items regarding their children. For example, the original ACE checklist (Felitti et al., 1998) asked, "Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?" The question was rewritten to state, "Has your child lived with anyone who is/ was a problem drinker, or alcoholic or had a problem with street drugs or prescription drugs?" The ACE Checklist (Cronholm et al., 2015) included the original 10 ACEs (Felitti et al., 1998) and extended ACEs identified by Wade et al. (2016). For clarity purposes, wording chosen for the study was derived from both checklists. All of the original ACEs were included and I extended the checklist to include placement in foster care resulting in the ACE Checklist – modified (See Appendix F).

Strengths and Difficulties Questionnaire (SDQ)

Strengths and Difficulties Questionnaire (SDQ: Goodman, 2001) is a 25-item assessment completed by parents/caregivers and used to identify behavioral problems and interpersonal strengths of children four to seventeen years of age. The SDQ Total Difficulties score is a

composite of four subscales including Emotional Symptoms, Conduct Problems, Hyperactivity and Attentional Difficulties, and Peer Relationship Problems. The Total Difficulties score can range from 0 – 40. An additional fifth subscale indicates Prosocial Behavior. Higher total difficulties scores have been correlated to greater psychopathology (Goodman & Goodman, 2009). Normative data for the parent questionnaire was obtained on 10,298 children aged 5 to 15 living in urban, suburban, and rural areas; consisting of 50% female and 50% male participants. The sample respondents included biological parents, adoptive parents, step-parents, and grandparents. Goodman (2001) reported internal consistency reliability coefficients for scales ranging from .41 to .87, with .82 for the total parent score. Factor analyses support the five-factor solution. The reported mean test-retest reliability for the SDQ is r =.72 while the mean internal consistency is α = .71 (NCTSN, n.d.). For the current study, the SDQ total score was used as the weekly measurement of behaviors for the participants.

The Trauma Symptom Checklist for Young Children (TSCYC)

The Trauma Symptoms Checklist (TSCYC; Briere, 2005) is an assessment used to evaluate posttraumatic stress and consists of 90 questions and eight subscales including: Anxiety, Depression, Anger/ Aggression, Posttraumatic Stress-Intrusion, Posttraumatic Stress-Avoidance, Posttraumatic Stress-Arousal, Dissociation, Sexual Concerns. The subscales result in an overall Posttraumatic Stress score (Briere, 2005). Normative data for the parent questionnaire was obtained on 219 children with a mean age of 7.1 years including 62% females and 38% males. The racial composition was 38% Non-Hispanic Caucasian, 25% Black/ African American, and 28% Hispanic. The norming sample included children who had been exposed to abuse and were recruited from child advocacy centers, child abuse programs, or child trauma centers. Internal consistency alphas were reported as ranging from .73 to .86. The test-retest reliability for the

TSCYC correlation coefficients ranged from .68 to .96 with a median r = .88 (Briere, 2005). For the purposes of the current study, the TSCYC total score was used a descriptive measurement of change from pre to post test across the duration of the study.

Procedures

The researcher gained human subjects approval by the University of North Texas Institutional Review Board (IRB) prior to beginning the study. Additionally, parents received and signed informed consent for participants prior to beginning the study. I utilized a single case experimental design for measurement of treatment effectiveness with a reversal/withdrawal ABA design. In order to recruit participants, I examined intake documentation of children ages four to nine who presented to the clinic for services. Upon determination of the children having a strong probability of experienced ACEs based on intake caretaker report, I contacted the caregivers to provide an overview of the study and inquire about interest in participation. If parents indicated interest, I set up parent interviews in which I gained background information, consent to participate (Appendix E), and determined eligibility through the use of the ACEs checklist-modified (Appendix F). Of 6 children identified as potential participants, 4 met criteria of reporting four or more ACEs. For those 4 children, parents/guardians completed the initial TSCYC and SDQ. Parents continued to complete the SDQ weekly for a minimum of three weeks to establish a baseline during which time the participants received no treatment. Over the course of the study, two of the participants were removed from the study due to disruption in the home environment. For both participants completing the study, consistent baseline was established at six weeks. Once a consistent baseline was established, the treatment phase began.

During the treatment phase, participants participated in 24 play therapy sessions held bi-weekly for 45 minutes each. Occasionally, participants only engaged in one play therapy session

due to participant or play therapist illness. The participants did not engage in play therapy for two weeks due to holiday vacations. Parents continued to complete the SDQ weekly. At the 12-session midpoint and following the 24th session, parents/guardians completed the TSCYC. After completion of the 24th session, final interviews (Appendix G) were conducted with the caregivers to gather information about caregivers' and children's experiences of CCPT. Following the 24th session, the SDQ was completed for four weeks during the follow-up phase during which parents/guardians and children did not receive services. Table B.1 provides information for each participant's procedure during this study.

Table B.1.

Participant Protocol Across Phases

Participant	Baseline	Treatment		Parent Consultation	Follow-Up
	# of Weeks	# of Weeks	# of Sessions	# of Sessions	# of Weeks
Justin	6	13	24	6	4
Megan	6	12	24	6	4

Description of CCPT Intervention

CCPT intervention was facilitated by one play therapist who is an advanced doctoral student in a CACREP-accredited counselor education doctoral program. She completed two and a half years of doctoral work in counseling, 23 hours of graduate-level coursework in play therapy, and had 5 years of experience utilizing child-centered play therapy. Additionally, she was a licensed professional counselor intern and certified school counselor. She participated in weekly supervision of play therapy with a doctoral level faculty member who is a licensed professional counselor supervisor and a registered play therapist supervisor.

Each child was scheduled to receive 45 minutes of individual CCPT twice a week for 12 weeks. In order to ensure treatment adherence, the Play Therapy Skills Checklist (PTSC; Ray, 2011) was used to review one session per week for each child. A rater trained in PTSC procedures viewed 15 minutes of each session and rate using the PTSC. Threshold for fidelity adherence is met when ratings fall at 80% or higher on adherence to protocol (Ray, 2011). For the current study, fidelity adherence was 96%.

For play therapy sessions, the playroom was equipped according to Ray's (2011) Child Centered Play Therapy Manual. Each room used was equipped with a video camera to provide the opportunity to check for fidelity. The rooms varied in size but were equipped with toys and materials recommended by Landreth (2012) which are detailed in Table B.2.

Table B.2.

Toys in Playroom

Balls (large and small)	Nursing bottle (plastic)
Band-Aids	Pacifier
Barbie doll	Paints, easel, newsprint, brushes
Bendable doll family	Pitcher
Blunt scissors	Play camera
Bobo (bop bag)	Play money and cash register
Broom, dustpan	Pots, pans, silverware
Building blocks (different shapes and sizes)	Puppet theater
Cereal boxes	Purse and jewelry
Construction paper (several colors)	Rags or old towels
Crayons, pencils, paper	Rope
Cymbals	Rubber knife
Dart gun	Rubber snake, alligator
Dinosaurs, shark	Sandbox, large spoon, funnel, sieve, pail
Dishes (plastic or tin)	School bus (Fisher Price type)
Dishpan	Soap, brush, comb
Doll bed, clothes, blanket	Spider and other insects
Doll furniture	Sponge, towel
Dollhouse	Stove (wood)
Dolls, baby clothes	Stuffed animals (two or three)
Dress-up clothes	Telephone (two)
Drums	Tinker toys

Egg cartons	Tissues
Empty fruit and vegetable cans	Tongue depressors, popsicle sticks
Erasable nontoxic markers	Toy noise-making gun
Flashlight	Toy soldiers and army equipment
Hand puppets	Toy watch
Handcuffs	Transparent tape, nontoxic
Hats - fireman, policeman, tiara, crown	Truck, car, airplane, tractor, boat, ambulance
Lone Ranger-type mask and other masks	Watercolor paints
Medical kit	Xylophone
Medical mask	Zoo animals and farm animal families

CCPT therapists provide the therapist attitudinal conditions of person-centered theory including congruence, empathic understanding, and unconditional positive regard to create a therapeutic relationship with children (Landreth, 2012). In the CCPT protocol, Ray (2011) established eight categories of therapeutic verbal responses: (a) tracking behavior; (b) reflecting content; (c) reflecting feeling; (d) facilitating decision making, returning responsibility; (e) facilitating creativity, spontaneity; (f) esteem building, encouraging; (g) facilitating relationship; and (h) limit-setting. The study utilized therapeutic verbal responses and nonverbal body language to embody the attitudinal conditions.

Parent Consultation

In order to ensure consistency with CCPT, parent consultations were conducted for thirty minutes biweekly, in addition to the CCPT sessions. Schottelkorb, Swan, and Ogawa (2015) created a child-centered parent consultation model that was utilized to maintain consistency for the therapist. The five components of the parent consultation model are: 1) creating and maintaining the therapeutic relationship with parents; 2) demonstrating an awareness and understanding by listening and responding; 3) honoring parents as the experts of their children; 4) providing pertinent knowledge; and 5) teaching therapeutic skills. Parent consultations followed the five components of the model in order to provide parents with information about

their child and the therapeutic process while teaching skills deemed necessary to help facilitate the child-parent relationship. Schottelkorb, Swan, and Ogawa (2015) suggested a session format in order to insure the five components are met. The first parent consultation session focused on the building of the relationship and gathering a deeper understanding of the child. Each subsequent session continued to build the relationship, gaining and providing understanding of the child; and teaching therapeutic techniques relevant to each individual. Final parent consultation sessions consisted of the parents and therapist reporting progress and changes witnessed throughout the process (Schottelkorb, Swan, & Ogawa, 2015).

Data Analysis

Using weekly data gathered from the SDQ, I used visual data analysis to examine predictable baseline patterns, data within each phase, data between each phase, and integration of data between all phases (Ray, 2015). Following the standards from What Works Clearinghouse on Single Case Design studies (Kratochwill et al., 2013), I analyzed and reported the following: 1) the level of each phase which is the mean of each phase; 2) the trend which is the slope of data between each phase; 3) the variability which is the difference between the trend and individual data points; 4) the immediacy of effect which measures how quickly there was an effect with the intervention; 5) the consideration of overlap which compares how much one phase overlaps with another one; and 6) the consistency of data patterns across the phases (Ray, 2015). In order to find the strength of the relationship between variables, I calculated effect size using Nonoverlap of All Pairs (NAP; Parker & Vannest, 2009) and interpreted according to the following criteria: 0-.65 weak effect size, .66-.92 medium effect size, and .93-1.0 strong effect size (Parker & Vannest, 2009). Data from the TSCYC was used descriptively to provide further information of change over duration of the study.

APPENDIX C

UNABRIDGED RESULTS

This study utilized a single-case design to examine the impact of child-centered play therapy (CCPT) on children who experienced four or more adverse childhood experiences (ACEs). More specifically, the measure used was designed to assess emotional symptoms, conduct problems, hyperactivity and attentional difficulties, and peer relationship problems, as well as generate a total difficulties score for each individual. For these subscales, lower numbers indicate a reduction in problem behaviors. In addition to difficulty subscales, this measure examined prosocial behavior for which higher numbers indicate improvement in prosocial behaviors. In this section, I present the findings for each individual participant, including the results of visual analysis and information gathered from follow-up parent interviews. After using scoring software to score each assessment, I graphed each participant's scores from the SDQ on separate graphs. The SDQ included the following seven subscales: Emotional Symptoms (ES), Conduct Problems (CP), Hyperactivity and Attentional Difficulties (HAD), Peer Relationship Problems (PRP), Prosocial Behavior (PB), and Total Difficulties. After utilizing visual analysis, I calculated effect sizes for Total Difficulties using the Nonoverlap of All Pairs (NAP) statistic.

Participant 1: Justin

Justin participated in 6 weeks of a non-intervention baseline phase, 13 weeks of intervention phase where he participated in 24 play therapy sessions, and 4 weeks of a non-intervention follow-up phase. Table C.1 provides the means and standard deviations for each subscale in each phase of the study. For five subscales, Emotional Symptoms, Conduct Problems, Hyperactivity and Attentional Difficulties, Peer Relationship Problems, and Total Difficulties, means continually decreased across all phases of the study demonstrating improvement. The means of Prosocial Behavior increased across all phases demonstrating improvement. Figure C.1 provides a graphical representation of all data.

Table C.1.

Means and Standard Deviations for Justin's SDQ Scores

Subscale	Baseline		Intervention		Follow-Up	
	M	SD	M	SD	M	SD
Emotional Symptoms	7.83	.75	2	3.32	.25	.5
Conduct Problems	4.33	.52	1.77	1.17	.5	.58
Hyperactivity/Attention Difficulties	9.67	.52	5.78	1.89	2.25	1.26
Peer Relationship Problems	4.5	.84	2.08	1.66	0	0
Prosocial Behavior	5.44	.79	7.23	1.48	9.5	1
Total Difficulties	26.5	1.22	11.69	7.60	3	.82

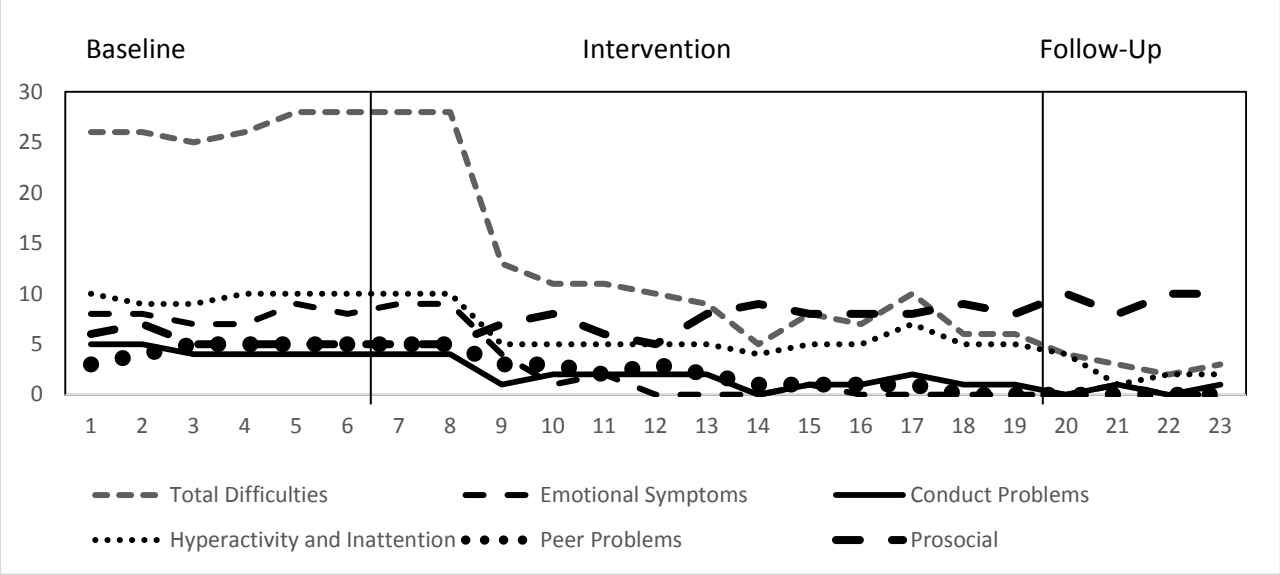

Figure C.1. Justin's SDQ scores during baseline, intervention, and follow-up phases

Justin's mother completed an SDQ each week that generated one score for each of the subscales. I separately evaluated each subscale by assessing the level, trend, variability, immediacy of effect, and overlapping data. In addition to visual analysis, I calculated the NAP for Total Difficulties.

Emotional Symptoms

Figure C.2 presents the data levels and trend for Emotional Symptoms across phases of the study. Level analysis of graph indicated a decrease from a mean of 7.83 in the baseline phase to 2 in the treatment phase followed by another decrease to .25 in the follow-up phase. Trend analysis revealed a downward trend across the baseline and treatment phase of the study with a large correlation (R^2=.77), indicating a large relationship between play therapy phase and Justin's decrease in emotional symptomology. Analysis of variability between conditions revealed moderate variability between phases with standard deviations (SD) of .75 in the baseline phase, 3.32 in the intervention phase, and .5 in the follow-up phase. The decrease was not immediate, as the data did not visibly decrease until the third data point of the intervention phase. Additionally, there was overlapping data between these two phases. The mean of the last three data points in the baseline (M=8) was similar to the mean of the first three data points in the intervention phase (M=7.33).

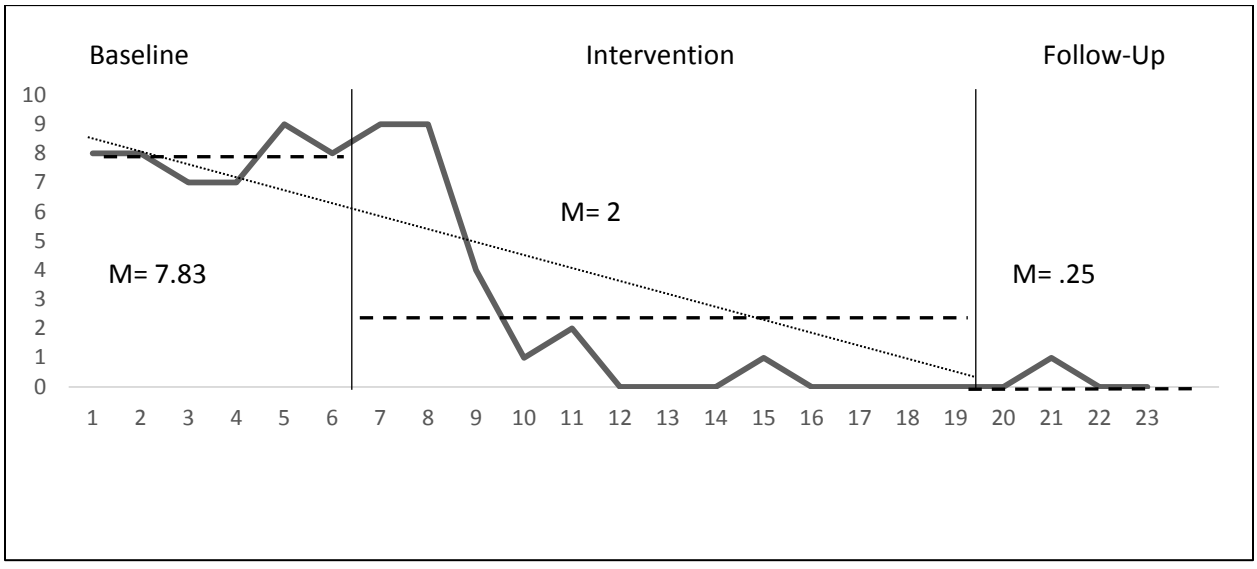

Figure C.2. Justin's emotional symptoms scores across all phases

Conduct Problems

Figure C.3 presents the data levels and trend for Conduct Problems across phases of the study. Level analysis of graph indicated a decrease from a mean of 4.33 in the baseline phase to 1.77 in the treatment phase followed by another decrease to .5 in the follow-up phase. Trend analysis revealed a downward trend across the baseline and treatment phase of the study with a large correlation (R^2=.77), indicating a large relationship between play therapy phase and Justin's decrease in conduct problems. Analysis of variability between conditions revealed moderate variability between phases with standard deviations (SD) of .52 in the baseline phase, 1.17 in the intervention phase, and .58 in the follow-up phase. The decrease was not immediate, as the data did not visibly decrease until the third data point of the intervention phase. Additionally, there was overlapping data between these two phases. The mean of the last three data points in the baseline (M=4) was the same as the mean of the first two data points in the intervention phase (M=4).

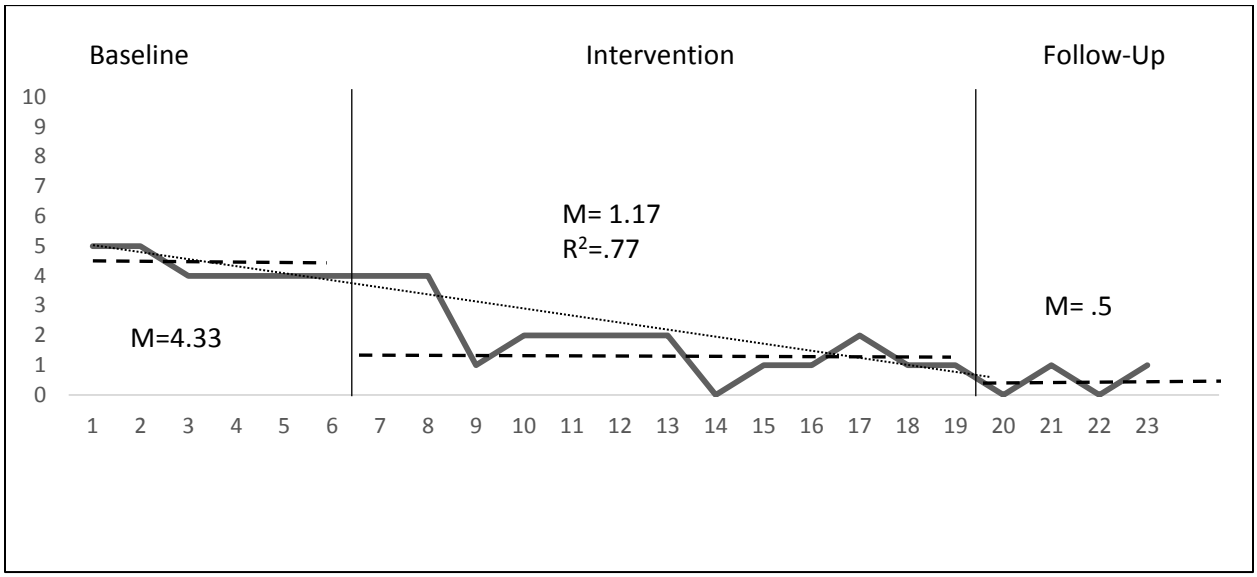

Figure C.3. Justin's conduct problems scores across all phases

Hyperactivity and Inattention

Figure C.4 presents the data levels and trend for Hyperactivity and Inattention across phases of the study. Level analysis of graph indicated a decrease from a mean of 9.67 in the baseline phase to 5.78 in the treatment phase followed by another decrease to 2.25 in the follow-up phase. Trend analysis revealed a downward trend across the baseline and treatment phase of the study with a large correlation (R^2=.62), indicating a large relationship between play therapy phase and Justin's decrease in hyperactive and inattentive behaviors. Analysis of variability between conditions revealed moderate variability between phases with standard deviations (SD) of .52 in the baseline phase, 1.89 in the intervention phase, and 2.25 in the follow-up phase. The decrease was not immediate, as the data did not visibly decrease until the third data point of the intervention phase. Additionally, there was overlapping data between these two phases. The mean of the last three data points in the baseline (M=10) was the same as the mean of the first two data points in the intervention phase (M=10).

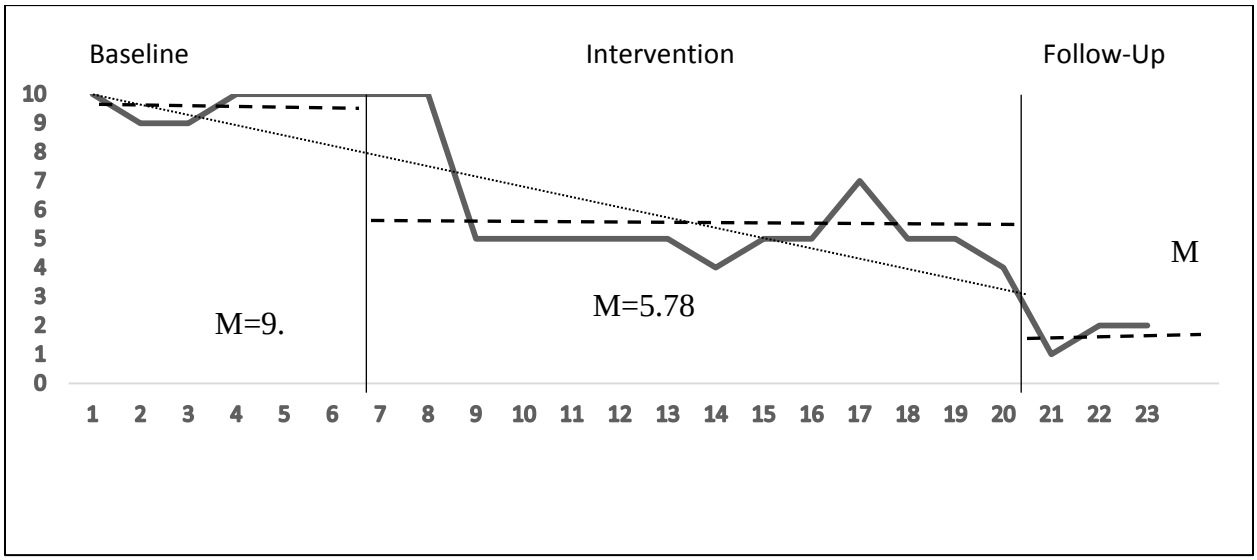

Figure C.4. Justin's hyperactivity and inattention scores across all phases

Peer Problems

Figure C.5 presents the data levels and trend for Peer Problems across phases of the study. Level analysis of graph indicated a decrease from a mean of 4.5 in the baseline phase to 2.08 in the treatment phase followed by another decrease to 0 in the follow-up phase. Trend analysis revealed a downward trend across the baseline and treatment phase of the study with a large correlation (R^2=.75), indicating a large relationship between play therapy phase and Justin's decrease in difficulty with peers. Analysis of variability between conditions revealed moderate variability between phases with standard deviations (SD) of .84 in the baseline phase, 1.66 in the intervention phase, and 0 in the follow-up phase. The decrease was not immediate, as the data did not visibly decrease until the third data point of the intervention phase. Additionally, there was overlapping data between these two phases. The mean of the last three data points in the baseline (M=5) was similar to the mean of the first three data points in the intervention phase (M=4.33).

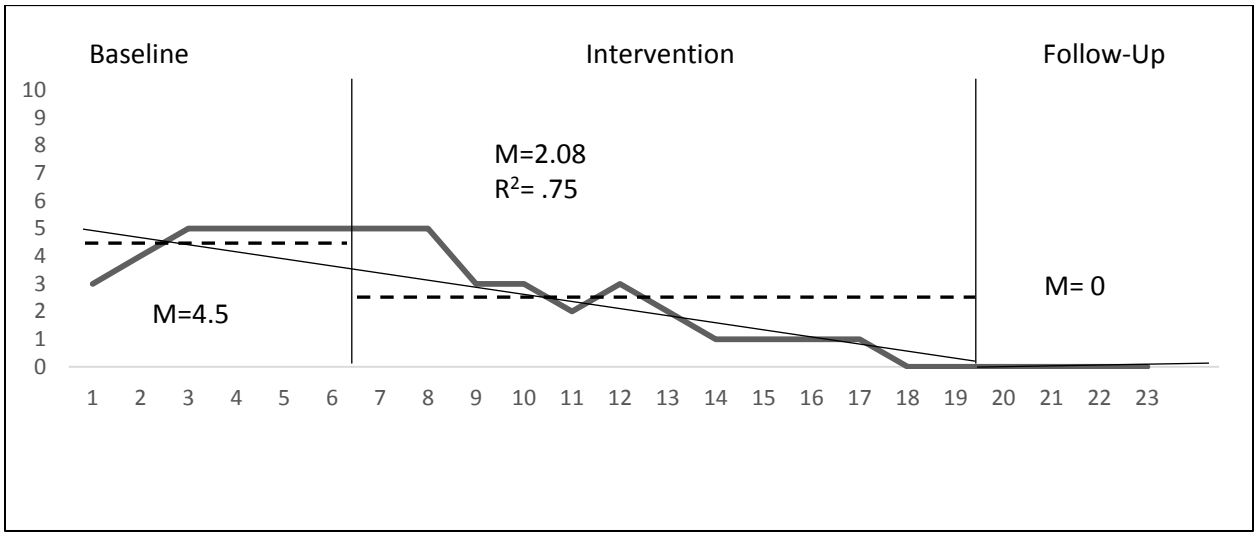

Figure C.5. Justin's peer problems scores across all phases

Prosocial Behavior

Figure C.6 presents the data levels and trend for Prosocial Behavior across phases of the study. Level analysis of graph indicated an increase from a mean of 5.42 in the baseline phase to

7.23 in the treatment phase followed by another increase to 9.5 in the follow-up phase. Trend analysis revealed an upward trend across the baseline and treatment phase of the study with a large correlation (R^2=.52), indicating a large relationship between play therapy phase and Justin's increase in prosocial behaviors. Analysis of variability between conditions revealed moderate variability between phases with stand deviations (SD) of .79 in the baseline phase, 1.48 in the intervention phase, and 1 in the follow-up phase. The increase was not immediate, as the data did not visibly increase until the third data point of the intervention phase. Additionally, there was overlapping data between these two phases. The mean of the last three data points in the baseline (M=5) was similar to the mean of the first three data points in the intervention phase (M=5.67).

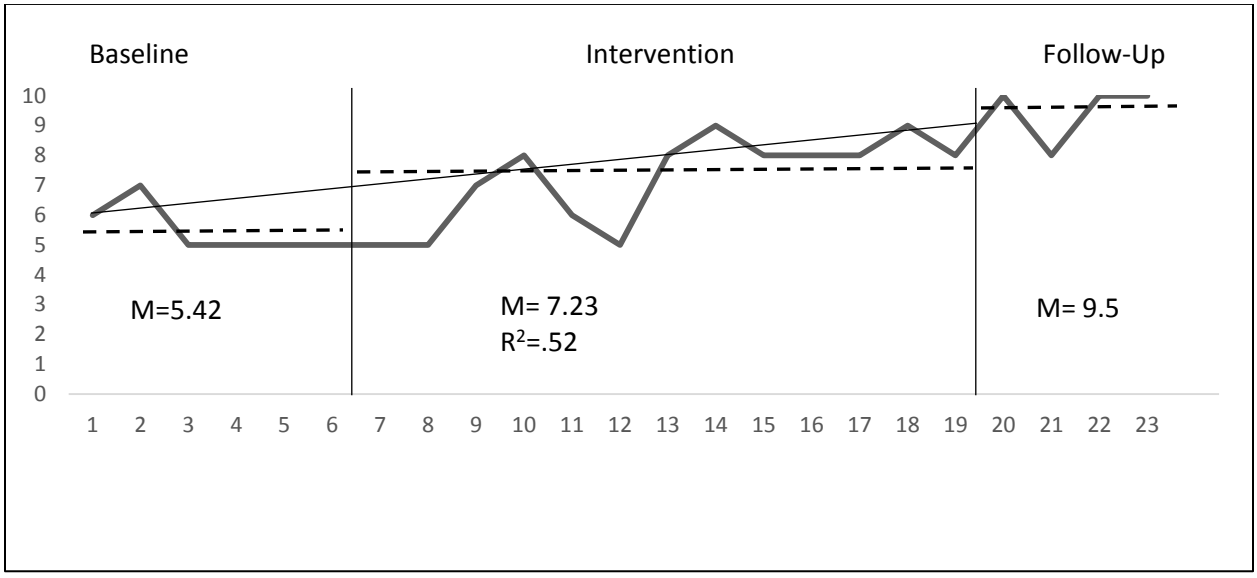

Figure C.6. Justin's prosocial behavior scores across all phases

Total Difficulties

Figure C.7 presents the data levels and trend for Total Difficulties across phases of the study. Level analysis of graph indicated a decrease from a mean of 26.5 in the baseline phase to 11.69 in the treatment phase followed by another decrease to 3 in the follow-up phase. Trend

analysis revealed a downward trend across the baseline and treatment phase of the study with a large correlation (R^2=.78), indicating a large relationship between play therapy phase and Justin's decrease in overall difficulties. Analysis of variability between conditions revealed large variability between phases with standard deviations (SD) of 1.22 in the baseline phase, 7.66 in the intervention phase, and .82 in the follow-up phase. The decrease was not immediate, as the data did not visibly decrease until the third data point of the intervention phase. Additionally, there was overlapping data between these two phases. The mean of the last three data points in the baseline (M=27.33) was similar to the mean of the first two data points in the intervention phase (M=28). In addition to visual analysis, I calculated the NAP statistic to examine the degree of the treatment's effectiveness. The NAP effect size comparing the baseline phase data and the intervention phase data was a medium effect size of .87, whereas effect size calculation of the baseline phase data compared to the follow-up phase data was a strong effect size of 1 (Parker & Vannest, 2009).

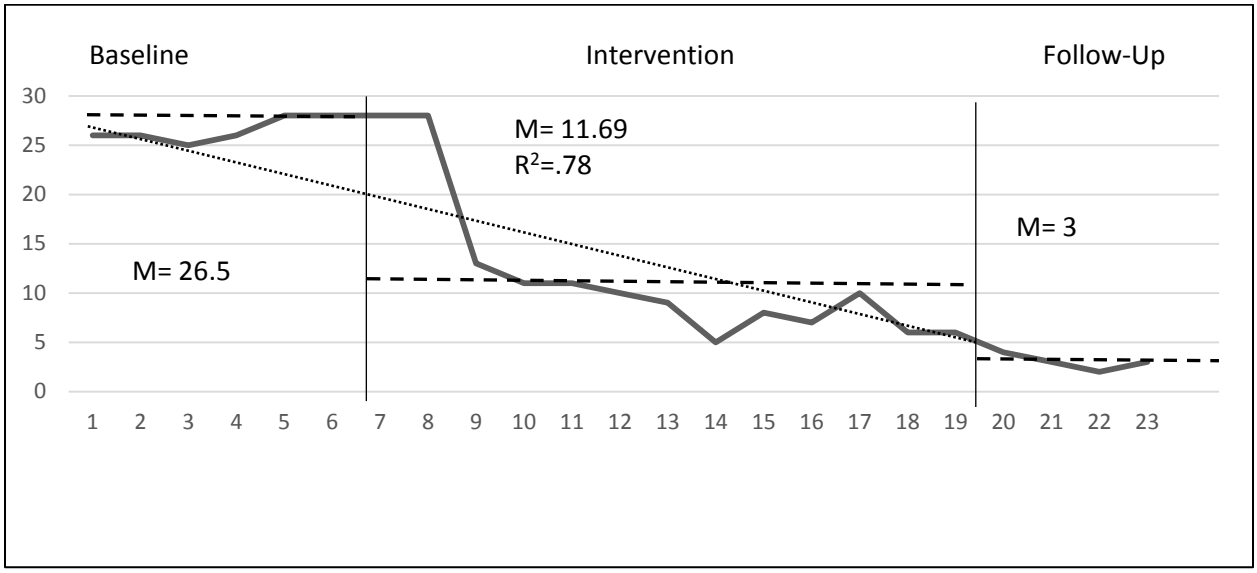

Figure C.7. Justin's total difficulties scores across all phases

Post-Traumatic Stress

The TSCYC was completed by Justin's mother prior to the baseline, at the twelfth intervention session, and at the twenty-fourth session. The Posttraumatic Stress T-scores were 98 prior to the intervention, 48 at the twelfth session of the treatment phase, and 46 at the twenty-fourth session. The Posttraumatic Stress scores decreased over the time of the study with substantial improvement reported after 12 sessions.

Follow-Up Parent Interview

Upon completion of the intervention phase, Justin's mother participated in a follow-up interview. She reported Justin demonstrated less anger and was more carefree than when the study began. He was no longer displaying sadness at school or home and he was verbalizing his feelings and opinions. He no longer erupted in tears and anger, instead he spoke up and shared what he was thinking and feeling. Justin's meltdowns at school stopped and his teachers reported he was no longer displaying problem behaviors. Justin's mother reported he was helpful and kind at home and more readily used his manners. In regards to peer relationships, she reported Justin had better relationships with peers and he was able to problem solve when he was upset. Justin's mother reported positive changes to their parent-child relationship. She previously felt that Justin hated her and blamed her for the divorce, yet at the final interview, she reported feeling reconnected to him. Additionally, Justin's mother reported that he had demonstrated nurturing behaviors toward her. Overall, she reported Justin looked forward to coming to play therapy during the intervention phase.

Participant 2: Megan

Megan participated in 6 weeks of a non-intervention baseline phase, 12 weeks of intervention phase where she participated in 24 play therapy sessions, and 4 weeks of a non-intervention follow-up phase. Table C.2 provides the means and standard deviations for each

subscale in each phase of the study. For two subscales, Emotional Symptoms and Hyperactivity and Attentional Difficulties means continually decreased across all phases of the study demonstrating improvement. For Conduct Problems, the means remained the same during the baseline and intervention phases and decreased during the follow-up phase. For Peer Relationship Problems and Total Difficulties, the means increased between the baseline and intervention phases and decreased during the follow-up phase. The means of Prosocial Behavior decreased between the baseline and intervention phases and increased during the follow-up phase. Figure C.8 provides a graphical representation of all data.

Table C.2.

Means and Standard Deviations for Megan's SDQ Scores

Subscale	Baseline		Intervention		Follow-Up	
	M	SD	M	SD	M	SD
Emotional Symptoms	.83	.41	.75	.86	0	0
Conduct Problems	4.83	.75	4.83	1.33	2.25	.96
Hyperactivity/Attention Difficulties	8.83	.98	8.25	2.01	5.25	.5
Peer Relationship Problems	1	.63	2.5	1	1.75	.95
Prosocial Behavior	8.5	.55	7.83	1.93	9.5	.58
Total Difficulties	15.5	1.64	16.18	3.59	9.25	1.71

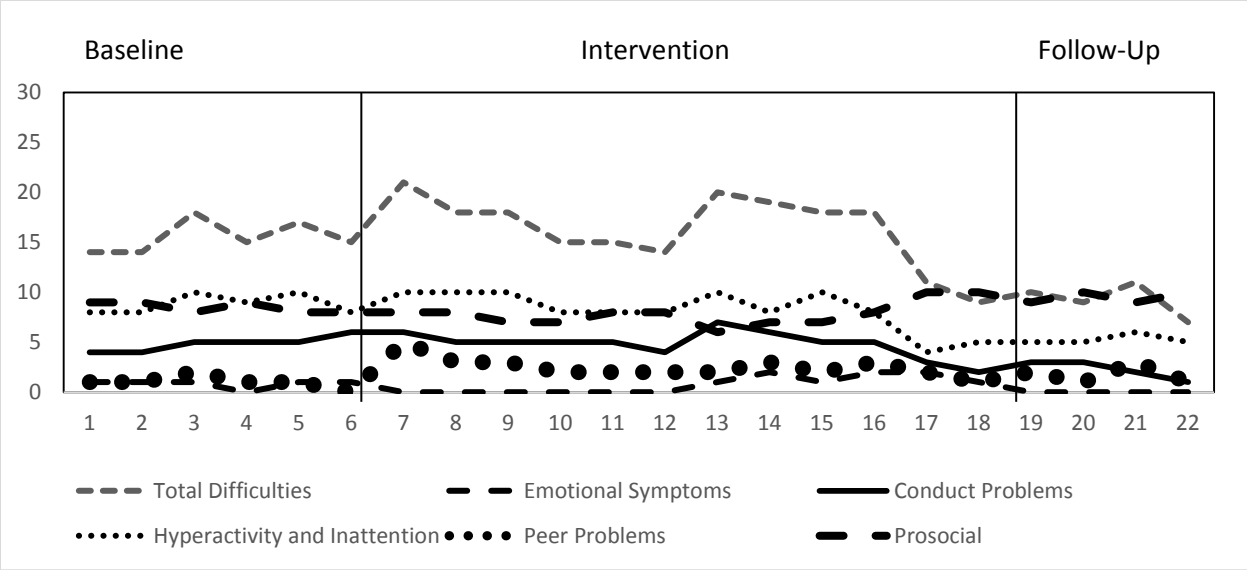

Figure C.8. Megan's SDQ scores during baseline, intervention, and follow-up phases

Megan's stepmother completed an SDQ each week that generated one score for each of the subscales. I separately evaluated each subscale by assessing the level, trend, variability, immediacy of effect, and overlapping data.

Emotional Symptoms

Figure C.9 presents the data levels and trend for Emotional Symptoms across phases of the study. Level analysis of graph indicated a decrease from a mean of.83 in the baseline phase to .75 in the treatment phase followed by another decrease to 0 in the follow-up phase. Although the initial scores were in the normal range, trend analysis revealed a slight downward trend across the baseline and treatment phase of the study with a small correlation (R^2=.13), indicating a weak relationship between play therapy phase and Megan's decrease in emotional symptomology. Analysis of variability between conditions revealed moderate variability between phases with standard deviations (SD) of .41 in the baseline phase, .86 in the intervention phase, and 0 in the follow-up phase. Due to initial scores falling in the very low range, there was overlapping data between phases. The scores across phases were not in the problematic range.

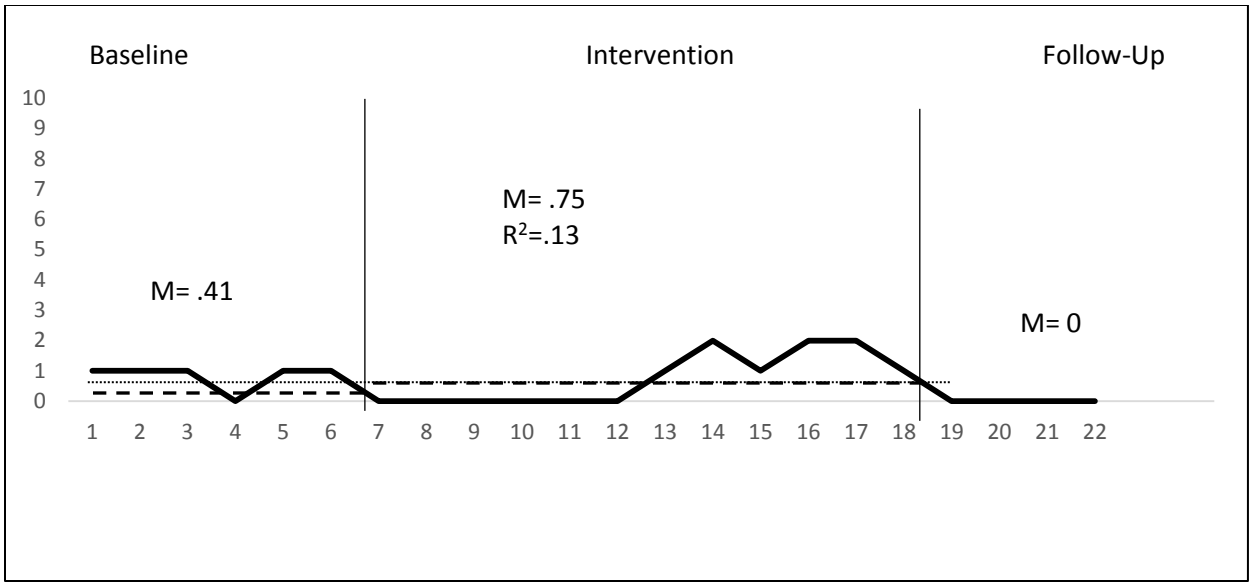

Figure C.9. Megan's emotional symptoms scores across all phases

Conduct Problems

Figure C.10 presents the data levels and trend for Conduct Problems across phases of the study. Level analysis of graph indicated a consistency of means between the baseline and treatment phase with means of 4.83 followed by a decrease to 2.25 in the follow-up phase. Trend analysis revealed a downward trend across the baseline and treatment phase of the study with a small correlation (R^2=.04), indicating a weak relationship between play therapy phase and Megan's decrease in conduct problems. Analysis of variability between conditions revealed moderate variability between phases with standard deviations (SD) of .75 in the baseline phase, 1.33 in the intervention phase, and .96 in the follow-up phase. The increase was not immediate, as the data did not visibly decrease until the seventeenth data point of the intervention phase. Additionally, there was overlapping data between these two phases. The mean of the last three data points in the baseline (M=5.33) was the same as the mean of the first three data points in the intervention phase (M=5.33).

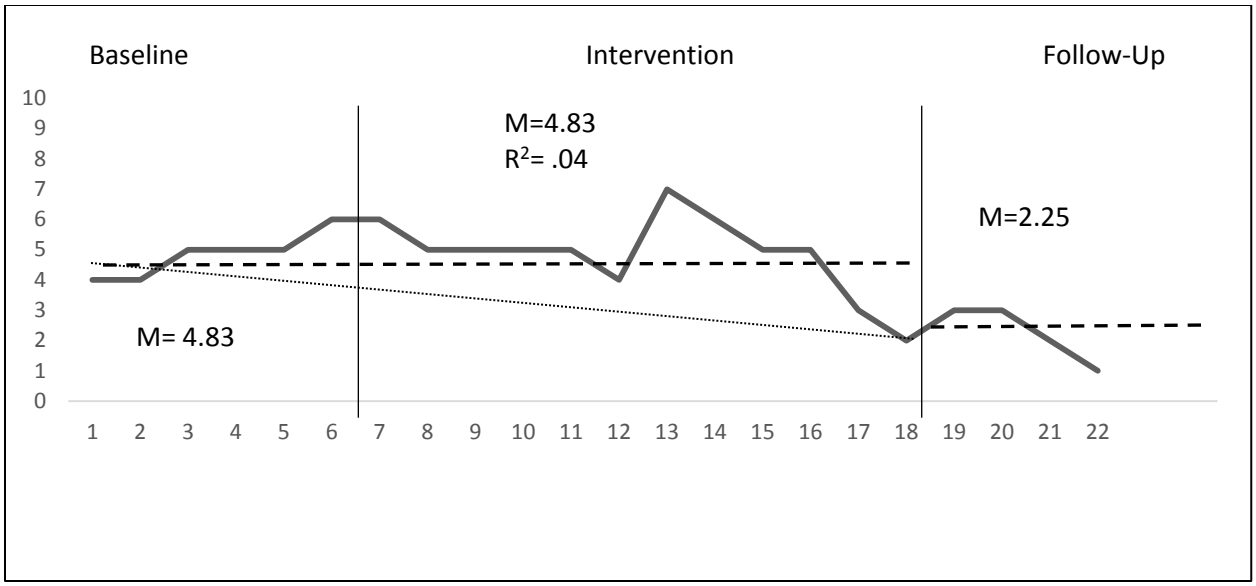

Figure C.10. Megan's conduct problems scores across all phases

Hyperactivity and Inattention

Figure C.11 presents the data levels and trend for Hyperactivity and Inattention across phases of the study. Level analysis of graph indicated a decrease from a mean of 8.83 in the baseline phase to 8.25 in the treatment phase followed by another decrease to 5.25 in the follow-up phase. Trend analysis revealed a downward trend across the baseline and treatment phase of the study with a medium correlation (R^2=.22), indicating a relationship between play therapy phase and Megan's decrease in hyperactive and inattentive behaviors. Analysis of variability between conditions revealed moderate variability between phases with standard deviations (SD) of .98 in the baseline phase, 2.01 in the intervention phase, and .5 in the follow-up phase. The decrease was not immediate, as the data did not visibly decrease until the seventeenth data point of the intervention phase. Additionally, there was overlapping data between these two phases. The mean of the last three data points in the baseline (M=9) was similar to the mean of the first three data points in the intervention phase (M=10).

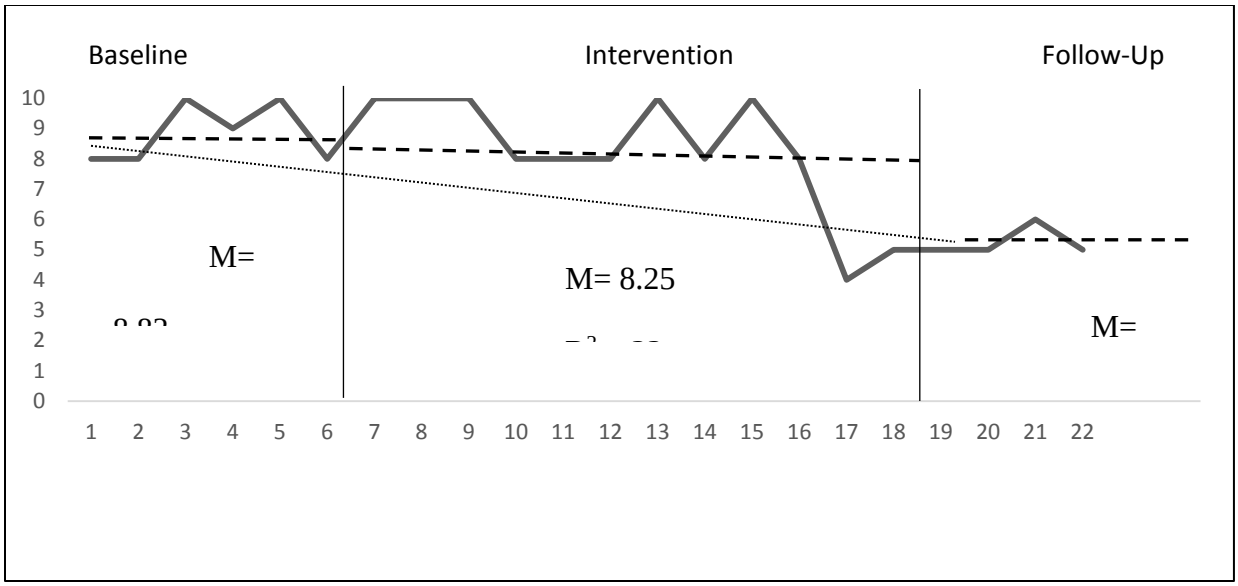

Figure C.11. Megan's hyperactivity and inattention scores across all phases

Peer Problems

Figure C.12 presents the data levels and trend for Peer Problems across phases of the study. Level analysis of graph indicated an increase from a mean of 1 in the baseline phase to 2.5 in the treatment phase followed by a decrease to 1.75 in the follow-up phase. Trend analysis revealed an upward trend across the baseline and treatment phase of the study with a small correlation (R^2=.06), indicating an inverse relationship between play therapy phase and Megan's decrease in difficulty with peers. Analysis of variability between conditions revealed moderate variability between phases with standard deviations (SD) of .63 in the baseline phase, 1 in the intervention phase, and .95 in the follow-up phase. Initial scores were in the normal range with low variability indicating peer problems were not an issue of concern. Subsequent scores remained in the normal range across all phases.

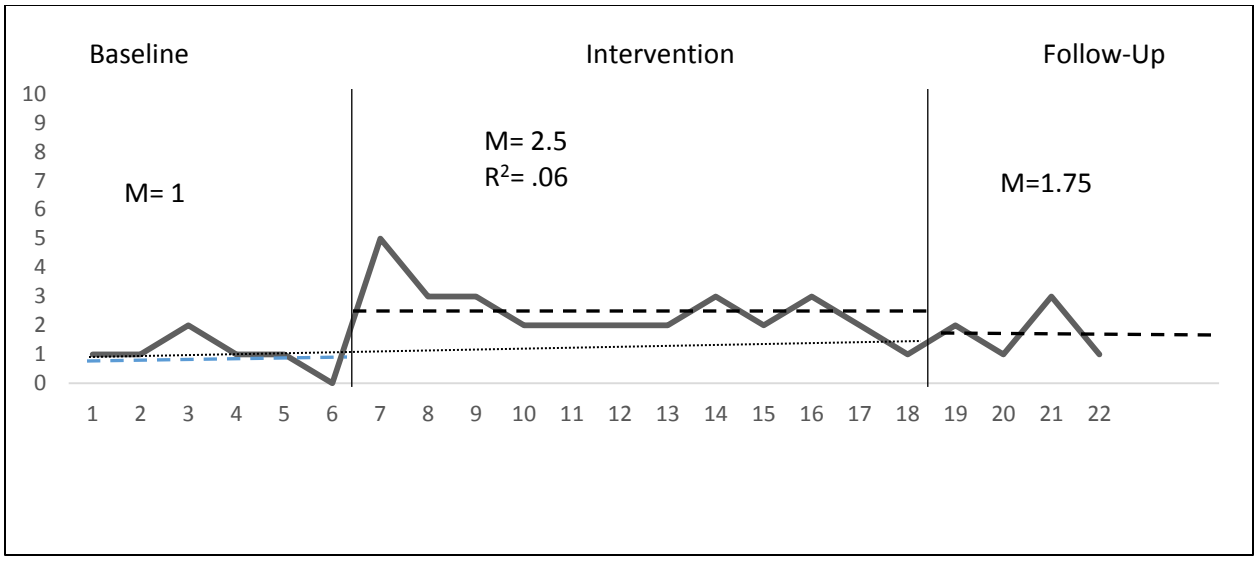

Figure C.12. Megan's peer problems scores across all phases

Prosocial Behavior

Figure C.13 presents the data levels and trend for Prosocial Behavior across phases of the study. Level analysis of graph indicated a decrease from a mean of 8.5 in the baseline phase to 7.83 in the treatment phase followed by an increase to 9.5 in the follow-up phase. Trend analysis revealed an upward trend across the baseline and treatment phase of the study with a negligible correlation (R^2=.004), indicating little to no relationship between play therapy phase and Megan's increase in prosocial behaviors. Analysis of variability between conditions revealed moderate variability between phases with standard deviations (SD) of .55 in the baseline phase, 1.93 in the intervention phase, and .58 in the follow-up phase. Improvement was not immediate, as the data did not visibly decrease until the seventeenth data point of the intervention phase. Additionally, there was overlapping data between these two phases. The mean of the last three data points in the baseline (M=8.33) was similar to the mean of the of the first three data points in the intervention phase (M=7.67) and overlapped with subsequent data points in intervention phase.

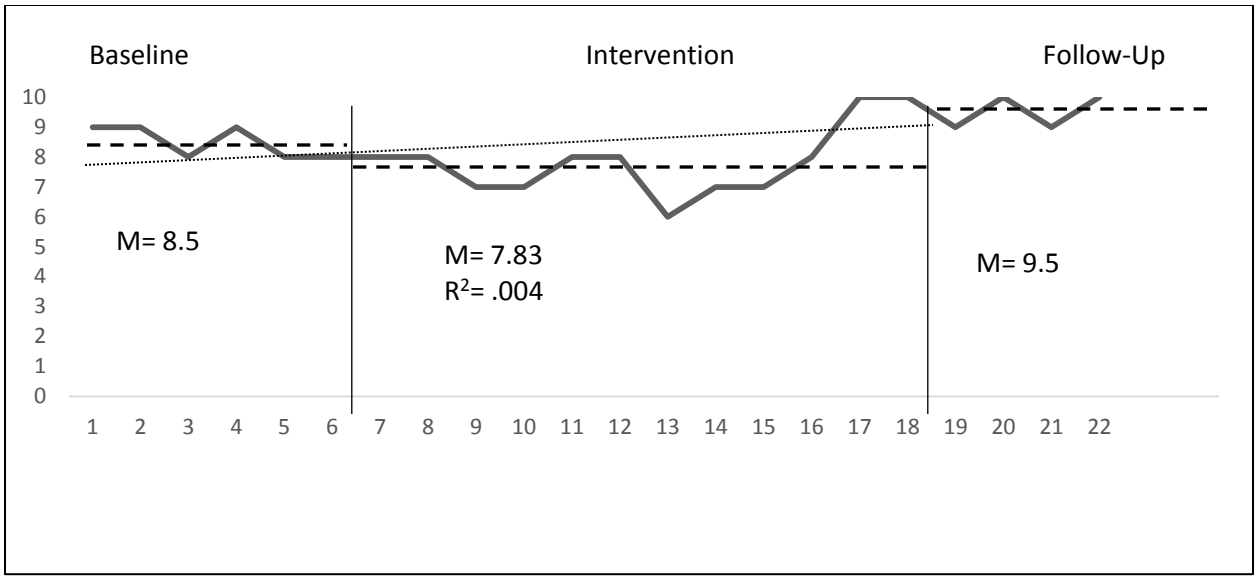

Figure C.13. Megan's prosocial behavior scores across all phases

Total Difficulties

Figure C.14 presents the data levels and trend for Total Difficulties across phases of the study. Level analysis of graph indicated an increase from a mean of 15.5 in the baseline phase to 16.18 in the treatment phase followed by a decrease to 9.25 in the follow-up phase. Trend analysis revealed a consistent trend across the baseline and treatment phase of the study with a small correlation (R^2=.03), indicating a weak relationship between play therapy phase and Megan's decrease in overall difficulties. Analysis of variability between conditions revealed variability between phases with standard deviations (SD) of 1.64 in the baseline phase, 3.59 in the intervention phase, and 1.71 in the follow-up phase. The decrease was not immediate, as the data did not visibly decrease until the seventeenth data point of the intervention phase. Additionally, there was overlapping data between these two phases. The mean of the last three data points in the baseline (M=15.67) was smaller than the mean of the of the first three data points in the intervention phase (M=19). In addition to visual analysis, I calculated the NAP statistic to examine the degree of the treatment's effectiveness. The NAP effect size comparing

the baseline phase data and the intervention phase data was a weak effect size of -.35 in the negative direction, whereas effect size calculation of the baseline phase data compared to the follow-up phase data was a large effect size of 1.

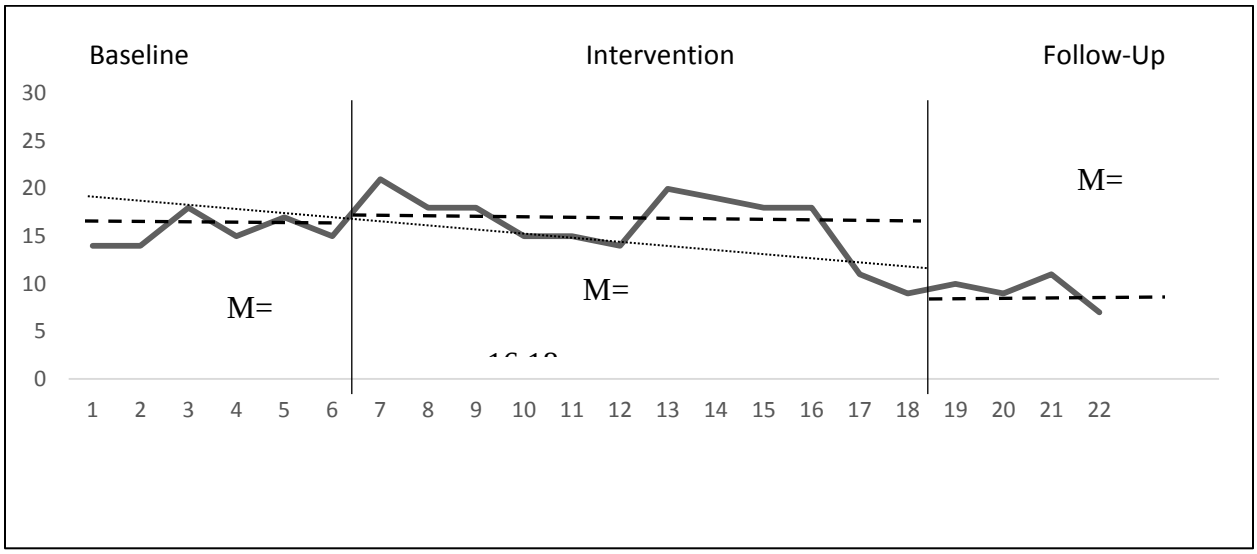

Figure C.14. Megan's total difficulties behavior scores across all phases

Posttraumatic Stress

The TSCYC was completed by Megan's stepmother prior to the baseline, at the twelfth intervention session, and at the twenty-fourth session. The Posttraumatic Stress T-scores were 78 prior to the intervention, 76 at the twelfth session of the treatment phase, and 50 at the twenty-fourth session. The Posttraumatic Stress scores decreased over the time of the study with most substantial improvement occurring from play therapy phase to follow-up.

Follow-Up Parent Interview

Upon completion of the intervention phase, Megan's father and stepmother participated in a follow-up interview. They reported that following participation in CCPT, Megan appeared happier and that she bounced backed from disappointments when things did not go as planned more quickly. She discusses her feelings with them and accepts responsibilities for mistakes. They reported Megan had a greater attention span and a better ability to stay focused at home

and school. Megan was less impulsive and she started thinking before acting. Megan became more selective with her peer choices; therefore, she had a better relationship with friends. Megan discontinued physically reacting when she was upset and she demonstrated remorse when she was upset. They reported that Megan had become more affectionate with her stepmother, whereas prior to the study she was only affectionate with her father. They reported they have a deeper stronger relationship and connection with Megan. Although they reported in the final interview that they initially had mixed feelings about seeking counseling, they reported it was a positive experience. They reported that once Megan began feeling heard in the therapeutic relationship, she tried calmer ways of receiving attention at home. Through parent consultations, they discovered Megan's desire for relationships and physical touch and discontinued removing relational activities as consequences. Megan's father reported seeing gradual changes throughout the study, however her stepmother reported that she was unaware of the gradual changes but recognized the drastic changes toward the end.

Summary of Results

Table C.3 provides a summary of results for Justin and Megan. Both Justin and Megan demonstrated lack of improvement during the baseline phase of no treatment. Justin's scores demonstrated a rapid improvement in which he was positively responsive to play therapy intervention within six sessions. Megan's scores demonstrated delayed improvement that became noticeably pronounced following 19 play therapy sessions.

Table C.3.

SDQ Total Scores Visual Analysis

Participant	Component	Visual Analysis
	Level	Decrease from baseline (M= 26.5) to intervention (M= 11.69) to follow-up (M= 3)
Justin	Trend	Downward trend (R^2= .78)

	Variability	Baseline (SD = 1.22), Intervention (SD= 7.66), Follow-up (SD= 3)
	Immediacy	Improvement following 3 intervention data points
	Overlap	Overlap was present at initial intervention data points; no overlap at follow-up
	NAP	Baseline to intervention NAP=.87 (strong effect), baseline to follow-up NAP= 1 (strong effect)
Megan	Level	Increase from baseline (M= 15.5) to intervention (M= 16.18) to decrease in follow-up (M= 9.25)
	Trend	Slight negative trend (R^2= .03) from baseline to intervention
	Variability	Baseline (SD = 1.64), Intervention (SD= 3.59), Follow-up (SD= 1.71)
	Immediacy	Improvement following 10 intervention data points
	Overlap	Overlap was present frequently in intervention phase; no overlap at follow-up
	NAP	Baseline to intervention NAP= -.35 (negligible effect), baseline to follow-up NAP= 1 (strong effect)

APPENDIX D

DISCUSSION

The purpose of this study was to investigate the impact of Child-Centered Play Therapy (CCPT) on children who have experienced four or more Adverse Childhood Experiences (ACEs). Specifically, I examined the effectiveness of CCPT on the child's level of emotional symptoms, conduct problems, hyperactivity and inattention, peer relationship problems, post traumatic stress and prosocial behavior. Single-case design was implemented and data was collected throughout baseline, intervention, and follow-up phases for two children, Justin and Megan, participating in CCPT.

Results from the study indicated play therapy was beneficial for both participants across subscales. Justin demonstrated a rapid decrease in symptomology across subscales within the intervention phase and continued throughout the follow-up phase. Megan's decrease in symptomology occurred for clinically-scored subscales further into the intervention phase and continued throughout the follow-up phase. While both participants decreased problematic behaviors and increased prosocial behaviors, the time in which the change occurred was different for participants.

CCPT, Emotional Symptoms, and ACEs

Emotional symptoms are defined as somatic complaints, worrying, perceptions of unhappiness, clinginess, fears, and preferring being solitary (Goodman, Lamping, & Ploubidis, 2010). Children who have experienced ACEs may have increased emotional symptoms. Clarkson Freeman (2014) discovered children who experienced four or more ACEs were 4.87 times more likely to experience internalizing problems. In CCPT, the therapeutic relationship provides the opportunity for children to express their feelings and emotions without judgment (Landreth, 2012). Children are able to express their feelings and emotions in ways they need and therapists demonstrate full acceptance of the children. Unconditional positive regard (UPR) is

one of the six necessary but sufficient conditions and aids in creating an environment where children are fully accepted (Landreth, 2012).

In the current study, one participant, Justin, presented with clinical levels of reported emotional symptoms. In initial presentation, Justin's mother reported that Justin had witnessed domestic violence and experienced emotional and verbal abuse. Throughout the baseline phase and for the first two weeks of the intervention phase, Justin demonstrated high concerns with emotional symptoms including parent report that Justin appeared unhappy, worried, and fearful. In play therapy, Justin's play scenes included wars and battles in which one side was fearful and lacked power. As part of CCPT procedures, the therapist reflected Justin's feelings of fear and powerlessness and accepted his verbalization regarding lack of defense and protection. Additionally, the therapist used encouraging responses to support Justin through building up the defenseless army. When Justin's fears of weakness and victimization were accepted and acknowledged, he began to offer more support to his defeated army. After a brief four sessions, Justin's reported emotional symptoms decreased to the normal range. His mother reported he seemed happy the majority of the time and was no longer appearing worried or expressing fears. Justin's improvement of emotional symptoms sustained throughout the remainder of the study.

CCPT, Conduct Problems, and ACEs

Goodman et al. (2010) described conduct problems as having a temper, being disobedient, fighting, lying, and stealing. Clarkson Freeman (2014) demonstrated a correlation between ACEs and externalizing behaviors, finding children who experienced four or more ACEs were 3.75 times more likely to experience externalizing problems. Theoretically, maladjusted behaviors become more pronounced when children are striving for self-actualization but barriers are in their way (Axline, 1947). Rather than discontinuing the drive for self-

actualization, children build up destructive behaviors with the intention of fighting what is standing in their way (Axline, 1947). When children are able to develop self-worth, they begin getting closer to self-actualization (Axline, 1947). CCPT provides an environment where necessary and sufficient conditions are met allowing children to discover self-worth and continue drive for self-actualization (Axline, 1947).

In the current study, both participants were reported to demonstrate high levels of conduct problems during the baseline phase. After the second week of the intervention phase, Justin's conduct problems significantly decreased, whereas Megan's conduct problems significantly decreased after the tenth week. Justin's and Megan's improvement of conduct problems continued throughout the remainder of data collection.

In Justin's case, his mother reported his negative orientation toward her as well as behavioral problems at school. In play therapy, Justin appeared to be responsive to the therapist's provision of genuineness, UPR, and empathic understanding. Within two CCPT sessions, Justin increased his direct interaction with the therapist as evidenced by facing the therapist physically, talking directly to the therapist, and including the therapist in his play. Increased interaction with the therapist seemed to indicate that Justin was open to receiving the conditions provided by therapist. As his relationship with the therapist became stronger, Justin's sense of self was impacted by his ability to feel worthy and valuable in the eyes of his therapist. His need to act out negatively toward his environment appeared to dissipate and he engaged in more self-enhancing actions toward his mother and teachers as indicated in their reports.

In Megan's case, her father and stepmother reported Megan's negative orientation toward her stepmother and siblings as well as problem behaviors at school. In play therapy, Megan was not immediately responsive to the therapist's provision of genuineness, UPR, and empathic

understanding. Her actions in the playroom appeared that she was doing what she believed she was supposed to rather than what she needed. When Megan entered the playroom she sat in front of the therapist and engaged in talking with the therapist. She frequently inquired if she was playing in the way she was supposed to or in the way other children played. After eight sessions, Megan appeared to become responsive to the conditions provided by the therapist, as demonstrated by Megan appearing comfortable engaging in other activities without asking for permission. Megan frequently felt comfortable not facing the therapist, which appeared to demonstrate a sense of safety to engage in activities in the ways she deemed necessary. As Megan's safety with the therapist grew, the interactions became more meaningful. Megan's sense of self was impacted by being able to be in control while still being unconditionally positively regarded. Megan's need to engage in negative behavior toward her stepmother, siblings, and teachers lessened and she engaged in more self-enhancing actions.

CCPT, Attentional Difficulties, and ACEs

Hyperactivity and inattention problems are defined as being restless or fidgety, fighting, lying, and stealing (Goodman et al., 2010). While some characteristics overlap with conduct problems, being restless and fidgety are unique to this category. CCPT provides the opportunity for a child to experience growth while playing out accumulated negative feelings (Landreth, 2012). By bringing the emotions to the surface and having the opportunity to explore and face the emotions, children are able to achieve emotional relaxation (Axline, 1947). Once children have achieved emotional relaxation, their bodies are able to relax, decreasing fidgeting and restlessness (Axline, 1947). Schottelkorb and Ray (2009) reported that children in their study who had attention difficulties also presented with negative emotional and behavioral symptoms that were positively impacted by participation in CCPT. Ray, Schottlekorb, and Tsai (2007)

discovered children who participated in CCPT demonstrated statistically significant fewer attention difficulties as well as a decrease in emotional instability. Because inattentive symptoms are often comorbid with other emotional and behavioral difficulties, CCPT is often effective in demonstrating holistic reduction of problem behaviors (Schottelkorb & Ray, 2009; Ray et al., 2007). Theoretically, because CCPT concentrates on the holistic organism of the child, symptomatic behaviors often subside when the person of the child perceives empathic understanding and UPR from the therapist, releasing the self-actualizing tendency toward enhancement.

In the current study, both participants were reported to demonstrate high levels of hyperactivity and attentional difficulties during the baseline phase. After the second week of intervention, Justin's hyperactivity and attentional difficulties significantly decreased, whereas Megan's hyperactivity and attentional difficulties significantly decreased after the tenth week of intervention. Their improvement continued throughout data collection.

In Justin's case, his mother reported that Justin was fidgety, always moving, and had difficulty focusing at school and home. Justin had experienced emotional neglect and yelling directed at him within his home environment which may have intensified his inattention symptoms. Children who experience ongoing adverse and traumatic experiences likely live in a world of fear which translates to them being hyperaroused (Hawkins, 2014). In play therapy, Justin appeared overly focused and rigid during his play at the beginning as evidenced by his repetition of play and his focused quietness. Justin appeared to be responsive to the therapist's provision of genuineness, UPR, and empathic understanding by comfortably interacting with the therapist throughout his play. After two sessions he began to appear less rigid in his play which was demonstrated through his changing of play and integrating the therapeutic relationship into

his play. His mother reported a significant increase in Justin's ability to focus. She said he demonstrated an overwhelming calmness even during difficult situations.

In Megan's case, her stepmother and father reported that Megan was fidgety, very talkative, and had difficulty following through with instructions at home and school. Before and throughout the study, Megan experienced emotional neglect and yelling directed at her within her home environment. During the first sessions, Megan changed tasks fairly quickly and was overly talkative. As Megan began to establish comfort within the therapeutic relationship, Megan's pace of play began to slow down. Megan began to maintain focus while playing and she appeared calmer and quieter throughout sessions. Her stepmother and father reported Megan had an overall calmer disposition and she began following through with instructions at school and home.

CCPT, Peer Relationships, and ACEs

Goodman et al. (2010) described peer relationship problems as not being a good friend, being bullied, preferring to be alone, and preferring adult interactions. Children utilize interactions with therapists to work through emotional concerns impacting their peer relationships (Landreth, 2012). Because children direct the play, they experience the emotions connected to their peers (Landreth, 2012). Children may engage with therapists in the same manners they would engage with peers. Authenticity of the play therapists provides children with the opportunity to understand the impact of negative behaviors on others (Landreth, 2012). Because play therapists have UPR for clients, children engage in these experiences without feeling judged or risking the loss of relationships (Landreth, 2012). By focusing on the relationship with children, they are able to activate their self-actualizing tendency (Ray, 2011). Through fully accepting children when they are struggling to interact, they are able to overcome

what is hindering them, which allows them to have better peer relations (Ray, 2011). Through the utilization of CCPT, children become more aware of their thoughts, feelings, and needs and how the impact others. This awareness provides them with the ability to have more appropriate peer interactions (Ray, 2011).

In the current study, only one of the participants, Justin, presented with clinical levels of reported peer relationship problems. In initial presentation, Justin's mother reported that Justin had difficulty interacting with peers and he frequently stated that he felt disliked by peers. Throughout the baseline phase and for the first two weeks of the intervention phase, Justin demonstrated high concerns with peer relationship problems. Through the trust of the therapeutic relationship, Justin began to build trust and self-confidence within himself. As Justin's self-acceptance in the playroom increased he began to have positive interactions with classmates. Justin's self-acceptance provided Justin with a new sense of worth. He began to feel worthy and capable of peer relationships. His mother reported he began making new friends, engaged in less conflict, and appeared genuinely happy when discussing friendships. She also reported that Justin became aware of how his behavior impacted others and he frequently inquired about how others were affected by him.

Child-Centered Play Therapy and Prosocial Behaviors

Goodman et al. (2010) described prosocial behavior as being considerate, sharing with others, caring about others, kind to children, and helping out. Children with problem behaviors often experience difficulty in their interpersonal relationships. Through the CCPT relationship, a child's self-actualizing tendency is released to move toward self-enhancing ways of being (Ray, 2011). As children's self-actualizing tendencies begin to move toward positive growth, their behaviors and emotions will move toward self-enhancement; therefore, children become more

capable of engaging in healthy relationships with others (Ray, 2011). One expected outcome of CCPT is that children will engage in social behaviors that lead to connectedness with others.

In the current study, one participant, Justin, presented with clinical levels of reported concerns of prosocial behaviors. Justin's mother reported he was unhelpful at home and did not demonstrate care for others. When Justin was upset, he removed himself from the situation or reacted by crying. Throughout the baseline phase and for the first two weeks of the intervention phase, Justin demonstrated high concerns with prosocial behaviors such as not considering others' feelings and not helping others. Through the experienced safety within the playroom, Justin began utilizing prosocial behaviors within the therapeutic relationship. He demonstrated care for the therapist by asking questions about her and demonstrating overall care. Justin's mother first noticed his increase of prosocial behaviors, when he calmly told her that he thought she was being too hard on his sister. Justin was considerate and demonstrated care for his sister. Overall, Justin's care and concern for others increased throughout the study.

CCPT and Posttraumatic Stress

Posttraumatic stress is the presence of significant emotional stress or disorganized behavior following the witnessing/experiencing of a trauma (Briere, 2005). Children who have experienced multiple or ongoing ACEs require experiences that contradict the traumatic experiences which have influenced a breakdown of their self-structures (Hawkins, 2012). Children who experience ongoing adverse and traumatic experiences live in a world of fear (Hawkins, 2014). Posttraumatic stress leads to fear associated with the events that caused the stress. Posttraumatic stress may be formed by avoiding psychologically processing the negative occurrences (Wilkins, 2011). Due to the interpersonal nature of ACEs, children may have fear or anxiety around interpersonal relationships. Children who have experienced multiple or ongoing

ACEs may develop a stress that is extreme, frequent, or extended (Hornor, 2015). Children who have posttraumatic stress symptomology may appear distressed and disturbed by events in their lives (Murphy & Joseph, 2014).

CCPT provides children the opportunity to psychologically process the emotions that occurred as a result of ACEs. Children are able to utilize play therapy sessions to process feelings and situations in the ways they deem necessary (Ray, 2011). CCPT provides the conditions necessary to allow children to receive new experiences which facilitate their healing; however, the initial forming of the relationship can prohibit a psychological connection from occurring immediately. Because of the fear involved with interpersonal relationships, play therapists must maintain patience throughout the process. As children receive the conditions and safety is formed, they might be able to process the emotions caused by posttraumatic stress through their play.

In this study, both participants presented with problematic posttraumatic stress levels prior to beginning the intervention phase. When the TSCYC was administered on the twelfth session, Justin's scores had significantly decreased, whereas Megan's score were in the problematic range. Upon completion of the intervention, both participants' reported scores were in the normal range indicating a substantial decrease of posttraumatic stress symptomology.

In Justin's case, his mother reported his viewing of domestic violence and his fears of not feeling safe and protected within his home environment. His post-traumatic stress symptoms appeared to be related to a felt lack of safety. In the playroom, Justin tensed up when he heard loud noises. He also screamed and cried without matched provocation. When Justin entered play therapy, the therapist allowed Justin to lead the play which provided him with ability to control the environment and avoid having fear responses (Hawkins, 2014). The therapist was mindful to

avoid forcing a relationship with Justin. As Justin began to trust the therapeutic relationship, he engaged the therapist in his play. Throughout the sessions, Justin maintained control of the relationship, which provided Justin with the ability to engage in controlled practice of situations that might be frightening, such as hiding behind the puppet theater and requesting the therapist to sneak up on him and scare him. As the safety of the relationship continued, Justin's emotional distress decreased and hence, his posttraumatic stress symptomology decreased.

In Megan's case, her stepmother and father reported Megan observing dangerous behavior early in life as well as ongoing stress due to her relationship with her stepmother. Megan's mother died early in Megan's life and Megan was unaware of the cause. Megan had a fear of being left, not cared for, and not belonging which all contributed to her emotional distress and difficulty connecting with others. When Megan entered play therapy, the therapist remained patient as Megan established contact. Megan had not been exposed to interpersonal relationships that provided the six necessary and sufficient conditions prior to play therapy. Because Megan had been exposed to multiple negative interpersonal relationships, she appeared to have fear associated with meaningful relationships. Due to her fear of interpersonal relationships, Megan took eight weeks to achieve psychological contact with the therapist. Megan appeared to avoid psychological contact as a way to protect herself from engaging in interpersonal relationships. As Megan's perceived safety increased, she began to establish psychological contact which in turn allowed her to receive the core conditions offered by the therapist. Megan's ability to perceive the core conditions lessened her emotional distress which decreased her posttraumatic stress symptomology.

Process of CCPT for Children with ACEs

Manifestation of change and growth is a slow process (Landreth, 2012). Children who lived through difficult situations, typically present with intensified emotions. Children's emotions are most often negative and no longer tied to reality. When they enter therapy their emotions are heightened, indiscriminate, and easily aroused (Moustakas, 1953). Through qualitative research, Moustakas (1953) identified four stages of change during the therapeutic process which lead toward improved functioning. As children receive faith, acceptance, and respect, relationships between therapists and children are strengthened and children begin to move through the stages (Moustakas, 1953). Although there are significant shifts, parents and caregivers may not be immediately aware of the changes outside of the playroom.

In the first stage, children diffuse negative feelings and express them throughout their play. Typically, children no longer tie their negative emotions and frustrations to the people who originally aroused those emotions. Children's emotions might be magnified, generalized, and easily evoked. Children are often frightened, angry, or immature without focusing their emotions on any one person or experience. In Justin's case, his first stage of play occurred immediately upon entering play therapy. During his first stage of play, he demonstrated fear toward many toys in the room. Justin picked up toys and verbalized how scary they were to him. When he began using the army men, he verbalized the fear one team had toward the other. During the first stage, Justin's mother described him as inconsolable when he was upset at school and home. When Justin was upset he reacted by throwing objects or hiding while screaming or crying. Justin had difficulty putting words to his feelings even once he was calm. In Megan's case, the first stage occurred after the initial exploratory sessions. Megan had an overall negative affect during the first stage of play. Her body language and facial expressions demonstrated negative feeling throughout her play regardless of the play. Megan's father and stepmother reported that

when Megan was upset she would hit her siblings or scream and yell at her stepmother. When they attempted to engage Megan in conversations about her feelings, she would disengage from the conversations.

During the second stage, children express negative emotions more directly and typically express emotions toward particular people or experiences. While in the second stage, children may focus aggressions on family members or therapists by attacking, denouncing, or threatening them during play. During Justin's second stage, the negative play continued but it appeared more focused. In play with army men, he created fighting scenes where one team was weaker and unable to defend themselves. He maintained focus during play and utilized the army men throughout entire sessions. During the second stage, his mother reported that Justin's negative emotions began to feel more proportionate to the situations occurring and he was verbalizing his negative emotions more clearly. During Megan's second stage, her affect began to vary. She had negative affect during times when she was quieter and focused. Megan's father and stepmother reported Megan was continuing to display anger toward her stepmother and siblings, however the intensity had increased toward her stepmother.

Throughout the third stage, children no longer have completely negative emotions. They begin to fluctuate between negative and ambivalent emotions during their play. Intensity of ambivalent emotions may be high in the beginning of the third stage but the intensity might lessen toward the end of the third stage. During the third stage, Justin wavered back and forth between negative emotions and ambivalence. Justin created ways for soldiers to be safe and also created new ways for them to be attacked. During the third stage, Justin's mother reported that Justin was communicating his frustrations with words and seemed calmer at home and school. During the third stage of play, Megan began to show more fluctuation in her affect. She had

moments when she conveyed looks of anger but more often she seemed relaxed. She was still not displaying positive emotions, but she appeared ambivalent. Her father reported that Megan would avoid her stepmother while finding him to hug. Her stepmother reported feeling disconnected from Megan and left out from her affection.

In the final stage, positive feelings begin to emerge. Children may see themselves and their relationships more realistically. Positive and negative emotions become separated, more consistent, and realistic (Moustakas, 1953). During the fourth and final stage, Justin began to integrate positive and negative emotions. Justin began to integrate laughter into his play. He created situations where people were hurt and then he took care of them or found a way for them to get better. As the stage progressed, Justin moved away from the army men and other negative play and began playing games he created in the playroom with the therapist. Justin's mother reported that Justin was verbalizing his love and anger toward his parents in a very calm way. Justin's mother also reported that all behavior problems had ceased to occur. She said he demonstrated strong care toward others and he was a joy to be around. During the fourth stage of play, Megan's affect became evidently positive. Like Justin, Megan began to display happiness through authentic laughter. Although she still had moments where she appeared angry, the majority of the time she appeared positive. As Megan entered the fourth stage, her outward changes became apparent to her stepmother and father. When Megan became upset, she requested a hug from her stepmother. As Megan began seeking affection from her stepmother, their relationship began to grow closer. Megan's stepmother and father reported that all of Megan's behaviors concerns were no longer present. They verbalized that she was no longer a child of concern.

When the conditions that created the maladjustment are still present, healing may take longer (Axline, 1947). Therapeutic relationships provide the environment for healing, but when children are still subjected to relationships which facilitated their conditions of worth, discovering their self-worth may take longer (Axline, 1947). Therefore, if children still reside in the environment where the ACEs occurred, their maladjusted behaviors may remain persistent compared to potential for change in a stable, nurturing environment.

In Justin's case, he still had contact with his father, but he no longer resided in the same house. Therefore, the majority of the ACEs were occurring less frequently or less present. Justin was not exposed as often to the ongoing adverse conditions he had previously experienced. Justin's progress was identified by his mother quickly after the intervention phase began. Because many of the adverse experiences were less present, when Justin received the core conditions his self-structure was able to adapt more quickly. His movement toward self-actualization as evidenced through desire to connect to others became apparent to his mother and she observed his self confidence change and grow.

In Megan's case, she continued to live in an environment where some of the adverse experiences were still present. Throughout the first half of the study, Megan experienced being yelled at and ignored by her caregivers. Megan verbalized her feelings of being unwanted from her family. Therefore, the healing nature of the therapeutic relationship took longer than if those factors had been removed. As Megan strived to self-actualize during her play sessions, she was met with messages of being unwanted at home. Therefore, her self-structure remained rigid for a large portion of the session. As Megan's self-structure became more flexible, in spite of her environment, she began to demonstrate care and kindness toward her family. Megan's healing

relationship with her stepmother led to alleviating some of the ACEs that were still occurring which allowed her to continue to self-actualize.

Implications for Practice

Results of this single case research design provide implications for clinicians who are working with children who have experienced multiple ACEs. CCPT is a promising intervention modality for working with children who have experienced multiple or ongoing ACEs. Rogers (1957) stated there are six necessary and sufficient conditions that had to be met for to healing occur. Six necessary and sufficient therapeutic conditions include: 1) psychological contact between two people; 2) incongruence from the client; 3) a congruent therapist; 4) UPR for the client is conveyed by the therapist; 5) therapist experiences empathic understanding for the client; and 6) the client receives the congruence, UPR, and empathic understanding communicated by the therapist (Rogers, 1957). When the six necessary and sufficient conditions are present in the therapeutic process, healing transpires (Rogers, 1957). Although providing core conditions, therapist congruence, UPR, and empathic understanding, are important to healing, all six necessary and sufficient conditions must be met for healing to occur (Wilkins, 2010). As counselors, it is easy to mistakenly believe that the six necessary and sufficient conditions are being met based on counselors' views of providing the core conditions. Due to the negative nature of ACEs, therapists might encounter difficulty in regards to meeting the six necessary and sufficient conditions.

Rogers (1957) postulated that psychological contact between two people is necessary for healing to occur. When children who experienced traumatic and adverse experiences enter a therapeutic setting, they may have difficulty experiencing psychological contact. Because psychological contact is required for healing to occur, it is important that it is made within the

therapeutic relationship. Van Werde and Prouty (2013) proposed the use of pre-therapy with adults who were unable to establish contact. In pre-therapy, counselors use contact reflections to develop or restore contact by meeting clients at the concrete level of their expression. Contact reflections are concrete in nature and succinctly focus on what people are doing, saying, or feeling (Van Werde & Prouty, 2013). The utilization of contact reflections conveys UPR and empathy through therapists' willingness to meet clients at their concrete level. Similarly, CCPT therapists use tracking, reflecting content, and reflecting feeling skills utilized in CCPT (Landreth, 2011). In addition to therapeutic responses, play therapists can fully attune to children's nonverbal gestures, facial expressions, and child-therapist interactions (Ray, 2011). Therefore, if children are unable to make psychological contact, focusing on tracking, reflecting content, reflecting feeling, and nonverbal interactions will provide the concreteness necessary for the child and therapist to develop or restore contact while the therapist conveys UPR and empathy.

When entering play therapy, children should be in states of incongruence, which may be demonstrated through children's anxiety or vulnerability (Ray, 2011). Incongruence of clients is necessary for therapy because it is an indicator of maladaptive behavior (Landreth, 2012). Incongruence occurs when children's self-concepts and experiences do not align (Landreth, 2012). When children who have experienced adverse and traumatic experiences first enter therapy their ability to show vulnerability or anxiety may not be visibly apparent. Through therapists creating understanding and accepting relationships, children are likely to feel safe enough to demonstrate their incongruences (Landreth, 2012).

Regarding the third necessary and sufficient condition, play therapists strive to be genuine with each of their clients (Landreth, 2012). Being real and genuine within therapeutic

relationships provides therapists opportunities to fully express feelings and emotions occurring within therapeutic relationships (Ray, 2011). Genuine therapists possess high degrees of self-acceptance within counseling relationships (Landreth, 2012). In order for therapists to convey UPR and empathy, therapists may want to be genuine first (Wilkins, 2010). Because children who have experienced ACEs may exhibit challenging behaviors in play therapy, therapists may experience negative reactions in the playroom. Genuineness from therapists may be interpreted in negative ways if therapists react out of anger or fear (Ray, 2011). Children who have experienced ACEs are likely to be more sensitive to negative reactions and internalize reactive genuine behaviors from therapists. Therefore, therapists might continue to improve their self-understanding in order to convey genuineness while maintaining acceptance (Landreth, 2012).

Having UPR for clients is the fourth necessary and sufficient condition. UPR is the ability to fully accept clients (Landreth, 2012). Full acceptance requires therapists accept children as they are without the desire to change them (Axline, 1947). Therapists might struggle with conveying full acceptance if they are wanting to fix or cure children (Ray, 2011). Children who have experienced multiple or ongoing ACEs have the probability of having limited exposure to people who demonstrate UPR for them (Powers, 2012). Children who experienced ACEs are likely to have been exposed to conditional positive regard or negative regard (Powers, 2012). Due to the lack of exposure, children might have difficulty receiving UPR. Children might interact in ways that test therapists' UPR (Clarkson Freeman, 2014). Therefore, therapists might have difficulty providing UPR due to children behaving in negative ways in order to met their previous experiences. While maintaining UPR for children is important it can be a difficult endeavor.

The fifth necessary and sufficient condition is empathic understanding. Empathic understanding is the ability to enter the client's world fully without losing personal sense of self (Ray, 2011). Having empathy for children who have experienced multiple or ongoing ACEs might be difficult and painful for play therapists (Ray, 2011). Children may have endured painful situations outside of play therapists' experiences which may lead the therapist to and take on the feelings and emotions of children. (Ray, 2011). Although empathic understanding may be difficult, offering full understanding to children is crucial. When children feel understood they are more likely to express more of themselves and venture more into therapeutic relationships (Landreth, 2012).

In regard to the sixth necessary and sufficient condition, the child must perceive upr and empathic understanding for change to occur. Rogers (1951) proposed that when experiences occur they are either integrated into the perception of self, ignored because they do not fit the current self-structure, or denied or given distorted meaning because the experience is not consistent with the current self-structure. Therefore, core conditions may be rejected or given a distorted meaning for children to protect and preserve their self-structures. Children who have consistently perceived a lack of regard or worth due to negative experiences are likely to respond slowly and cautiously to an experience in which they are attended to and prized.

Although CCPT can be a lengthy process, the consistent attendance of clients is likely to lead to healing. As children slowly perceive and integrate the core conditions, they are able to form a new self-structure. When counselors hold few expectations of child clients while unconditionally positively regarding them, children are able to grow and develop (Rogers, 1957). Although their self-actualizing tendency may have been halted, it is still a positive force inside of them. By having the six necessary and sufficient conditions met, children can begin to integrate

new experiences and establish a more fluid self-structure (Ray, 2011). The fluidity of their self-structure will provide them with abilities to accept more positive experiences without rejecting them fully. Child-centered play therapists provide the core conditions, which over time allow for the six necessary and sufficient conditions to be met. If the six necessary and sufficient conditions are met, the self actualizing tendencies continue moving in a positive direction (Wilkins, 2010). By allowing children to heal and develop at their own pace, therapists are unconditionally regarding children and their processes.

Children who have experienced multiple or ongoing ACEs might have sporadic healing experiences (Powers, 2012). Children may appear to be healing when negative behaviors reoccur. Although their healing may not be a linear process, children are working through their difficulties in their own ways (Landreth, 2012). Patience from the therapist throughout the process is of the utmost importance. Recovering from adverse or traumatic experiences can be a long process due to the experiences children have endured (Powers, 2012). The process of healing from adverse or traumatic experiences can take a long period of time, therefore the therapist should understand the lengthy process and remain patient throughout therapy (Powers, 2012).

Children who have experienced ACEs may still be exposed to the same ACEs while in play therapy. Children who have endured ongoing or multiple ACEs, have had a difficult childhood prior to entering play therapy (Clarkson Freeman, 2014). The adversities faced by children who experienced ACEs differ based on individuals (Clarkson Freeman, 2014). Due to the varying nature of the experiences, it is difficult to predict how children will present during play therapy. Sessions with children exposed to ACEs may differ greatly.

Overall, CCPT appears to be a promising intervention for children who have experienced multiple or ongoing ACEs. When implementing CCPT, it is important to consider that number of sessions with children might vary and healing might occur quickly or gradually. Although parents may not report sudden changes, it is important to notice small changes.

Implications for Research

This pilot study provided information for future research with children who have experienced four or more ACEs. Following this study another SCRD is suggested with a multiple baseline design with three or more participants. By recreating this study, using the guidelines from What Works Clearinghouse (Kratochwill et. Al, 2010), researchers can assist in building the evidence-based literature for children who experienced ACEs.

In addition to another SCRD, a correlation study should be conducted to continue to discover how ACEs impact children. While there are a few studies examining the correlations between ACEs and children's behaviors, a study should be conducted to increase researchers understanding of which assessment measures are more indicative of the problematic symptomology resulting from ACEs.

A randomized controlled trial could be the following step in research. Comparisons between children who have experienced four or more ACEs receiving the CCPT intervention and children who have experienced four or more ACEs not receiving the intervention will provide researchers a further understanding of the effects of CCPT with children who have experienced four or more ACEs.

When researchers begin recruitment for any of the suggested studies, they should recruit more participants than needed. Due to the nature of ACEs, attrition is likely to occur at a higher rate than with other studies. In addition to attrition, recruitment is difficult with this population

due to the nature of the questions used to determine eligibility. Recruitment processes should begin well in advance and participants should be entered into the studies at different times.

Limitations

There are a few limitations to the study. Single case design has minimal external validity which limits the ability to generalize the findings to the general population. Although both participants demonstrated changes within the study, it is difficult to generalize these findings to all children who have experienced ACEs due to the individual nature of single-case design.

As a result of children returning home to biological parents, two participants withdrew from the the study. Due to the attrition, there were fewer participants which prohibited the use of a multiple baseline approach. Home disruptions and instability of placement inhibited the researcher's ability to locate enough participants to participate in a clinic-based intervention.

Disruptions in the home environment may have impacted the way in which participants were rated by their parents. Having one rater per participant may have inhibited the researchers from gaining a deeper understanding of the effectiveness of CCPT. In order to have gained more insight, the researcher could have utilized more raters per child or incorporated an observation measure.

By being able to attend clinical sessions twice a week, children in the study had protective factors in place that not all children who have experienced ACEs have available to them. Their caregivers were able to bring them frequently and engage in outside parent consultations. Many children who experience ACEs may not have those protective factors in place.

Due to caregivers' report regarding the occurrence of ACEs rather than the children who have experienced them, not all of the ACEs may have been reported. Reports are based on the

parents' views of the child's experiences and due to changes in home environments, parents may not have a full understanding of the depth of the ACEs. When answering the questions parents may not fully grasp how their children are experiencing the environments.

Conclusion

ACEs have been shown to have negative effects throughout the lifespan beginning in childhood after the ACEs have occurred (Argawal, 2015). D'Andrea et al. (2015) reported a negative impact on cognitive, emotional, and social development for children who experience ACEs. Theoretically, the younger the child is when experiencing adverse childhood experiences, the more vulnerable the child is to delays in development (Clarkson Freeman, 2014). Adverse childhood experiences lead to impairment of social, emotional, and cognitive development. Impairment of development increases the possibility of adopting health risk behaviors, which can lead to disease, disability, and social problems resulting in an early death (Anda, 2006).

The purpose of this study was to examine the effectiveness of facilitating CCPT with children who had four or more ACEs. Each of the participants in the study had eight ACEs which was well over the requirements for the study. Both participants demonstrated clinical levels in some or all of the subscales from the SDQ as well as high levels of posttraumatic stress. Through the duration of the study, both participants significantly decreased in all areas of concern and were not clinical in any area. Although the improvements occurred at different times of the intervention phase, both children had lasting changing once the initial change was reported. Through the play therapy experience, both participants were able to begin self-actualizing which allowed them to build self acceptance and self confidence. Through thorough examination of the data, there appeared to be a correlation between CCPT and healing from ACEs for these participants.

APPENDIX E

INFORMED CONSENTS

University of North Texas Institutional Review Board
Parent/Guardian Informed Consent Form

Before agreeing for your child to participate 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: Play Therapy for Children Who Experienced Adverse Childhood Experiences: A Single-Case Design

Principal Investigator: Dee Ray, PhD, LPC-S, NCC, RPT-S, University of North Texas (UNT) Department of Counseling & Higher Education

Student Investigator: Sara Haas**,** MA, LPC-Intern, NCC, University of North Texas (UNT) Department of Counseling & Higher Education

Purpose of Study: You are being asked to allow you and your child to participate in a research study designed to explore the impact of play therapy on children who experienced Adverse Childhood Experiences (ACEs). An ACE is a traumatic experience that occurs in a child's life prior to the age of 18, such as abuse or negative environmental conditions.

Study Procedures: Your child will be asked to participate in play therapy. Play therapy is a type of counseling for children where they can express themselves in a way that is most comfortable for them. Young children often have a hard time working through problems with words, so play therapy helps the process by providing a play environment where they can work through social and emotional concerns. Your child gets to decide what materials to play with and what to discuss in play therapy. Your child will not be asked intrusive questions or forced to play. Your child will participate in two 45-minute play therapy sessions per week for approximately 12 weeks. The play sessions will be video-recorded and a member of the research team will watch the recordings to look at the quality of play therapy services provided to your child. All recordings will be treated according to procedures for maintaining confidentiality.

You will be asked to participate in two 30-minute interviews with a researcher at the beginning and end of the study. Additionally, you will be asked to complete two assessments prior to beginning. One of the assessments will take approximately 15 minutes and will be completed weekly for a minimum of three weeks before the first session. You will be asked to complete the same assessment weekly during the duration of treatment and for four weeks after the treatment has completed. You will also be asked to complete the initial assessment, which will take approximately 30 minutes, at the midway point and final session.

Foreseeable Risks: There are no significant personal risks expected from involvement in this study. Your child's participation is completely voluntary. You may withdraw you or your child at any time during the course of the study. However, possible risks may include one or more of the following:

1. Because detailed information will be gathered about your child to understand his or her development, the primary risk to you and your child is the possible break of

confidentiality. Although every effort will be made to disguise you and your child's identity, results of this study will be published and there is the possibility that someone may recognize details written about your child. To help increase confidentiality and the risk of someone recognizing you or your child's identity, a summary of your interviews will be written up for you to read and approve before any information is published.

2. Anything that is said or done during play therapy is considered confidential, meaning that the therapist will not reveal anything that happens in the session to another person outside of the UNT Child and Family Resource Clinic. However, if your child discloses child abuse, neglect, exploitation or intent to harm another person, the therapist is required by law to report it to the appropriate authority.

3. Because play therapy is a counseling method, your child could possibly feel and/or express negative emotions. The therapist will help your child work through his/her feelings in a healthy and appropriate way.

Benefits to the Subjects or Others: We hope that the information collected from this study will be used to help the services available for children who experienced ACEs. The results of this study may provide counselors and other professionals across the nation with information that helps provide more comprehensive treatment for children who experienced ACEs. Participation may or may not directly benefit to your child. We hope this project benefits children by improving social and emotional abilities and overall functioning of children who experienced ACEs.

Compensation for Participants: Neither you nor your child will be compensated for participating in the study. The $50 counseling session fees will be waived during the study to compensate for services given.

Procedures for Maintaining Confidentiality of Research Records: All information will be kept confidential in a locked cabinet in the clinic of the Counseling Program at the University of North Texas. Names of parents and children will not be revealed in any publication or discussion of this material. Information gotten from the assessments will be recorded with a code number. Only the research team will have a list of the participants' names. The play sessions will be video-recorded and a member of the research team will watch the recordings to look at the quality of play therapy services provided to your child. At the end of this study, the videos may possibly be shown in professional presentations for educational purposes. Identity information such as name, place of living, and other specific information will not be revealed when video recordings are shown in educational settings and will be destroyed through digital deletion after 5 years. Although we will not use identifying information when videorecordings are shown in educational settings, your child's face can be seen which means we cannot guarantee anonymity. However, you may choose to withdraw your consent at any time and the video recordings of your child will not be used.

Questions about the Study: If you have any questions about the study you may contact Dr. Dee Ray, Professor, University of North Texas via telephone at 940-565-2066 or through email at dee.ray@unt.edu or Ms. Sara Haas, University of North Texas, via telephone at 940-565-2066 or through email at sara.haas@unt.edu.

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.

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:

- Sara Haas has explained the study to you and answered all of your questions. You have been told the possible benefits and the potential risks and/or discomforts of the study.
- You understand that your child does not have to take part in this study and 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 child's participation at any time.
- You understand why the study is being conducted and how it will be performed.
- You understand your child's rights as a research participant and you voluntarily consent for your child to participate in this study.
- You have been told you will receive a copy of this form.

☐ By checking this box, I understand that video recording of my child in play therapy services will be seen by one research member to ensure that the therapist was conducting child-centered play therapy correctly.

☐ By checking this box, I give my permission for the video recordings of my child in play therapy to be used for educational purposes to help teach others about how play therapy can be used with children who experienced ACEs. Videos will be destroyed 5 years after the completion of this study.

_____ _____

Printed Name of Parent/Legal Guardian Name of Participant (child)

_____ _____

Signature of Parent/Legal Guardian Date

For the Student Investigator:

I certify that I have reviewed the contents of this form with the subject signing above. I have explained the possible benefits and the potential risks and/or discomforts of the study. It is my opinion that the participant understood the explanation.

_____ _____

Signature of Student Investigator Date

APPENDIX F

PARENT/GUARDIAN INTERVIEW

Final Parent/Guardian Interview

Child_____ Date_____

Since the start of this study, has your child experienced any significant events or changes in his or her home and/ or school environment?

If so, how do you believe that it has affected him or her?

Have any changes taken place in your life that could possibly affect the home or school environment?

Please describe any changes you have observed in your child since the start of this study.

What changes, if any, have you seen in your child's behaviors?

What changes if any have you seen in your child's ability to maintain friendships and/or feel comfortable with peers?

What changes, if any, have you seen in how your child deals with emotions?

Have there been any changes in your relationship to your child or child's relationship to you?

What has this play therapy experience been like for you and your child?

Is there anything else you think I should know about your child at this time?

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