

CHILD-CENTERED PLAY THERAPY WITH CHILDREN WHO HAVE EXPERIENCED DISRUPTIONS IN
CARE

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The current study is the first ever exploring the impact of child-centered play therapy (CCPT), an evidence-based children counseling intervention, on the trauma symptoms and social-emotional competencies of children who have experienced disruptions in care. The study utilized a within-subjects single cohort design and repeated measures over four times during intervention based on parent report. Participants consisted of 16 children recruited from three Title-1 elementary schools and two community counseling clinics in the southwest United States who were aged 5 years to 12 years ($M = 8.31$, $SD = 2.18$), had experienced between 2 and 9 care disruptions ($M = 4.5$, $SD = 2.68$), and were reported by caregivers as having clinically concerning levels of trauma symptoms and/or social-emotional assets. Results indicated that participants who participated in CCPT demonstrated statistically significant improvement in trauma symptoms over time as measured by Trauma Symptom Checklist for Young Children (TSCYC) total posttraumatic score with a very large effect size. Results also indicated that participants who participated in CCPT demonstrated an increase in social-emotional competencies as measured by Social-Emotional Assets and Resilience Scales – Parent (SEARS-P) total score with a medium to large effect size. Findings of this study revealed meaningful changes in trauma symptoms and social-emotional strengths at 12 CCPT sessions, continuing into 16 sessions. Clinical significance, implications for practice, and limitations of the study are discussed.

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The most difficult page of my dissertation to write! How can I possibly fit all my gratitude on to one page? This dissertation process has been one of the most challenging and rewarding experiences of my life (cliché yet true), and I couldn't have made it through without the relationships that have walked through this journey with me. To Dee, thank you for everything. Your warmth and genuineness gave me the strength to be seen. Your acceptance and love for me as a person has helped me grow and flourish. You have shaped not only my doctoral experience, but my life. To Peggy, thank you for always having an open door, a safe space, and a warm hug ready for me, even from afar. To Leslie, thank you for being with me every step of the way and for driving me to my car after late night practicums. To Dalena, thank you for cheering me on and believing in my abilities from day one.

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CHILD-CENTERED PLAY THERAPY WITH CHILDREN WHO HAVE EXPERIENCED CAREGIVING DISRUPTIONS

Care disruptions, which can include foster care, state custody, kin or non-kin guardianship, or other custody arrangements, are relational traumas that inherently impact the child's attachment bonding (D'Andrea et al., 2012). A child's attachment to a safe and consistent caregiver has long been understood as the foundation for the child's well-being (Bowlby, 1982; Erikson, 1994; Madigan et al., 2023). Four percent of children in America live with neither of their parents (Federal Interagency Forum on Child and Family Statistics, 2023), including nearly 400,000 children in the foster system (United States Children's Bureau, 2022). Since the seminal attachment work of John Bowlby (1982; 1973; 1980) and Mary Ainsworth (Ainsworth, et al., 1978), research has continued to explore the mental health needs of children who have experienced displacement (Fisher et al., 2006; Ruff et al., 2016; Baker et al., 2017); however, few studies have explored the effectiveness of mental health interventions with this population.

Though a child's attachment to their primary caregiver is determined in infancy (Bowlby, 1982), secure attachment to non-caregivers has been shown to be a protective factor for children (Bethell et al., 2019; Denault et al., 2021). Children exist within a network of attachment figures, as opposed to one singular attachment figure (Denault et al., 2021), suggesting that non-caregiver adults may still provide a safe and secure relationship within which a child may feel safe to explore and express themselves as they would in a secure attachment with a caregiver (Bowlby, 1982). In fact, non-caregiver adults have been shown to play a role in facilitating growth and development throughout a child's life (Bethell et al., 2019).

The promising benefits of a child's attachment network provides an opportunity for non-caregiver adults to provide healing relationships for a child who has otherwise experienced harmful or inconsistent relationships. Child-centered play therapy (CCPT) is an intervention that utilizes the therapeutic relationship as the healing factor (Axline, 1947; Landreth, 2024; Ray, 2011); given that displacement is a relational trauma, CCPT is theoretically well-matched for this population.

Impact of Care Disruptions on Children

The impacts of attachment disruptions have been long documented, from Bowlby's seminal work (1982; 1973; 1980) to decades' worth of continued exploration of the impacts of attachment disruption on children's wellness (Dagan et al., 2022; Denault et al., 2021; Fearon et al., 2010; Groh et al., 2017; Madigan et al., 2013; Madigan et al., 2023; van IJzendoorn et al., 1999). Research indicates that displacement from caregivers results in disrupted attachment experiences and impacts children's attachment behaviors (Bowlby, 1973; Bowlby, 1980; Lake, 2005; Madigan et al., 2023; Stinehart et al., 2012), trauma related symptoms (Bederian-Gerdner et al., 2018; Baker et al., 2017), social-emotional competencies (Mitchell & Kuczynski, 2010; van IJzendoorn et al., 1999), and externalizing and internalizing problems (Zhao et al., 2021; Baker et al., 2017; van IJzendoorn et al., 1999).

Children with care disruptions typically experience numerous traumas (Baker et al., 2017), which often result in an increased likelihood of a variety of poorer physical and mental health outcomes (Burke et al., 2011; Felitti et al., 1998; Hughes et al., 2017). Moreover, D'Andrea et al. (2012) identified traumatic disruption in attachment bonding with primary caregivers as a primary type of developmental trauma, and Spinazzola et al. (2021) further

stated that children who experience a traumatic disruption in attachment bonding are more likely to present with posttraumatic symptomology including emotion or somatic dysregulation, attentional or behavioral dysregulation, and self- or relational-dysregulation. The unique and layered disruptive experience may result in similarly unique trauma symptoms, prompting targeted research on this population.

Posttraumatic symptoms include thoughts, feelings, and behaviors that develop following an individual's exposure to a traumatic event and vary from individual to individual with developmental considerations for children (American Psychiatric Association [APA], 2022; D'Andrea et al., 2012; Spinazzola et al., 2021). Posttraumatic symptoms include intrusive symptoms, avoidance symptoms, arousal symptoms, and negative thoughts or feelings (APA, 2022). Developmentally, children may experience posttraumatic symptoms including repetitive play, scary nightmares with no recognizable content, trauma reenactment in play, and extreme temper tantrums (APA, 2022). Additionally, attachment insecurity, maladaptive self-soothing, betrayal-based relational schemas, and impaired interpersonal empathy have been shown to impact children who have been exposed to interpersonal trauma, especially traumatic separation from a primary caregiver (D'Andrea et al., 2012). The cyclical nature of attachment disruptions resulting in attachment insecurity (D'Andrea et al., 2012; Spinazzola et al., 2021) highlights the need for early intervention to break the cycle.

Children with care disruptions often present with decreased social-emotional competencies and strengths, including decreased interpersonal skills (Mitchell & Kuczynski, 2010), decreased self-concept and self-esteem (Goodvin et al., 2008; Zhao et al. 2021), and increased internalizing and externalizing concerns (Baker et al., 2017; Zhao et al., 2021). Social-

emotional competencies have been identified as a protective factor for children at risk of developing maladaptive characteristics (Domitrovich et al., 2017; Ray et al., 2020). Social-emotional competencies also encompass internalizing and externalizing problems. Internalizing behaviors may include emotional competence, while externalizing behaviors may be related to the child's self-management abilities. Zhao and colleagues (2021) suggested that experiencing 12 or more months of separation from one's biological parents resulted in higher internalizing behaviors, including depressive symptoms, anxious symptoms, and feeling lonely or sad; as well as higher externalizing behaviors, including arguing, fighting, acting impulsively, having trouble concentrating, and feeling angry. As such, child therapists may benefit from investigating interventions to support the growth of children's social-emotional strengths following disruptions in their caregiving.

Without intervention, attachment disruptions and adverse childhood experiences have been shown to have long-lasting and detrimental impacts to individuals' holistic wellness. However, little research has been conducted regarding mental health interventions with children who have experienced care disruptions, who often experience layered traumatic experiences. In fact, although nearly half of the children investigated by child welfare agencies present with clinical emotional or behavioral concerns, only one fourth of these children received mental health support services (Burns et al., 2004), further supporting the assertion that mental health services are the largest unmet need for children in the foster care system (American Academy of Pediatrics, 2021).

Child-Centered Play Therapy

Child-centered play therapy (CCPT) is a developmentally appropriate counseling intervention that utilizes play as the child's natural language and the therapeutic relationship as the healing factor (Axline, 1947; Landreth, 2024; Ray, 2011). Child-centered play therapy emphasizes that "it is the relationship that is the therapy" (Landreth, 2024, p. 76), adding that the role of a CCPT therapist is to be rather than to do. This therapeutic relationship is facilitated by the play therapist's conveyance of genuineness, empathic understanding, and unconditional positive regard (Axline, 1947; Landreth, 2024; Rogers, 1957).

In CCPT, empathic understanding is the counselor's ability to experience accurate understanding of the client's world as if it is the therapist's own world yet without forgetting the "as if" quality (Rogers, 1957). With this deep understanding, the counselor is then able to communicate this understanding to the client, at times putting words to things of which the client themselves is unaware (Rogers, 1957). Unconditional positive regard is the therapist's experiencing of the client as worthy just as they are, embracing a warm acceptance toward all parts of the client with "no 'ifs,' 'buts,' or 'not reallys'" (Rogers, 1957). Axline (1947) further explored this concept, stating that the therapist must accept the child exactly as they are without any expectation or hope that they change. The counselor's congruence, also known as genuineness, suggests that, within the therapeutic relationship, the counselor is fully and authentically connected with themselves (Rogers, 1957). Rogers' attitudinal conditions (1957) are echoed in Landreth's four healing messages (2024, p. 232-233): "I am here. I hear you. I understand. I care." Embodying these attitudinal conditions creates a nonthreatening and nonjudgmental relationship within which the child can move toward self-actualizing growth and

healing (Rogers, 1951). The emphasis on the quality and depth of the therapeutic relationship places CCPT theoretically aligned with the needs of children who have experienced caregiver disruptions.

Children who experience care disruptions from their primary caregivers experience a substantial relational wound. Research indicates that the loss of their primary attachment figure is a traumatic experience that impacts the way they view themselves, relate to others, and interact with the world around them. Therefore, to best meet the needs of children who have experienced care disruptions, mental health interventions can provide children with a safe space to explore and make sense of their traumatic experiences within a trusting and secure therapeutic relationship. Disruptions in caregiving is characterized by inconsistency, unpredictability, and unreliable relationships. To counteract this, children who have experienced care disruptions may benefit from consistent, predictable, and reliable relationships within which to heal. Child-centered play therapy is a mental health intervention that utilizes such a therapeutic relationship as the healing mechanism in the developmentally appropriate language of the child, play. Simply put, disruptions in caregiving are relational traumas (D'Andrea et al., 2012), and CCPT is a relational intervention (Landreth, 2024).

Purpose of the Study

The purpose of the current study is to examine the relationship between participation in Child-Centered Play Therapy (CCPT) and the trauma symptoms and social-emotional wellness of children who have experienced disruptions in caregiving. Specifically, I sought to explore children's outcomes on trauma symptoms and social-emotional competencies over time when participating in CCPT. This study addressed the following research questions: (a) What is the

relationship between participation in child-centered play therapy over time and report of trauma symptoms for children who have experienced care disruptions? (b) What is the relationship between participation in child-centered play therapy over time and report of social-emotional competencies for children who have experienced care disruptions?

Method

To explore these relationships thoroughly, I conducted a repeated measures, single cohort design. To detail the growth in participants at different stages of their CCPT intervention, I utilized a within-subject design. Specifically, I explored the participants' trauma symptoms and social-emotional competencies before and after participation in 8, 12, and 16 sessions of CCPT in order to understand patterns of change over time in relationship with CCPT intervention.

Participants

Due to the uniqueness of the identified population, I used a purposive sampling approach to recruit participants from three Title-I elementary schools and two university-based clinics in the southwestern United States. In order to participate in the study, the participant met the following criteria: a) the child must be between ages 5 to 12; b) the child must currently be or have previously been separated from their biological parents by circumstances such as foster care, state custodial arrangements, or other guardianship arrangements such as grandparents, kin guardians, or non-kin guardians; c) the child must score in the Possibly Concerning or Clinically Significant range on a subscale of the Trauma Symptom Checklist for Young Children (TSCYC) or in the Tier 2 (At Risk) or Tier 3 (High Risk) range on a subscale of the Social-emotional Assets and Resilience Scales (SEARS); and d) the child must not be receiving counseling services elsewhere during the duration of the study. An a priori power analysis using

G*Power ($\alpha = .05$, power = .80, medium treatment effect) determined a sample size of 16 participants was needed to find statistical significance over four measurement points (Faul et al., 2007).

At the start of the study, 22 children met criteria for inclusion. Over the course of the study, two children experienced a change in caregivers and relocated during the study, three children's caregivers did not complete data collection procedures, and one child was omitted from analysis due to their active custody dispute and unstable caregiving throughout intervention, resulting in clinically meaningful differences from rest of sample. A total of 16 participants were included in the final study. Participants were aged between 5 years and 12 years ($M = 8.31$, $SD = 2.18$). Caregivers reported participants' gender identities were 62.5% male ($n = 10$) and 37.5% female ($n = 6$). Caregivers reported participants' racial/ethnic identities were 25% Black ($n = 4$), 12.5% Black/White ($n = 2$), 12.5% Hispanic ($n = 2$), 12.5% Hispanic/White ($n = 2$), and 37.5% White ($n = 6$).

Additionally, caregivers reported between 2 to 9 caregiver placements ($M = 4.5$, $SD = 2.68$), with the average age at first separation from biological parent occurring at age 2.3 years ($SD = 3.03$). Caregivers reported that the child participant had been in their care between one month to 8 years ($M = 2.86$, $SD = 2.82$). Within that, multiple participants experienced caregiving experiences that were difficult to quantify. For example, one child was placed in foster care on five separate occasions, but their current caregiver was unaware of how many placement changes they experienced during their time in foster care. Additionally, multiple clients experienced repeated caregiving changes between two placements (i.e., biological

parent and grandparent). In other words, the provided means may not be representative of the sample as a whole.

Instruments

Demographic Questionnaire

I verbally administered a demographic questionnaire with each guardian. The questionnaire included questions about the guardian's relationship to the child as well as questions about the child's age, gender, ethnicity, and caregiving experiences.

Trauma Symptom Checklist for Young Children (TSCYC)

The TSCYC is a 90-item standardized assessment of trauma symptoms for children aged 3 to 12 that allows for the guardian to report on their perspective of their child's concerns (Briere, 2005). The TSCYC includes nine clinical scales to explore the nuances of trauma symptoms, including Anxiety (ANX), Depression (DEP), Anger/Aggression (ANG), Posttraumatic Stress – Intrusion (PTS-I), Posttraumatic Stress – Avoidance (PTS-AV), Posttraumatic Stress – Arousal (PTS-AR), Posttraumatic stress – Total (PTS-TOT), Dissociation (DIS), and Sexual Concerns (SC; Briere, 2005). Items are rated on a four-point scale, from 1 (Not At All) to 4 (Very Often), and scores can be interpreted as possibly concerning (*T*-score of 65-69) or clinically significant (*T* greater than or equal to 70; Briere, 2005). The TSCYC reports good overall test-retest reliability, with coefficient alphas ranging from .81 to .93 (Briere, 2005). For the current sample, the Cronbach's alpha for the total score was calculated at .90.

The Social-emotional Assets and Resilience Scales™ (SEARS)

The SEARS is a strength-based assessment that measures social-emotional assets and resiliencies for children ages 5 to 18 (Merrell, 2011). For this study, I utilized the SEARS-Parent

Form (SEARS-P), which consists of 39 items and results in a total score made up of three domains: Self-Regulation/Responsibility (SR/R), Social Competence (SC), and Empathy (E; Merrell, 2011). Items on the SEARS-P are rated on a four-point scale, from 0 (Never) to 3 (Always), and scoring results in placement in Tier 1 (Average to High Functioning), Tier 2 (At Risk), or Tier 3 (High Risk; Merrell, 2011). The SEARS-P reports strong internal consistency reliability for the total score at $\alpha = .96$ (Merrell, 2011). For the current sample, the Cronbach's alpha for the total score was calculated at .96.

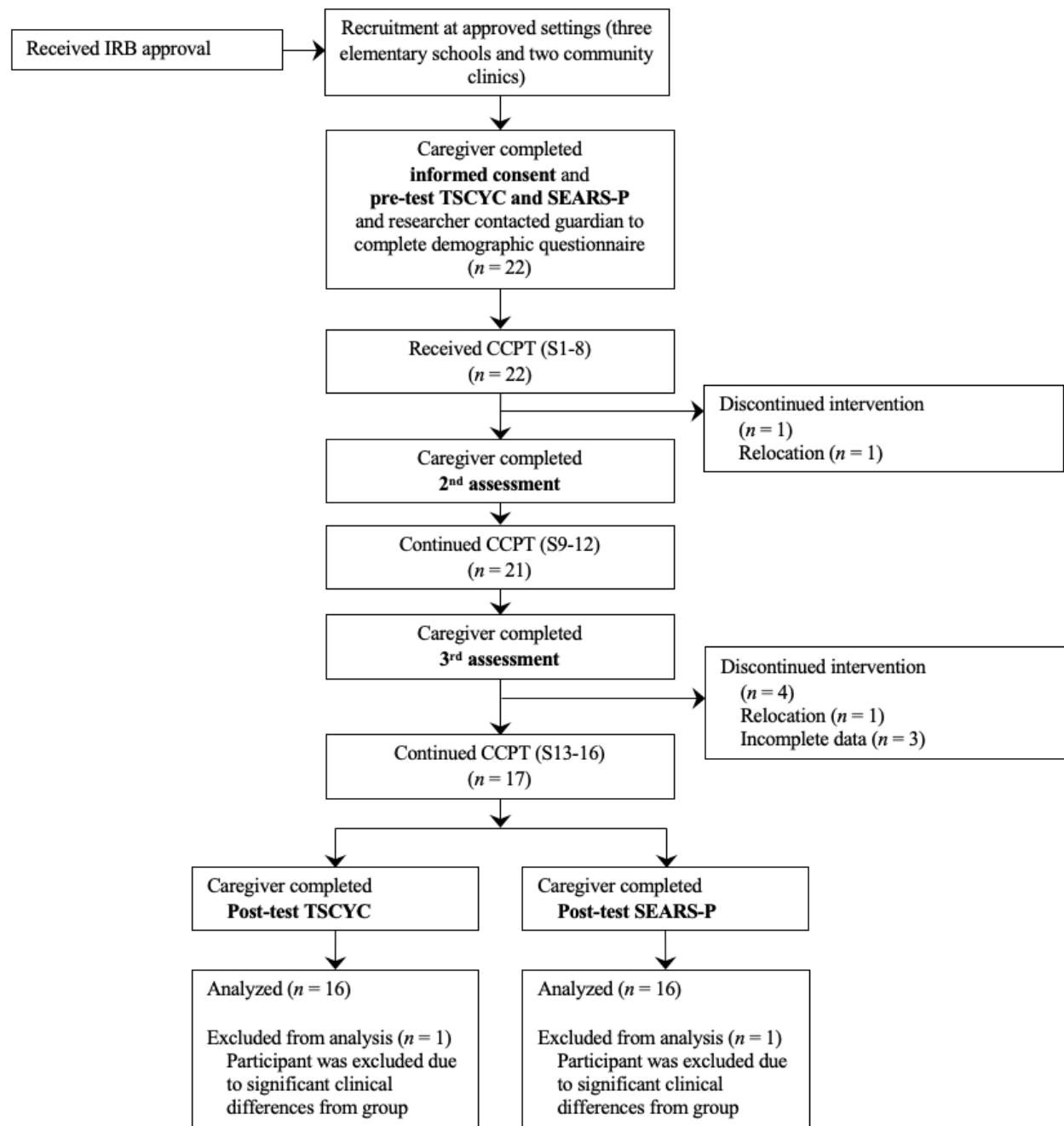
Procedures

Prior to beginning my study, I obtained approval from the Institutional Review Board (IRB). I distributed flyers to the clinical directors of each approved clinic and the school counselors of each approved elementary school, and these flyers were posted for caregivers to see. Confidential packets including an informed consent, a contact form, and the TSCYC and SEARS-P assessments were then provided to guardians who expressed interest. Once the packet was returned, I contacted the caregivers by phone to answer any questions, to confirm eligibility, and to verbally complete the demographic questionnaire. For one parent who did not speak English, I arranged for a translator in order to ensure that the caregiver understood the study and that language differences were not a barrier to receiving services.

Children who met all criteria received individual CCPT services twice weekly for 30 minutes over 8 weeks for a total of 16 sessions. All play therapy sessions were recorded on a video camera and digitally stored on confidential and encrypted video software used by the clinic to be used for later fidelity checks. The TSCYC and SEARS-P assessments were completed by the guardians prior to beginning services, between the 8th and 9th sessions, between the 12th

and 13th sessions, and upon completion of the 16 sessions. To ensure that assessments were completed in the appropriate time frames, I worked with the teachers to deliver the assessments to guardians in the child's backpack; if assessments were not returned on time, I called the guardian to administer verbally. For participants receiving clinic services, guardians completed the assessments in the lobby while the child was in their play therapy session. Figure 1 illustrates the procedures and treatment of the current study.

Figure 1
Research Procedures and Treatment



Intervention

Children participating in this study received individual CCPT. CCPT is a developmentally appropriate and culturally inclusive mental health intervention that emphasizes the therapeutic

relationship as the healing factor (Landreth, 2024; Ray, 2011). The interventionists for this study followed the CCPT manualized treatment protocol as outlined by Ray (2011). In CCPT, the play therapist works to create an environment within which the child can feel welcome by setting up the playroom with a carefully selected variety of toys and materials across a variety of categories, including real-life, acting-out aggressive-release, and creative expression and emotional release (Landreth, 2024). Relationally, the therapist embodies the attitudinal conditions of empathic understanding, unconditional positive regard, and congruence (Rogers, 1957) to create a warm and safe relationship. Additionally, the therapist utilizes verbal and nonverbal therapeutic responses congruent with CCPT, including tracking and reflecting content, reflecting feeling and meaning, facilitating decision making and creativity, esteem building and encouragement, and limit setting as well as open and warm body language (Ray, 2011).

For this study, the participants received a total of 16 CCPT sessions twice weekly over 8-10 weeks. Each session lasted 30 minutes in their elementary school or at a community counseling clinic on a university campus. The play therapy rooms in the clinics and schools were designed in accordance with Landreth's (2024) design and recommendations regarding size, location, and set up. Additionally, the inclusion of toys and materials were selected based on Landreth's (2024) historically recommended playroom as well as multicultural playroom recommendations (Chung et al., 2023; Turner, 2024) and were developmentally appropriate for children aged 3 through 12. The play therapy room was intentionally designed to allow for children's expression and exploration of themselves, others, and their environment (Landreth, 2024).

The interventionists for this study included two doctoral-level play therapists as well as six play therapists currently pursuing a doctoral degree. All play therapists had completed at least four graduate-level play therapy courses and were trained in CCPT. The play therapists self-identified as the following: a White cisgender female, a cisgender Jamaican-American Black female adoptee, an Indigenous Latina cisgender female, a Hispanic queer transgender man, a Pakistani cisgender female, a Filipino-American cisgender female, a White cisgender female, and a Black cisgender female.

To ensure fidelity to CCPT, all sessions were recorded, and two randomly selected session recordings per child were reviewed to check for fidelity in accordance with the CCPT protocol (Ray, 2011) by utilizing the Child-Centered Play Therapy – Research Integrity Checklist (CCPT-RIC; Ray et al., 2017). Protocol fidelity was defined as being at or above 90% adherence to CCPT verbal responses per the recommendations of Ray et al. (2017). The fidelity checks were carried out by a trained auditor who identifies as a White cisgender female. The auditor was a master's student who was in her internship experience, had taken three graduate play therapy courses, and was trained in utilizing the CCPT-RIC. For the current study, protocol adherence was calculated at .98, confirming that CCPT protocol was followed. In order to test the effects of the intervention as directly provided to children, therapists did not hold parent consultations nor engage with parents in conversation or discussion beyond scheduling. Following data collection, a therapy treatment plan was developed for each child to determine the need for and type of further clinical services.

Data Analysis

In order to answer the primary research questions, I completed a one-way repeated measures ANOVA analysis using the TSCYC Posttraumatic Stress – Total score and the SEARS-P Total score to understand the relationship between CCPT sessions and assessment scores over time and throughout intervention. Prior to running the analyses, I ensured that the assumptions necessary for running an ANOVA were met, including normal distribution, homogeneity of variance, and sphericity (Pallant, 2020). I conducted planned post hoc pairwise comparison analyses to determine the time of measurement for which significant changes occurred. Due to the number of analyses conducted, the Bonferroni method was applied to account for Type 1 error. Regarding interpretation of analyses, alpha was set at .05, meaning statistical significance was defined as a p value less than or equal to .05. Practical significance was measured using a multivariate partial eta squared (η_p^2) with a score of .01 being identified as small, .06 as moderate, and .14 as large (Cohen, 1988).

I decided that if statistical significance or meaningful practical significance was found for the main analyses, I would explore the subscale data with exploratory analyses that should be interpreted with caution due to higher possibility of Type 1 error based on multiple analyses with a small sample. The clinical significance was explored by noting how many participants' trauma symptomology decreased from the possibly concerning or clinically significant ranges to the average range.

Results

Trauma Symptoms

A repeated measures ANOVA was conducted to explore the impact of CCPT on participants' total trauma scores across time as reported by parents on the Trauma Symptom

Checklist for Young Children (TSCYC). Results of repeated measures ANOVA indicated a statistically significant difference at the $p \leq .05$ for time, Wilks' $\lambda = .444$, $F(3, 13) = 5.42$, $p = .01$, $\eta_p^2 = .56$. Thus, there was a statistically significant correlation between time and parent-reported improvement in participants' total posttraumatic stress symptoms, and 56% of the variance in outcome could be explained by increased time in CCPT.

Because a statistically significant result was obtained, post-hoc pairwise comparison analyses utilizing the Bonferroni method were completed to determine where the difference in scores occurred (see Table 1). Statistically significant differences were found between time points 1 and 3 and time points 1 and 4. In subsequent paired samples t-test analyses, between points 1 and 3 results indicated a statistically significant effect with large effect size ($p < .01$, $d = .88$) and between points 1 and 4 results indicated a statistically significant effect with large effect size ($p < .01$, $d = .88$). In summary, participants demonstrated statistically significant improvement with large effects after 12 and 16 sessions of CCPT.

Table 1
Pairwise Comparisons for TSCYC Posttraumatic Stress – Total Scores (N = 16)

Time (I)	Time (J)	Mean Difference (I-J)	Std. Error	Sig.
1	2	10.63	4.55	.20
	3	15.13	4.32	.02*
	4	14.44	4.10	.02*
2	1	-10.63	4.55	.20
	3	4.50	1.87	.18
	4	3.81	2.34	.75
3	1	-15.13	4.32	.02*
	2	-4.5	1.87	.18
	4	-.69	1.97	1.00
4	1	-14.44	4.10	.02*
	2	-3.81	2.34	.75
	3	.69	1.97	1.00

Note: * indicates statistical significance at $p \leq .05$

Due to statistically significant results with a large effect size, I decided to conduct exploratory analyses on the TSCYC subscales (see Table 2). These analyses should be interpreted with caution. Repeated measures ANOVAs identified statistically significant decreases in the participants' Posttraumatic Stress – Intrusion, Posttraumatic Stress – Avoidance, Posttraumatic Stress – Arousal, Anxiety, and Anger/Aggression scores, all of which showed very large effect sizes. Though Depression, Dissociation, and Sexual Concerns did not result in statistically significant differences, all still indicated very large effect sizes.

Table 2

One-Way Repeated Measures ANOVA Comparing TSCYC Scores Across Time (N = 16)

Dependent Variable		<i>M</i>	<i>SD</i>	<i>df</i>	<i>F</i>	<i>p</i>	η_p^2
Posttraumatic Stress – Total	Intake	70.56	21.84	3, 13	5.42	.01*	.56
	Session 8	59.94	11.52				
	Session 12	55.44	12.89				
	Session 16	56.13	10.81				
Anxiety	Intake	60.06	14.88	3, 13	7.73	<.01*	.64
	Session 8	52.94	10.42				
	Session 12	52.31	12.32				
	Session 16	53.44	11.63				
Depression	Intake	61.25	17.55	3, 13	2.78	.08	.39
	Session 8	54.50	11.78				
	Session 12	52.63	10.05				
	Session 16	53.94	12.74				
Anger	Intake	64.81	18.91	3, 13	8.33	<.01*	.66
	Session 8	56.69	15.52				
	Session 12	54.63	16.31				
	Session 16	54.25	13.43				
Posttraumatic Stress – Intrusion	Intake	66.56	24.71	3, 13	3.55	.05*	.45
	Session 8	56.69	14.35				
	Session 12	50.88	10.34				
	Session 16	53.31	10.39				
Posttraumatic Stress – Avoidance	Intake	73.00	26.99	3, 13	4.86	.02*	.53
	Session 8	63.69	21.21				
	Session 12	54.94	12.93				
	Session 16	57.75	17.28				
Posttraumatic Stress – Arousal	Intake	65.44	18.55	3, 13	3.40	.05*	.44
	Session 8	55.37	10.22				
	Session 12	56.81	17.86				
	Session 16	55.38	12.16				
Dissociation	Intake	62.56	17.71	3, 13	2.98	.07	.41
	Session 8	55.31	13.67				
	Session 12	52.50	8.75				
	Session 16	52.69	11.81				
Sexual Concerns	Intake	56.69	22.04	3, 13	2.30	.13	.35
	Session 8	52.63	10.63				
	Session 12	50.06	9.57				
	Session 16	49.25	9.18				

Note: M = Mean, SD = Standard Deviation, * indicates statistical significance at $p \leq .05$

Social-emotional Competencies

A repeated measures ANOVA was conducted to explore the impact of CCPT on participants' total social-emotional competencies across time as reported by parents on the Social-emotional Assets and Resilience Scales (SEARS-P). Results of repeated measures ANOVA indicated no statistically significant difference at the $p \leq .05$ for time, Wilks' $\lambda = .886$, $F(3, 13) = .560$, $p = .651$, $\eta_p^2 = .11$. However, the partial eta squared indicated a medium to large effect size as interpreted by Cohen's (1988) criteria. Pairwise comparisons were not analyzed due to lack of statistical significance on the total score. Due to the meaningful effect size on the total score, further analyses were conducted on SEARS subscales for deeper understanding (see Table 3). Although none of the subscales reached statistical significance, Self-Regulation/Responsibility resulted in a very large effect size, while Social Competence and Empathy resulted in medium to large effect sizes, indicating practical significance in the outcomes.

Table 3
Mean Scores of SEARS-P Scores Across Time (N = 16)

Dependent Variable		<i>M</i>	<i>SD</i>	<i>df</i>	<i>F</i>	<i>p</i>	η_p^2
Total	Intake	36.69	10.88	3, 13	.56	.65	.11
	Session 8	37.56	10.53				
	Session 12	38.31	10.71				
	Session 16	39.06	12.49				
Self-Regulation/ Responsibility	Intake	35.44	11.78	3, 13	1.28	.32	.23
	Session 8	37.31	9.80				
	Session 12	39.31	10.45				
	Session 16	39.31	11.92				
Social Competence	Intake	39.75	9.77	3, 13	.52	.68	.11
	Session 8	41.38	10.97				
	Session 12	40.50	10.46				
	Session 16	41.75	12.10				
Empathy	Intake	40.13	13.04	3, 13	.51	.68	.11
	Session 8	40.88	12.26				
	Session 12	39.12	11.62				
	Session 16	41.31	12.79				

Note: M = Mean, SD = Standard Deviation

Clinical Significance

To address the clinical significance of trauma symptoms, I explored the participants' clinical scores on the TSCYC Posttraumatic Stress – Total (PTS-TOT) subscale to determine meaningful clinical progress for participants. Of the 16 participants, eight participants' TSCYC PTS-TOT intake scores indicated clinically significant or concerning levels of posttraumatic symptomology at pretest. Of those eight, six progressed to lesser concerning categories at the completion of 16 CCPT sessions. Of those, three went from significantly clinical scores at intake to average scores at completion of 16 sessions. Two went from significantly clinical scores at intake to the lesser concerning category. One went from concerning scores at intake to average category at the final rating. Of all 16 participants, no participants were reported to have had worsening PTS-TOT scores from intake to completion of sessions.

Discussion

In this study, I examined the impact of Child-Centered Play Therapy (CCPT) on the trauma symptoms and social-emotional competencies of children who have experienced care disruptions. By utilizing a within-subject single cohort design, I investigated changes in the participants' scores on the TSCYC and SEARS-P across four points of measure throughout their participation in CCPT, allowing for a deeper exploration of the relationship between trauma symptoms and social-emotional competencies over time in CCPT. Caregivers reported statistically significant improvements in trauma symptoms following participation in CCPT. Trauma symptoms included posttraumatic intrusion, avoidance, and arousal (Briere, 2005). To provide a more holistic perspective, subscales of behaviors commonly exhibited by traumatized children were also explored, including anxiety, depression, anger and aggression, dissociation, and sexual concerns (Briere, 2005). Caregivers reported meaningful improvements in all the associated concerning behaviors. Additionally, caregivers reported practically significant improvements in social-emotional competencies following participation in CCPT. Social-emotional competencies included self-regulation and responsibility, social competence, and empathy. Overall, results indicated the beneficial effects of CCPT over time for children who have experienced disruptions in care in reducing their trauma symptoms and improving their social-emotional competencies.

Trauma and CCPT

Children who have experienced disruptions in caregiving often experience a layered trauma experience. Disruptions in the child's caregiving experiences impact the child's attachment bonding with their primary caregiver, which is conceptualized by D'Andrea et al.

(2012) as a primary developmental trauma and results in a higher likelihood of attachment insecurity (Madigan et al., 2023), which impacts the way that the child relates to the world, to themselves, and to others (Ainsworth et al., 1978). In addition to attachment trauma, the care disruption is often preceded by a separate traumatic experience, such as abuse or neglect (Baker et al., 2017), which have far-reaching emotional, physical, and mental impacts on the children they impact (Burke et al., 2011; Felitti et al., 1998; Hughes et al., 2017). Because CCPT prioritizes the therapeutic relationship as the healing factor in play therapy, the intervention appeared well-suited to address the attachment trauma experienced by children with care disruptions.

Past exploration of therapeutic interventions with children who have experienced care disruptions has provided some insight into the benefits of counseling as well as the unique factors counselors may need to consider. Firstly, conceptualization of an “attachment network” suggests that children may develop unique attachment relationships with the various adults in their lives (Denault et al., 2021), and that these attachments to non-caregiver adults may have a cumulative impact on the child’s well-being (Bethell et al., 2019; Denault et al., 2021), suggesting that the CCPT therapist may serve as a secure attachment figure within the child’s attachment network. CCPT highlights the direct therapeutic relationship between child and therapist as the primary factor of healing.

Research has also continued to show the long-term impacts (Spinazzola et al., 2021) and cyclical nature of attachment disruptions (Vreeland et al., 2020). In other words, disruptions in caregiving may result in increased externalizing behaviors which then may result in another caregiver placement and attachment disruptions which then may result in even more

externalizing behaviors and so forth. This suggests the need for early intervention to attempt to intervene and disrupt the cycle. In the current study, the mean age of participants was eight years old, allowing for intervention at an early age to address disruptions prior to worsening of behaviors. Results indicated that participation in CCPT over time resulted in reduced problem trauma symptoms highlighted in the symptom checklist.

Overall, results of this study indicated that CCPT may be a well-matched therapeutic intervention for children who have experienced care disruptions to decrease their trauma symptoms. Previous CCPT research has explored the impacts of the intervention of children who have experienced trauma (Frawley & Dillman Taylor, 2024; Ray et al., 2021; Schoonover & Perryman, 2022). These studies concluded that utilizing CCPT with children who have experienced adverse childhood experiences may result in improved social-emotional competencies (Ray et al., 2021) and decreased externalizing behaviors (Ray et al., 2021; Schoonover & Perryman, 2022) by providing an attuned relationship within which the child can engage in relational coregulation with a safe adult (Frawley & Dillman Taylor, 2024).

Disruptions in caregiving can be experienced by a child as traumatic (D'Andrea et al., 2012; Spinazzola et al., 2021), and therefore these children may present with posttraumatic symptoms. The TSCYC measures posttraumatic symptoms as an accumulation of intrusive, avoidant, and aroused thoughts and behaviors as well as by externalizing and internalizing behaviors often experienced by traumatized children including anxiety, depression, anger and aggression, dissociation, and sexual concerns (Briere, 2005). Posttraumatic intrusion includes maladaptive and unexpected memories related to the traumatic experience and can include nightmares and trauma reenactment (Briere, 2005). Posttraumatic avoidance includes the

child's attempt to ignore or avoid trauma reminders, triggers, or memories and can include declining to talk about their experiences or avoiding places or people that remind them of their trauma experiences (Briere, 2005). Posttraumatic arousal includes hypervigilance to a lack of felt safety and can include jumping or flinching (Briere, 2005). Results of the current study indicated statistically significant improvements in the overall posttraumatic symptoms of the participants following participation in CCPT with very large effect sizes. In other words, this study suggests that participation in CCPT may decrease the intrusive, avoidant, and arousal symptoms of children who have experienced disruptions in caregiving.

CCPT views the relationship as the therapeutic factor (Landreth, 2024), which may provide a unique and healing relationship within which the child can begin to process this relational trauma. Additionally, the CCPT therapist trusts the child's process and meets them where they are in their healing journey. As the child experiences such a relationship with their therapist, they experience a safe and predictable relationship for, perhaps, the first time. CCPT aims to create a safe relationship that is characterized by empathy and warmth, understanding and acceptance, and authenticity. These conditions may serve to counteract the coldness, expectation, and duplicitousness the child may have experienced in their traumatic relationships. Within the CCPT relationship, the traumatized child is able to work through their experiences with the support and understanding of the therapist. By embodying the tenets of CCPT, the therapist seeks to form a secure attachment with the child and act as a secure base and a safe haven (Bowlby, 1982). As a secure base, the therapist conveys trust in the child's pace and direction, allowing them to explore the experiences most pertinent to them. As a safe haven, the therapist serves as a connection during painful moments with whom the child can

seek comfort when feeling distressed. As CCPT emphasizes a warm and empathic relationship, the CCPT therapist is able to create a real and genuine relationship with the child and act as a secure attachment figure from within which the child is able to fully explore themselves and their experience and express their innermost thoughts and feelings. Hence, utilizing CCPT with children who have experienced care disruptions appears to be a well-matched intervention that is able to meet the child where they are and walk with them through their processing. This study confirmed that CCPT was a well-matched relational intervention for this sample. Care disruptions are characterized by inconsistency, unpredictability, and unreliable relationships, and CCPT provides a consistent, predictable, and reliable therapeutic relationship within which the child can work toward healing.

Social-emotional Competencies

Children who have experienced disruptions in caregiving may experience difficulties in their social-emotional strengths (Groh et al., 2017; Ray et al., 2020). Mitchell and Kuczynski (2010) found that initial removal from biological parents resulted in impeded ability to understand the world, relate to others, and predict how others will respond to them. McTavish et al. (2022) found that children with disruptive caregiving experiences desire meaningful and supportive adult relationships; however, due to the often unstable and unpredictable futures of children with a history of care disruptions, children may struggle to identify such relationships. This is particularly salient, as social support has been shown repeatedly to act as a protective factor for traumatized children (Bethell et al., 2019; Blodgett & Lanigan, 2018). Zhao et al. (2021) and Goodvin et al. (2008) found decreased self-esteem and self-concept in children with care disruptions indicating a need for intervention that targets the building of strengths.

Though not statistically significant, results of this study show moderate to large effect sizes with social-emotional assets, suggesting that CCPT may positively impact the self-regulation and responsibility, social competence, and empathy of children who have experienced care disruptions. Self-regulation and responsibility seemed strongly affected by participation in CCPT, given the resulting effect size. CCPT may have provided a space within which the children could build upon these strengths. Results of the current study confirm past research, which has shown support for the use of CCPT to promote children's social-emotional competencies (Taylor & Ray, 2021; Wilson & Ray, 2018). CCPT therapist responses including reflections of content and feeling, encouragement, and facilitating creativity affirm the child's sense of self-worth and capability. As the child experiences a stronger sense of self-concept, they are able to access strengths such as self-responsibility, self-regulation, and relational abilities.

Impact of Time and Number of Sessions in CCPT

This study utilized a within-subjects single cohort design, allowing for a deeper exploration into the impacts of CCPT over time. The results of this study showed statistically significant improvements in the participants' trauma symptoms and meaningful improvement in the participants' social-emotional strengths following 12 sessions, with continued improvement at 16 sessions. Improving means between sessions one and eight indicated a positive directional trend while the progress from sessions one to twelve demonstrated statistical significance with large effect for total trauma symptoms. These results indicate that short-term participation in CCPT (12 sessions over approximately 6 weeks) was correlated with noticeable reduction in trauma symptoms. In regard to trauma symptoms, six of the eight

participants rated in clinical categories on the TSCYC showed clinically significant progress on the reduction of trauma symptoms while two participants did not appear to improve based on their clinical cut off scores. Yet, both of these participants were rated with improved trauma scores from pre-test to post-test even though they did not move out of clinically concerning scores. This suggests that CCPT was, in fact, making a positive impact on the children yet perhaps needed more time to show significant changes. This highlights consideration of the importance of long-term counseling for children who have experienced care disruptions. Previous research has supported the use of long-term, relationship-based counseling services for children from disruptive caregiving backgrounds (Baker et al., 2017; Clausen et al., 2012). Although interpretation is difficult regarding length of treatment for this sample, results appeared to indicate that short-term CCPT may be a substantive intervention; however, some children will benefit from a longer-term treatment.

Trauma Symptoms and Social-emotional Competencies

This study also provides a unique perspective on the relationship between trauma symptoms and social-emotional competencies of children with care disruptions. In summary, children in this study showed significant improvements in their trauma symptoms and meaningful improvements in their social-emotional competencies. However, reduction of trauma symptoms was noticeably stronger than the demonstration of social-emotional competencies. Past research supports the use of CCPT with social-emotional competencies (Taylor & Ray, 2021; Wilson & Ray, 2018), even when the children have experienced trauma (Ray et al., 2021). This study showed progress in the participants' social-emotional competencies, albeit slower than progress in trauma symptoms. This suggests that, for children

who have experienced disruptions in care, counseling may first address negative trauma symptomology prior to building on positive social-emotional strengths. In other words, acute trauma symptoms such as intrusion, avoidance, and arousal may first need to be decreased before the child is able to build their self-regulation, social competence, and empathy skills. Results of the current study are supported by Weiner et al. (2009), who found that foster youth who received counseling intervention showed significant decreases in their posttraumatic stress symptoms. Furthermore, Deblinger et al. (1996) found that foster children's engagement in counseling intervention, even without parent involvement, resulted in improved posttraumatic stress symptoms but did not significantly decrease behavioral concerns. It appears as though children who have experienced trauma often present with acute symptomology, including "prominent personality changes" (Stover & Berkowitz, 2005), developmentally regressed behaviors (Schaefer, 1994; Stover & Berkowitz, 2005) including encopresis and enuresis, posttraumatic play and/or reenactment (APA, 2022), relational difficulties including attachment insecurity/disorganization and betrayal-based relational schemas as well as decreased interpersonal empathy (Spinazzola et al., 2021), and extreme externalizing behaviors such as intense temper tantrums (APA, 2022). Such acute symptoms may need to first be addressed before noticeable strengths can be built and observed. In this current study, it appears as though utilizing CCPT followed this pattern, as trauma symptoms significantly decreased and social-emotional strengths increased at a slower rate. It may be possible that, with time and continued trauma symptom decreases, social-emotional competencies would have continued to increase with sustained participation in CCPT.

Clinical Implications

This study demonstrated the importance of approaching relational trauma with a relational intervention. CCPT may be a developmentally appropriate intervention to implement when working with children who have experienced disruptions in their caregiving experiences. CCPT appeared to facilitate the addition of a new, secure attachment relationship to the child's attachment network, allowing for the opportunity for the child to feel safe and supported as they processed the experiences they have encountered and moved toward growth and healing. Within the therapeutic relationship, the children were able to express themselves fully, experience a feeling of control over their circumstances, and experience the feeling of being in a safe and trusting relationship.

This study also provided a deeper look at the clinical implications related to duration of treatment. Though it appeared as though a limited, 16-session treatment period resulted in improved trauma symptoms and social-emotional competencies, the children may have benefitted from longer-term therapy as supported by past research (Clausen et al., 2012). CCPT provides a unique perspective when working with children who have experienced care disruptions, as the relationship is the therapy (Landreth, 2024).

Additionally, though this study provided support for engaging in CCPT without parent support, research has regularly shown that parent involvement leads to increased improvements in children receiving CCPT (Lin & Bratton, 2015). In this current study, many of the caregivers presented with a high need for support and psychoeducation. Hence, treatment plans were developed for each child following completion of data collection, some consisting of more frequent parent consultations. Clinicians working with children who have had care

disruptions may consider ways to balance the importance of trusting the child and facilitating a secure therapeutic relationship with also providing the parent/caregiver with emotional support, trauma-informed psychoeducation, and parent skill building, especially when the child is presenting with high needs.

Limitations and Opportunities for Future Research

The current study was the first to explore individual CCPT directly provided to children who have experienced care disruptions. Findings from the current study allow a deeper understanding of outcomes related to participation in CCPT. However, there were several limitations to this project. The current study employed a repeated measures single cohort design, which does not employ randomization or a control group, limiting the ability to control for extraneous variables. Therefore, I am limited in attributing outcomes purely to CCPT participation. Additionally, though the number of participants ($N = 16$) met G*Power's a priori power analysis, the small sample size limits the ability to generalize the results. Finally, the research design relied only on parent report when exploring the participants' outcomes and changes which may have been impacted by the caregivers' hopefulness regarding intervention. Other limitations include discussion points regarding the lack of a caregiver component to intervention, study limitations on session number, and possible researcher bias due to the researcher's role as an interventionist in this study. Future research may consider utilizing a control group and randomization, a higher sample size, and teacher- and/or self-report measures as well as a parent component and longer intervention duration. Additionally, future researchers may consider engaging in case study research to provide a deeper exploration of a

child's CCPT experience or a qualitative exploration of the experiences of CCPT therapists working with children who have experienced care disruptions.

Conclusion

The current study serves as the first study exploring the impacts of CCPT on the trauma symptoms and social-emotional competencies of children who have experienced care disruptions. Utilizing a repeated measures single cohort design allowed me to identify the change process over time. Statistical results suggest that children with care disruptions showed significant decreases in trauma symptoms by 12 sessions, which continued to decrease at 16 sessions. Additionally, though not as pronounced, the children's social-emotional competencies steadily increased over time in CCPT. This study provides strong support for the use of CCPT with children who have experienced care disruptions. Results of this study indicated that CCPT may be a well-matched therapeutic intervention for children who have experienced care disruptions to decrease their trauma symptoms. CCPT honors the pace of the child (Landreth, 2024; Ray, 2011), and by following the child's lead, CCPT provides children with the autonomy to self-titrate their exposure and processing of their own traumatic experiences. Additionally, CCPT trusts in the child's ability to process their experiences and believes that children bring to the play therapy room the experiences that are most pertinent to them (Landreth, 2024; Ray, 2011). By providing a regulated and grounded presence and engaging in empathetic reflections, the counselor is able to convey a safe and trusting relationship. In summary, the emphasis that CCPT places on the relationship as the therapeutic factor provides a unique, healing experience for children who have experienced care disruptions.

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APPENDIX A.
EXTENDED LITERATURE REVIEW

The impact of child-centered play therapy with children who have experienced disruptions in caregiving has yet to be explored through research. The following section includes a review of relevant literature and research on understanding the lived experiences of children who have been displaced from their primary caregivers as well as the research supporting the use of child-centered play therapy, an evidence-based intervention. The outline of this extended literature review is as follows: (a) an exploration of the experiences and presenting concerns of children who have experienced disruptions in caregiving, (b) a discussion of attachment theory, (c) an explanation of child-centered play therapy, (d) theoretical application of child-centered play therapy with children who have experienced care disruptions, and (e) conclusion.

Care Disruptions

Children who have experienced care disruptions encompass a large range of children in different circumstances, including but not limited to children who are in the foster care system, children who are being cared for by extended family members such as grandparents, and children who are being cared for by nonrelative individuals. According to the most recent census, 4% of children in America live with neither of their parents (Federal Interagency Forum on Child and Family Statistics, 2023b). Foster children account for a percentage of that number. As of the most recent Adoption and Foster Care Analysis and Reporting System (AFCARS) report, over 600,000 children from infancy to age 20 spent some time in the foster system in 2021 (United States Children's Bureau, 2022). At any given moment, nearly 400,000 children are currently in foster care, and nearly a quarter of those children are less than 3 years of age (United States Children's Bureau, 2022). The average foster child is 8 years old, with a 51-49

split of males and females, respectively (United States Children's Bureau, 2022). White children make up 43% of children in the foster system, followed by both Black children and Hispanic children each making up an additional 22% (United States Children's Bureau, 2022). In the United States, White children account for 49% percent of all children, followed by 26% Hispanic children and 14% Black children (Federal Interagency Forum on Child and Family Statistics, 2023a), suggesting that Black children may be overrepresented in the foster care system.

While in the foster system, most children (44%) are placed with a non-relative foster family whereas other placements may include relative foster families (35%), an institution (5%), a group home (4%), or a pre-adoptive home (4%; United States Children's Bureau, 2022). Most placements have a case plan goal of family reunification (53%), while other goals may include adoption (28%), emancipation (5%), other guardianship (4%), living with other relative (3%), or long-term foster care (2%; United States Children's Bureau, 2022). Prior to leaving the foster system, the average child spends between 17 to 22 months in foster care (United States Children's Bureau, 2022). While in the foster care system, many children experience impermanence in their placements. Past research shows a range of percentages, from 8% to 25%, of foster children experiencing placement disruption during their time in foster care (Connell et al., 2006; Helton, 2011; Strijker et al., 2008). The U.S. Children's Bureau (2020) broke down recent data, stating that 15.5% of children who have spent less than 12 months in the foster care system experience 3 or more placements, 34.6% of children who have spent 12-24 months in the foster care system experience 3 or more placements, and 60% of children who have spent 24 or more months in the foster care system experience 3 or more placements. A variety of characteristics contribute to placement instability, though research has consistently

shown that children who experience behavioral concerns, especially externalizing behaviors, are at a higher risk to experience placement disruptions than children who do not (Vreeland et al., 2020). As children who have experienced trauma are more likely to exhibit externalizing behaviors (Ray et al., 2020), foster and displaced children are particularly at-risk to exhibit these behaviors resulting in further displacement. In fact, children who have experienced care disruptions have been shown to present with higher levels of externalizing behaviors (Baker et al., 2017; Dagan et al., 2022; Deneault et al., 2021; Fearon et al., 2022; Zhao et al., 2021), which has been shown to contribute to further displacement and placement instability (Vreeland et al., 2020), which may then in turn increase the child's externalizing behaviors, resulting in a layered cycle of displacement and behavioral concerns requiring intervention. Additionally, placement disruptions tend to be more frequent and more likely for older children, children with emotional concerns, and children who are struggling in the school setting (Vreeland et al., 2020; Oosterman et al., 2007; Aarons et al., 2010; Barth et al., 2007; Roelock et al., 2009; Goemans et al., 2018).

Children who have been removed from their primary caregivers have a multitude of precipitating reasons for removal. The AFCARS report identifies neglect as the primary reason (63%) that children are removed from their parents' care (United States Children's Bureau, 2022). Physical and sexual abuse account for 12% and 4%, respectively, of child removals (United States Children's Bureau, 2022). Additionally, many children are removed due to the parents' own struggles impacting their ability to parent, including parents' drug abuse (36%), parents' inability to cope with parenting (14%), and parents' housing instability (9%; United States Children's Bureau, 2022). Many, if not all, of these circumstances may qualify as a

traumatic or adverse childhood experience (see Felitti et al., 1998). On top of these adverse childhood events, the child then experiences forced separation from their primary caregiver, an additional and layered trauma that impacts their attachment (Spinazzola et al., 2021).

Care disruptions are a wide-spread and too-common experience among children in the U.S. Such displacement impacts the child's relationship with others in their lives, particularly their caregivers. As such, counselors benefit from exploring ways that disruptions in caregiving impact children's relational well-being to better understand how to support this population.

Attachment

Attachment styles, originally explored by John Bowlby, theoretically refer to the ways in which individuals typically respond relationally to others (Bowlby, 1969). In infancy, individuals are wholly reliant on a caregiver for survival. In healthy and ideal circumstances, the caregiver feeds, shelters, and provides nurturance for the infant. In situations like these, the infant learns that they are safe and cared for; in other words, the infant develops a secure attachment style (Ainsworth et al., 1978). In adverse circumstances, however, the infant may learn the opposite, resulting in an insecure attachment style (Ainsworth et al., 1978; Main & Solomon, 1990). The infant's attachment style impacts the way in which the infant interacts with and connects to adults (Ainsworth et al., 1978), and early disruptions in the child's relational attachments may impact the way that child relates to the world moving forward.

Bowlby (1982) theorized that attachment behaviors are rooted in infants' innate, biological instincts to seek their mother or mother figure for food and warmth, similar to the way ducklings imprint. Bowlby characterized attachment behaviors as an infant's attempts to remain close to their attachment figure, historically identified as their mother, including

attempting to follow their mother when she leaves, greeting their mother when she returns, and using their mother as a secure base from which to explore (Bowlby, 1982). These attachment behaviors are observationally present by six to nine months of age for children who have had a consistent primary attachment figure (Ainsworth, 1963; Ainsworth, 1967; Schaffer & Emerson, 1964). Infants who exhibit these behaviors may cry when their mother leaves and crawl or attempt to crawl to follow her; conversely, these infants may smile, babble, and lift their arms in a bid to be picked up when their mother returns (Ainsworth, 1963; Ainsworth, 1967; Schaffer & Emerson, 1964). These attachment behaviors show that infants are not passive in their attachment to their caregivers, but rather active in seeking these relationships (Ainsworth et al., 1978), suggesting the importance of caregivers' responsiveness.

For children who have experienced a consistent and safe attachment figure throughout their infancy, a secure attachment may develop. For those who have not, an insecure attachment may form. Mary Ainsworth and her colleagues (1978) studied and described attachment styles, historically referred to as attachment patterns, when furthering Bowlby's attachment theory. Ainsworth et al. shaped the way in which mental health professionals understand attachment styles through their strange situation study. The Strange Situation Procedure (SSP) has remained a consistent tool to assess attachment style since it was developed in 1969 (Ainsworth & Wittig, 1969). As such, a deeper exploration into the seminal attachment work provides an understanding of attachment applicable even in present day. In the strange situation study, Ainsworth and colleagues (1978) explored the way that young children reacted to a new space and a new person with their attachment figure present, when their attachment figure left, and when their attachment figure returned. From this study,

Ainsworth and colleagues (1978) identified patterns of attachment and classified the children's behaviors into secure and insecure categories. Since this seminal study, further studies have explored these attachment styles, resulting in the inclusion of a disorganized/disoriented attachment style (Main & Solomon, 1990). This theoretical understanding of attachment provides researchers with a deeper understanding of the ways in which relationship impacts well-being.

Secure Attachment

Ainsworth and her colleagues originally identified securely attached infants as being in Pattern B (1978); for the sake of this document, I will refer to this group of children as experiencing a secure attachment. Understanding secure attachment can provide researchers with a foundation for understanding relational wellness. When in the strange situation, a child who is securely attached to their mother-figure plays explores when their mother is present and seeks comfort from their mother when alarmed or when a stranger enters the room (Ainsworth et al., 1978). This child expresses distress when their mother leaves but can be comforted upon her return easily, returning to their play once calmed (Ainsworth et al., 1978).

A securely attached infant shows a clear desire for proximity, contact, or interaction with their mother and actively seeks such (Ainsworth et al., 1978). When they see their mother, they may exhibit a range of attachment behaviors, from smiling to approaching to clinging and resisting release (Ainsworth et al., 1978). While the securely attached infant's individual attachment behaviors may vary, the underlying characteristic of a securely attached infant is their desire for and preoccupation with their parent (Ainsworth et al., 1978).

A secure attachment is perhaps most strongly defined by the infant's tendency to seek contact with their attachment figure when they are in distress (Bowlby, 1982), using their attachment figure as a "haven of safety" (Bowlby, 1982, p. 303). In other words, the infant actively seeks the comfort of their primary attachment figure, moving toward and clinging to them, especially when alarmed, tired, or hungry (Bowlby, 1982). When feeling secure, the infant uses their attachment figure as a "base from which to explore" (Bowlby, 1982, p. 302), visually or physically connecting with them from time to time while independently exploring their environment.

Insecure Attachment

Ainsworth and colleagues (1978) identified two primary categories within the umbrella of insecure attachment: Pattern A, titled Anxious-Avoidant, and Pattern C, titled Anxious-Resistant and, later, Anxious-Ambivalent. For the sake of this manuscript, I will refer to Pattern A as Avoidant and Pattern C as Ambivalent. Consistent with Bowlby's (1982) assertion that a secure attachment is most strongly defined by the infant's tendency to seek contact with their attachment figure when they are in distress, an insecure attachment may then be best defined by an infant's tendency to not seek comfort and security from their identified attachment figure during moments of distress. More specifically, a child may be considered to have an avoidant attachment to their mother-figure if, upon reunification, they avoid her (Ainsworth et al., 1978), and they may have an ambivalent attachment if they oscillate between seeking and resisting closeness with her (Ainsworth et al., 1978).

Avoidant infants may, quite plainly, avoid their caregiver when distressed or, should they choose to approach their caregiver, intermingle connecting behaviors with avoidant

behaviors such as turning away, not looking at their caregiver, or moving past them instead of toward them (Ainsworth et al., 1978). Though these infants may not actively resist their caregiver's attempts at connection, they do not choose to engage in connection and even ignore their caregiver's attempts at times (Ainsworth et al., 1978).

Ambivalent infants, unlike anxious-avoidant infants, actively resist their caregiver's attempts at connection (Ainsworth et al., 1978). Similarly to securely attached infants, ambivalent infants seek proximity to their caregiver; however, once they have achieved this proximity or contact, they present as more resistant or angry toward their caregivers (Ainsworth et al., 1978). Additionally, ambivalent infants may present with more passive strategies of forming connection (Ainsworth et al., 1978); in other words, the infant may or may not actively crawl or move toward their caregiver and instead may cry or scream to communicate their desire for closeness or their desire for distance. This oscillation between seeking closeness and resisting closeness is a hallmark of ambivalent infants and is indiscriminate, with the infant often showing these behaviors toward their caregivers and toward strangers (Ainsworth et al., 1978).

Disorganized/Disoriented Attachment

In the approximate 12 years following Ainsworth's seminal work exploring patterns of attachment (Ainsworth et al., 1978), Mary Main identified and described a fourth pattern of attachment: disorganized/disoriented (Main & Solomon, 1990). Research at the time had previously noted a small percentage of children who did not fit into one of the three originally identified patterns, yet they struggled to describe why (Main & Solomon, 1990). A deeper exploration of these studies and these children led to the inclusion of a

disorganized/disoriented attachment style. This classification of attachment behaviors is best understood as an umbrella rather than a classification. Children who are identified as having a disorganized/disoriented attachment pattern are also classified as primarily being in one of the three aforementioned styles (Main & Solomon, 1990).

A child who fits into this category is, overall, described as exhibiting “inexplicable, odd, or conflicted” behavior patterns (Main & Solomon, 1990). Disorganized/disoriented children often display with moments of behavior that appears to be confusing, without any identifiable goal, intention, or reason; and often their behavior contradicts itself (Main & Solomon, 1990). In fact, children who have a disorganized/disoriented attachment style may also exhibit attachment behaviors that can be classified as secure, avoidant, or avoidant, making it particularly confusing and complicated to understand (Main & Solomon, 1990). The title of the classification itself speaks to this confusion and difficulty in classification. The concept of disorganized attachment behaviors implies that the child displays contradicting movements and behaviors, while the concept of disoriented implies that the child struggles to remain present in their environment, often presenting with behaviors that may appear as dazed or immobilized (Main & Solomon, 1990). While this broad definition helps understand the classification, each individual child who fits into this pattern of attachment exhibits individual, unique behaviors.

A wide range of behaviors have been observed with children who fit into the disorganized/disoriented pattern of attachment, including wandering around the room, freezing, hiding, acting confused, and engaging in contradictory patterns of interaction with their caregiver (Main & Solomon, 1990). As such, children with a disorganized attachment pattern present with a wide variety of support needs, and individuals working with these

children are advised to avoid making assumptions. Granqvist and colleagues (2017) identify false assumptions made by those who work with these children, including the beliefs that a disorganized/disoriented attachment pattern indicates maltreatment and that it is a fixed characteristic that cannot be helped. Instead, Granqvist et al. recommend that researchers and clinicians may benefit from maintaining an openness as they examine ways to support these children. Additionally, as these behaviors are often related to the child's underlying attachment style, clinicians and researchers may benefit from focusing on the child's attachment difficulties instead of the resulting behaviors.

Impact of Attachment Style on Presentation

Although early attachment research is dated, recent research has shown that approximately half of the infants worldwide develop a secure attachment relationship with their parent or primary caregiver (Madigan et al., 2023). Individuals who develop a secure attachment relationship in infancy have been shown to display a variety of positive outcomes in comparison to individuals who developed an insecure attachment (Dagan et al., 2022; Denault et al., 2021; Fearon et al., 2010; Groh et al., 2017; Madigan et al., 2013; Madigan et al., 2023; van IJzendoorn et al., 1999). The following section reviews the results of multiple meta-analyses utilizing the Strange Situation Procedures, a standardized 21-minute observational procedure first introduced in 1969 by Ainsworth and Wittig.

Madigan and colleagues (2013) explored the relationship between attachment and internalizing behaviors in a meta-analysis of 60 studies (5,236 families). They identified a significant relationship between insecure attachment and internalizing behaviors ($d=.37$), adding that their data suggests that an insecurely attached child is twice as likely to have

internalizing problems than a securely attached child (Madigan et al., 2013). When focusing on the specific categories of insecure attachment, they noted that a child with an avoidant attachment pattern has more internalizing symptoms than a child with a secure attachment pattern, while a child with a resistant attachment pattern had no significant differences in their internalizing problems than a child with a secure attachment pattern (Madigan et al., 2013).

Fearon and colleagues (2010) completed a meta-analysis using 69 studies (5,947 children) to examine the relationship between an insecure attachment and externalizing problems. They found a significant effect size of .31, concluding that children with insecure attachment present with higher levels of externalizing problems (Fearon et al., 2010). Fearon and colleagues (2010) then further explored each insecure attachment style: insecure-avoidant attachment, insecure-resistant attachment, and disorganized attachment. They found in an analysis of 3,675 children that an insecure-avoidant attachment pattern has a small effect on externalizing problems ($d=.12$; Fearon et al., 2010). They also found, when including 3,568 children, no significant relationship between insecure-resistant attachment and externalizing behaviors (Fearon et al., 2010). Finally, they uncovered, in 3,778 children, an effect size of .34 between disorganized attachment and externalizing behaviors (Fearon et al., 2010). Overall, Fearon et al.'s research suggests that insecure attachment negatively impacts a child's externalizing behavioral concerns and that a disorganized attachment pattern is the strongest indicator while a resistant attachment pattern has little correlation with externalizing behaviors.

Groh and colleagues (2017) explored the relationship between attachment and social-emotional development. In a meta-analysis, they concluded that there was a modest significant relationship between a child's secure attachment and their social-emotional competencies (i.e.

social skills and peer interactions) and externalizing behaviors (Groh et al., 2017). Additionally, they found that these relationships did not weaken over time, emphasizing that the importance of an early secure attachment and suggesting that the negative impacts associated with insecure relationships do not diminish over time (Groh et al., 2017); however, they note that this finding should be interpreted with caution because the enduring negative impacts may be due to the long-lasting impacts of attachment, to continuity of caregiving, or to something else for which the researchers did not account (Groh et al., 2017).

Deneault et al. (2021) completed a meta-analysis using 15 studies (1,304 child-father dyads) to explore the relationship between the child-father attachment pattern and the child's internalizing and externalizing behaviors and found comparable results to that of previous studies that explored child-mother attachments. Specifically, insecure child-father attachments were significantly and moderately related to the child's externalizing behaviors and significantly related to the child's internalizing behaviors (Deneault et al., 2021), suggesting that continued attention should be given to the attachment patterns the child has to all caretakers in their lives as opposed to solely their attachment to their mother.

Dagan and colleagues (2022) completed a meta-analysis using nine studies (1,097 children) and specifically focused on if and how children's attachment to their mothers and to their fathers predict behavioral concerns. They concluded that a child with an insecure attachment to one or both parents is at a higher risk than a child with secure attachments to both parents to present with internalizing problems (Dagan et al., 2022). Additionally, a child with a disorganized/disoriented attachment to both parents is at a higher risk than a child with

no disorganized/disoriented attachment to present with externalizing behaviors (Dagan et al., 2022).

To summarize, children who have insecure attachment styles tend to present with more internalizing behaviors (Madigan et al., 2013), externalizing behaviors (Fearon et al., 2010), and social-emotional competencies (Groh et al., 2017) than children with secure attachment styles, suggesting that these behaviors stem from relational and attachment wounds. Additionally, research suggests that children's attachments to multiple caregivers in their lives can serve as a protective factor even if the child's attachment to their primary caregiver is insecure (Dagan et al., 2022), suggesting the importance of numerous safe, secure, and consistent adults in the child's life.

Attachment to Non-Caregiver Figures

Though a child's attachment is determined in the child's early years based on their caregiving (Bowlby, 1982) and appears to have long-term implications (Dagan et al., 2022; Denault et al., 2021; Fearon et al., 2010; Groh et al., 2017; Madigan et al., 2013; Madigan et al., 2023; van IJzendoorn et al., 1999), there is continued work to suggest the benefits of non-caregiver attachment figures (Bethell et al., 2019; Denault et al., 2021). Denault and colleagues (2021) emphasized the importance of a child's "attachment network", which suggests that children may develop unique attachment relationships with different adult figures in their lives, impacting the child's development and well-being. Attachment networks may have a cumulative or multiplicative impact on child development (Denault et al., 2021), suggesting that increased healthy attachment figures within a child's network may be beneficial in supporting the child. Additionally, Bethell and colleagues (2019) identified having non-parent adults who

take genuine interest in a child's life as an experience that facilitates "optimal childhood development and adult flourishing" (p. E5). Therefore, researchers may consider the use of non-caregivers to facilitate secure attachments with children, particularly if the child has experienced nonsecure attachments with other figures.

The Cumulative Role of Attachment

A child's attachment is determined in the child's early years, which Bowlby (1982) terms as a sensitive developmental period. During this sensitive period, most often seen between ages six to nine months, a child's primary attachment style is developed and impacts the way the child responds not only to their mother-figure but to other individuals in their lives (Bowlby, 1982), perhaps because "no form of behaviours is accompanied by stronger feeling than is attachment behaviour" (Bowlby, 1982, p. 209). Children's attachment behaviors may become a deep-seated set of beliefs that they have regarding others, the world, and even themselves. This set of beliefs was originally referred to by Bowlby (1982) as one's internal working model. The perception of rejection from an attachment-figure spreads to other relationships one has. Bowlby summarizes this point as such: "an unwanted child is likely not only to feel unwanted by his parents but to believe that he is essentially unwanted, namely unwanted by anyone" (Bowlby, 1973, p. 204-205). These messages may become woven into the child's view of themselves, others, and the world around them. The separation from and, in more extreme situations, loss of one's attachment figure may have deep and harmful impacts on a child's holistic wellness.

Separation from an attachment figure may be physical or psychological. A caregiver's lack of responsiveness or comfort may be perceived by the child as psychological separation,

resulting in the child's anxiety or distress (Bowlby, 1973), even if the attachment-figure is physically present. This perceived separation can impact the child's attachment behaviors and overall attachment style. Physical separation, too, may have dramatic and lasting impacts on the child's attachment. Observations of children who were temporarily separated from their otherwise secure attachment-figures suggest that children may react strongly and aversely to separation situations (Bowlby, 1973). A child's attachment to their caregivers has been shown to have long-term impacts on their well-being (Dagan et al., 2022; Denault et al., 2021; Fearon et al., 2010; Groh et al., 2017; Madigan et al., 2013; Madigan et al., 2023; van IJzendoorn et al., 1999). However, researchers have also shown that attachment to non-caregiver figures has positive impacts on a child's development (Bethell et al., 2019; Denault et al., 2021). A child's attachment network may have a cumulative beneficial impact on their well-being (Denault et al., 2021), suggesting that even children who have experienced insecure attachment or displacement from their primary caregivers may benefit from attachment to and support from non-caregiver figures.

Children Who Have Experienced Care Disruptions

The impacts of attachment disruptions have been long documented, from Bowlby's seminal work (1982; 1973; 1980) to decades' worth of continued exploration of the impacts of attachment disruption on children's wellness (Dagan et al., 2022; Denault et al., 2021; Fearon et al., 2010; Groh et al., 2017; Madigan et al., 2013; Madigan et al., 2023; van IJzendoorn et al., 1999). Research indicates that displacement from caregivers results in disrupted attachment experiences and impacts children's attachment behaviors (Bowlby, 1973; Bowlby, 1980; Lake, 2005; Madigan et al., 2023; Stinehart et al., 2012), social-emotional competencies (Mitchell &

Kuczynski, 2010; van IJzendoorn et al., 1999), externalizing and internalizing problems (Zhao et al., 2021; Baker et al., 2017; van IJzendoorn et al., 1999), trauma related symptoms (Bederian-Gerdner et al., 2018; Baker et al., 2017), physiological changes (Burke Harris, 2018; Koita et al., 2018; Liu et al., 2021; Lund et al., 2020; Chen et al., 2019), and educational concerns (Levy et al., 2014; Zhao et al., 2021). Therefore, understanding displaced children's experiences involves investigation of these outcomes.

Experiences and their Impact on Attachment

Attachment behaviors can be best understood as being connected to a child's attachment style. To summarize in simplistic descriptions, children with a secure attachment feel safe with and seek proximity to their caregiver for comfort, children with an anxious-avoidant attachment passively ignore their caregiver, children with an anxious-resistant attachment actively oppose their caregiver, and children with a disorganized/disoriented attachment behave in inexplicable and conflicting behaviors toward their caregivers (Bowlby, 1982; Ainsworth et al., 1978; Main & Solomon, 1990). Children who have experienced disruption in caregiving often experience maltreatment, whether that maltreatment is a precursor to their removal from parent's caregiving or whether the separation from parents by choice is a relational maltreatment in and of itself. Therefore, it may be useful to examine the impact that care disruptions have on a child's attachment behaviors to best understand how to support these children.

Children who have experienced maltreatment experience much lower rates of secure attachment than children who have not experienced maltreatment (14% to 53%, respectively), as well as much higher rates of disorganized attachment (64% to 22%; Madigan et al., 2023).

Though children who have been fostered or adopted experience similar rates of secure attachment as their nonfostered or nonadopted counterparts (Madigan et al., 2023), fostered or adopted children experience higher rates of disorganized attachment than those who have not (40% compared to 23%, respectively; Madigan et al., 2023). In other words, children with a history of maltreatment and/or removal from their caregivers may have much more difficulty connecting to others and present with unexplained problem behaviors including aggression, dissociation, and rejection toward others when in distress.

Additionally, children who have experienced care disruptions are more likely to present as emotionally withdrawn from caregivers and/or overly familiar with strangers (Lake, 2005; Stinehart et al., 2012). These behaviors may be even more likely present in children who have experienced “repeated changes of primary caregivers,” which limits “opportunities to form stable attachments” (APA, 2022, p. 296 and p. 299). These atypical attachment behaviors are congruent with insecure attachment styles. Emotionally withdrawn attachment behaviors mirror the attachment behaviors exhibited by children with avoidant attachment styles, while engaging with strangers in an overly familiar way may be reflective of children with ambivalent attachment styles. In other words, a child’s maladaptive attachment behaviors may in fact be a typical, developmental response to disrupted attachment and caregiver inconsistency. With this in mind, researchers may be remiss to focus on behavior reduction as opposed to attachment healing. As attachment behaviors appear to stem from attachment styles, research exploration into relational wellness may offer support for children who have experienced care disruptions.

Trauma Symptoms

Children who have experienced care disruptions have often experienced trauma (Baker et al., 2017), which is defined as an event or circumstance resulting in physical, emotional, or life-threatening harm and may have long-term impacts on an individual's mental, physical, emotional, social, and spiritual well-being (Substance Abuse and Mental Health Services Administration, 2024). Trauma can be understood through the lens of adverse childhood experiences (ACEs). ACEs were first identified by Felitti and colleagues (1998) and include experiences such as emotional, physical, or sexual abuse; physical or emotional neglect; household substance abuse, mental illness, or domestic violence; parent's incarceration; felt discrimination or bullying; lack of neighborhood safety; and living in foster care. ACEs are not inherently traumatic but do often represent traumatic experiences; children who have been exposed to ACEs have an increased chance of experiencing trauma and presenting with posttraumatic symptomology (Turner et al., 2020). In fact, researchers have repeatedly shown that individuals who experience four or more ACEs in childhood have an increased chance of a variety of poorer physical and mental health outcomes (Burke et al., 2011; Felitti et al., 1998; Hughes et al., 2017). Children who have experienced care disruptions are therefore a high-risk population, as their displacement is considered an ACE and the precipitating events that led to their displacement are also often adverse and traumatic. Moreover, D'Andrea et al. (2012) identified traumatic disruption in attachment bonding with primary caregivers as a primary type of developmental trauma, and Spinazzola and colleagues (2021) further stated that children who experience a traumatic disruption in attachment bonding are more likely to present with posttraumatic symptomology including emotion or somatic dysregulation,

attentional or behavioral dysregulation, and self- or relational-dysregulation. The unique and layered disruptive experience may result in similarly unique trauma symptoms, prompting targeted research on this population.

Baker et al. (2017) found that, in a sample of 156 foster children, these children had experienced an average of over 5 adverse childhood experiences (ACEs), with loss of parents being the inherent ACE experienced by 100% of the children followed by emotional abuse or neglect (71.3%), physical neglect (58.9%), and witnessing or experiencing domestic violence (57.4%). More recently, the 2021-2022 AFCARS report supports the conclusion that foster children experience layered adverse experiences; 63% of foster children in the United States at that time were removed from their caregivers as a result of neglect, 36% were removed due to the parents' drug abuse, and 12% were removed due to physical abuse (United States Children's Bureau, 2022). Bederian-Gardner et al. (2018) explored the impact that disrupted attachment relationships played on the mental health of children in the foster system in comparison to non-foster children who experienced similar instability in their upbringing through frequent moves and financial difficulty. They found that the foster youth, who experienced instability as well as attachment disruptions, exhibited higher rates of posttraumatic symptoms, suggesting that attachment instability has unique impacts on children's well-being.

Posttraumatic symptoms include thoughts, feelings, and behaviors that develop following an individual's exposure to a traumatic event and vary vastly from individual to individual with developmental considerations for children (American Psychiatric Association [APA], 2022; D'Andrea et al., 2012; Spinazzola et al., 2021). Posttraumatic symptoms include

intrusive symptoms, avoidance symptoms, arousal symptoms, and negative thoughts or feelings (APA, 2022). Developmentally, children may experience posttraumatic symptoms including repetitive play, generally scary nightmares with no recognizable content, trauma reenactment in play, and extreme temper tantrums (APA, 2022). Additionally, attachment insecurity, maladaptive self-soothing, betrayal-based relational schemas, and impaired interpersonal empathy have been shown to impact children who have been exposed to interpersonal trauma, especially traumatic separation from a primary caregiver (D'Andrea et al., 2012). The cyclical nature of attachment disruptions resulting in attachment insecurity (D'Andrea et al., 2012; Spinazzola et al., 2021) highlights the need for early intervention to break the cycle.

Social-Emotional Competencies

Social-emotional competencies encompass a broad range of abilities and skills, including friendship skills, empathy, interpersonal skills, social support, problem-solving skills, emotional competence, social maturity, self-concept, self-management, social independence, cognitive strategies, and resilience (Merrell, 2011). While current research may not specifically explore the social-emotional competencies of children who have been displaced from their parents, many studies have explored certain facets that fit within this definition of social-emotional competencies.

Relating to the social-emotional competency of interpersonal skills, Mitchell and Kuczynski (2010) examined the experiences of 20 children as they transitioned into the foster care system for the first time, concluding that placement away from their parents impacted the ways that children related to themselves and to the world around them. They concluded that

the child's ability to understand the world, to learn how to relate to others, and to predict other's responses to them were disrupted (Mitchell & Kuczynski, 2010).

Relating to the social-emotional competency of social support, McTavish et al. (2022) completed a meta-synthesis of qualitative studies to better understand the perspectives of foster children on the child welfare system and concluded that these children highly emphasized and desired meaningful and supportive adult relationships. Additionally, researchers often identify social support as a protective factor for children experiencing ACEs (Bethell et al., 2019; Blodgett & Lanigan, 2018). However, disruptions from caregivers results in inconsistent social support, especially if the displacement involves the child moving to a new city or state or changing schools.

Relating to the social-emotional competency of self-concept, children with insecure attachments to their caregivers, which is often true of children who have experienced care disruptions, reported lower levels of self-concept by the time they were four years old (Goodvin et al., 2008). Additionally, Zhao et al. (2021) suggested that experiencing 12 or more months of separation from one's biological parents resulted in children experiencing lower self-esteem.

Social-emotional competencies also encompass internalizing and externalizing problems. Internalizing behaviors may include emotional competence, while externalizing behaviors may be related to the child's self-management abilities. Baker and colleagues (2017) found, in a sample of 156 foster youth, that 39% of these children sought counseling services due to concerns with internalizing problems, including depression and anxiety. Zhao and colleagues (2021) suggested that experiencing 12 or more months of separation from one's biological parents resulted in higher internalizing behaviors, including depressive symptoms,

anxious symptoms, and feeling lonely or sad. Baker et al. (2017) found, in a sample of 156 foster youth, that 36.5% of these children sought counseling services due to concerns with externalizing problems, including behavioral concerns. Zhao and colleagues (2021) suggested that experiencing 12 or more months of separation from one's biological parents resulted in higher externalizing behaviors, including arguing, fighting, acting impulsively, having trouble concentrating, and feeling angry.

Social-emotional competencies cover a wide variety of abilities and skills that have been shown to be impacted as a result of care disruptions. Moreover, social-emotional competencies have been shown to be a protective factor for children at-risk of developing maladaptive characteristics (Domitrovich et al., 2017; Ray et al., 2020). As such, counselors may benefit from investigating interventions to support the growth of children's social-emotional strengths following displacement from their primary caregivers.

Physiological Changes

Displacement from one's primary caregiver has been shown to have possible connections to future physiological changes. Chen and colleagues (2019) investigated the biological impacts of prolonged child-parent separation on 710 adolescents and discovered shortened telomeres, which suggests premature cellular aging and possible vulnerability for mental health disorders. Liu et al. (2021) furthered this research, additionally discovering increased inflammatory reactions in the bodies of these adolescents. These findings further support the seminal work of Felitti and colleagues (1998), which created the foundation for understanding the connection between adverse childhood experiences and future physiological impacts.

Additionally, increased exposure to ACEs have been shown to contribute to physiological changes and concerns. As children who have experienced care disruptions have been shown to have been exposed to higher rates of ACEs, they may be challenged with these concerns. Due to the plasticity of the brain in early childhood, children are particularly vulnerable to physiological and neurological effects of ACEs (Koita et al., 2018), including harmful behaviors typically controlled by the prefrontal cortex (Lund et al., 2020). In other words, some of the behavioral concerns previously noted may be further impacted by the physiological effects ACEs has on the brain. Additionally, ACEs have been linked to a variety of medical concerns. Infants in adverse environments are more likely to present with growth delays such as failure to thrive, cognitive delays, and sleep disruptions (Burke Harris, 2018). In childhood, asthma, increased rate of infection, and learning and behavioral issues become more common with ACE exposure (Burke Harris, 2018). As they reach adolescence, they are more likely to engage in risky behaviors including substance use, violence, and sexual activities (Burke Harris, 2018). Into adulthood, individuals with exposure to ACEs continue to feel the physiological impacts of an overactive stress response leading to decreased functioning of the prefrontal cortex, decreased impulse control, decreased short- and long-term memory, decreased sensitivity of dopamine, and decreased hormone production (Burke Harris, 2018).

Though the physiological impacts of ACE exposure and care disruptions are abundant, the same neuroplasticity of children's brains that made them vulnerable to the negative impacts of ACEs is the same neuroplasticity that makes them vulnerable for opportunities for effective treatment (Koita et al., 2018), supporting the use of early interventions. Therefore,

researchers should examine effective treatments that can provide early intervention during childhood to best support growth and healing.

Educational Concerns

Displaced children experience a multitude of unique experiences within the school system. Foster youth report a variety of both positive and negative school experiences (Levy et al., 2014). Within the school system, foster youth identified autonomous self-disclosure, receiving empathy and understanding from others, and self-motivated aspirations supported by school staff as positive experiences (Levy et al., 2014). Conversely, foster youth reported judgment and stereotyping, along with forced explanations and a lack of privacy or support, as negative experiences in school (Levy et al., 2014). Many foster youth specifically identified loss of relationships, partnered with abrupt removals and school changes, as one of the most difficult impacts related to their educational experience (Levy et al., 2014). Levy et al.'s (2014) research highlights the need for in-school support for displaced children in order to decrease the identified barriers to success that these children identify.

Children who have experienced separation from their caregivers also present with academic concerns within the school setting. Zhao and colleagues (2021) noted that prolonged separation from parents was associated with lower vocabulary and mathematics scores. In addition to impacts on learning, children who exhibit externalizing or internalizing problems have a more difficult time succeeding in a classroom setting (McKown et al., 2016; van Lier et al., 2012). In conclusion, children who have experienced care disruptions may face numerous challenges to their education from all angles, prompting researchers to specifically find ways to support children within the school system.

Mental Health Services

Without intervention, attachment disruptions and adverse childhood experiences have been shown to have long-lasting and detrimental impacts to individuals' holistic wellness. However, little research has been conducted regarding mental health interventions with children who have experienced care disruptions, who often experience layered traumatic experiences. There has been some exploration of parenting interventions with children who have experienced disruptions in caregiving, including child-parent relationship therapy (CPRT; Carnes-Holt & Opiola, 2019; Frawley & Kelchner, 2022; Gilmartin & McElvaney, 2020), parent-child interaction therapy (PCIT; Fricker-Elhai et al., 2005; Mersky et al., 2016; Timmer et al., 2006; Warren et al., 2022), and trust-based relational intervention (TBRI; Howard et al., 2014; Purvis et al., 2013; Purvis et al., 2015; Razuri et al., 2016). However, Warren and colleagues (2022) suggested that children with a history of trauma experiences, especially children who are engaging in expressive posttraumatic behaviors, may be better suited for individual therapy as opposed to a behavioral parenting intervention. Individual therapy may provide children with a safe experience and relationship within which to process their traumatic experiences, including their attachment disruptions, without risking a parent's reduced capacity to engage in expressive posttraumatic behaviors (Warren et al., 2022). Additionally, children may experience increased calmness and reduced externalizing posttraumatic behaviors in individual, child-led interventions as opposed to parent-directed interventions (Warren et al., 2022). Some researchers have begun exploring individual mental health services for children who have experienced care disruptions. These studies provide valuable insight into the perceptions of the

therapists who work with these populations, as well as individual circumstances and characteristics of clinical cases with children in this population.

Ruff et al. (2022) explored the perceptions of 85 therapists within an organization that works with foster children and foster alum and found significant decreases in the therapists' views of their clients' internalizing and externalizing behaviors. They additionally noted some improvements in the clients' peer relationships (Ruff et al., 2022). However, one thing they noted was no difference in their clients' relationships with their cohabitants, which Ruff and colleagues (2022) suggested may be due to the variability of the clients' households and different struggles that the unique households and family structures, such as foster families, biological families, and other family structures, may have. When exploring the treatment experience of 20 foster children receiving play therapy services from the same organization, Clausen et al. (2012) noted statistically significant improvements in foster children's peer relationships, anxiety, sleep problems, dissociative symptoms, aggression and violence, depression, and school problems. These 20 children came to counseling between the ages of 5 to 11 and received treatment for four months to over seven years, with an average duration of three years (Clausen et al., 2012), showing the need for potentially longer treatment duration and even suggesting the need for early intervention. A child who has experienced caregiving and attachment disruptions may require a longer therapeutic relationship before feeling safe enough with their therapist to begin their healing process.

Ryan (2004) explored her non-directive play therapy experience working with an eight-year-old boy who was in the process of transitioning from foster care, where he experienced multiple placements, to residential care. In this experience, Ryan (2004) noted how the client's

relationship to her and to other carers in his life, such as his social worker, seemed to mirror that of his relationship with his mother. Ryan identified it as an oscillation between the client's "care-seeking system" and "self-defence system" taking over his relationships (Ryan, 2004). This echoes Bowlby's (1982) assertion that attachment behaviors are active as opposed to passive. Ryan (2004) noted that the client appeared "desperate" to attach to a safe caregiver while also distrusting the environment that he had spent eight years learning was unsafe. An additional difficulty that Ryan (2004) discussed was the relational strain such a relationship may place on the therapist themselves, emphasizing the ways in which therapists may feel inadequate to provide the client with the safe, secure, and long-term attachment figure that they desire.

Bratton and colleagues (2011) explored utilizing CCPT with children who have experienced attachment disruptions, specifically referencing a six-year-old adoptee who had experienced multiple attachment disruptions in his early life. In this case example, Bratton et al. completed 55 play therapy sessions with the child, 16 of which were led by the child's adoptive parents following Child-Parent Relationship Therapy training, over the course of 20 months (Bratton et al., 2011). Bratton noted how fostering a safe, therapeutic relationship was particularly difficult because the child's past relationship experiences had taught him that relationships are dangerous and unstable. Additionally, Bratton tracked the ways in which the child's relational progress and play themes seemed to swing from safe to unsafe, mirroring the way he related to others in his life. The play therapy space served as a microcosm within which the child was able to process his resistant/ambivalent attachment style within a new relationship, ultimately feeling seen and worthy within the therapeutic relationship (Bratton et al., 2011).

In qualitatively exploring a case in which a three-year-old boy with an insecure attachment to his mother received individual play therapy, Anderson and Gedo (2013) discussed how play therapy may meet the needs of children who have experienced severely disrupted attachment experiences. Anderson noted that her building of an attachment with the child seemed to serve as a catalyst for his further growth and healing. She specifically noted his improvements in emotion regulation, self-control, and social interactions as well as a decrease in aggression and anxiety (Anderson & Gedo, 2013). As their therapeutic attachment strengthened, so did the child's ability to view himself in a more capable way and others as more trustworthy (Anderson & Gedo, 2013). However, one limitation noted in this case was the difficulty in engaging the caregiver, the child's biological parent, with whom the child had an insecure attachment. Seemingly as a result of this prolonged insecure attachment, the child's interactions with his mother did not seem to improve even though his interactions with the therapist and his teachers did, suggesting that he was able to simultaneously create and maintain a secure attachment with safe adults in his life while still in a parent-child relationship that he viewed as unsafe (Anderson & Gedo, 2013).

Although it seems to be generally agreed upon that children who have experienced caregiving and attachment disruptions need mental health support, many do not receive the services they need. Research has shown that, although nearly half of the children investigated by child welfare agencies present with clinical emotional or behavioral concerns, only one fourth of these children received mental health support services (Burns et al., 2004). Foster children, in particular, have been reported to receive inconsistent and inadequate mental health services, further challenged by their placement changes (Baker et al., 2017; Fontanella et

al., 2015). Though some states may have mandated mental health screening and subsequent referral processes (Baker et al., 2017), foster children in other areas are often faced with stigmas, barriers, and a lack of resources that impact referrals and access to mental health services (Ruff et al., 2016). Children who are displaced or experience disrupted guardianship placements also face the unique challenge of not having a consistent adult who is responsible for identifying, advocating for, and providing transportation to mental health support (Ruff et al., 2016). Even when referred, these children may not receive appropriate or adequate mental health services. The priority of social services is to protect children from experiencing further harm or maltreatment, and at times this focus may come at the cost of overlooking healing from past harm and maltreatment (Clausen et al., 2012). In fact, mental health services have been identified as the largest unmet need for children in the foster care system (American Academy of Pediatrics, 2021), yet even when mental health services are provided, they are rarely provided by a licensed mental health professional and instead are provided by a case manager (Clausen et al., 2012). Additionally, case workers are often overburdened and experience a high turnover rate, suggesting that even if a child is receiving mental health services, the services are often inconsistent (Clausen et al., 2012). Clausen et al. (2012) asserted that “this lack of consistent, long-term, therapeutic intervention not only leads to inconsistent care that impedes progress, but also serves to confirm the youths’ expectations that relationships are temporary” (p. 44).

Though there has been some theoretical and anecdotal exploration of therapeutic interventions with children who have experienced disruptions in caregiving, there have been no empirical studies to substantiate these claims. Therefore, mental health interventions used

with this population are under-researched as well as implemented by under-trained clinicians and with limited resources (Ruff et al., 2016). To begin investigating effective treatments with this population, researchers may consider a developmentally appropriate and relationship-based intervention that has been shown as effective in regard to the concerns exhibited by children who have experienced care disruptions.

Child-Centered Play Therapy (CCPT)

Child-centered play therapy (CCPT) is a developmentally appropriate counseling intervention that utilizes play as the child's natural language and the therapeutic relationship as the healing factor (Axline, 1947; Landreth, 2024; Ray, 2011). In more detail, Landreth (2024) defines CCPT as "a dynamic interpersonal relationship between a child (or person of any age) and a therapist trained in play therapy procedures who provides selected play materials and facilitates the development of a safe relationship for the child (or person of any 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). CCPT is based in the theoretical belief in the power of the therapeutic relationship, facilitated by the play therapist's conveyance of genuineness, empathic understanding, and unconditional positive regard (Axline, 1947; Landreth, 2024; Rogers, 1957).

Theoretical Underpinnings of CCPT

First practiced by Virginia Axline and identified as non-directive play therapy (1947), CCPT is rooted in Carl Rogers' person-centered tenets and is characterized by a foundational belief that the therapeutic relationship is the healing factor (Rogers, 1951). Person-centered counselors, and by extension child-centered play therapists, work to create and maintain a warm, safe

relationship with the client, child or adult, within which the client directs their own therapeutic process and healing. To build such a relationship, child-centered play therapists are grounded in Carl Rogers' six necessary and sufficient conditions for therapeutic change (1957, p. 95):

1. "Two persons are in psychological contact.
2. The first, whom we shall term the client, is in a state of incongruence, being vulnerable or anxious.
3. The second person, whom we shall term the therapist, is congruent or integrated in the relationship.
4. The therapist experiences unconditional positive regard for the client.
5. The therapist experiences an empathic understanding of the client's internal frame of reference and endeavors to communicate this experience to the client.
6. The communication to the client of the therapist's empathic understanding and unconditional positive regard is to a minimal degree achieved."

These six conditions are necessary, meaning without them healing cannot be achieved, and sufficient, meaning that nothing more than these six conditions is needed for healing. Though all six are equally important, the three attitudinal conditions are the attitudes that the therapist embodies in order to create the therapeutic relationship. The three attitudinal conditions are empathic understanding, unconditional positive regard, and genuineness (Rogers, 1957). By conveying these three attitudes, the therapist works to create a safe and secure relationship with the client. Within such a relationship and when the client perceives these core conditions, they are able to embrace their self-actualizing tendency, an innate forward movement that facilitates holistic and therapeutic growth (Rogers, 1951).

Rogers' theory of counseling is also based in his 19 propositions (1951), which outline the ways in which one makes sense of oneself, others, and the world. These propositions emphasize individuals' experiences and perceptions and the way in which those impact one's sense of self (Rogers, 1951). The 19 propositions also identify the innate, self-directed direction in which individuals strive for self-growth and healing (Rogers, 1951); this basic tendency is at the core of person-centered beliefs, and guides therapists in their theoretical understanding of how people heal and what their role in that healing is. Individuals have an organismic valuing system (Rogers, 1951), which guides them in determining what will and will not support them in their self-actualizing. However, at times the individual's environment may block or hinder one's organismic valuing system, leading the individual to deny or distort pieces of their existence that are perceived as threats (Rogers, 1951). It is only within a relationship safe of judgement that the individual can explore these parts of themselves and work toward congruence (Rogers, 1951).

Virginia Axline is one of the first individuals to apply these person-centered concepts to work with children, viewing play therapy as a way to help children help themselves by trusting the child to have self-responsibility and self-direction within the play therapy space (Axline, 1947). As she explored the application of Roger's person-centered counseling to work with children, Axline identified eight basic principles which guide child-centered play therapists to this day (Axline, 1947, p. 75-76):

1. "The therapist must develop a warm, friendly relationship with the child, in which good rapport is established as soon as possible.
2. The therapist accepts the child exactly as he is.

3. The therapist establishes a feeling of permissiveness in the relationship so that the child feels free to express his feelings completely.
4. The therapist is alert to recognize the *feelings* the child is expressing and reflects those feelings back to him in such a manner that he gains insight into his behavior.
5. The therapist maintains a deep respect for the child's ability to solve his own problems if given an opportunity to do so. The responsibility to make choices and to institute change is the child's.
6. The therapist does not attempt to direct the child's actions or conversation in any manner. The child leads the way; the therapist follows.
7. The therapist does not attempt to hurry the therapy along. It is a gradual process and is recognized as such by the therapist.
8. The therapist establishes only those limitations that are necessary to anchor the therapy to the world of reality and to make the child aware of his responsibility in the relationship."

Congruent with Rogers' theoretical underpinnings, these guiding principles emphasize the trust and respect the therapist has for the child while conveying empathic understanding, unconditional positive regard, and genuineness within the relationship. Additionally, these guiding principles serve as a reminder that the "person of the therapist is more important than anything the therapist knows how to do" (Landreth, 2024, p. 124); in other words, the attitudinal conditions outlined by Rogers (1957) and emphasized by Axline (1947) are an extension of the genuine humanness of the therapist's way of being as opposed to skills that the therapist utilizes to achieve a goal.

Building upon the foundation built by Axline, Landreth (2024) expanded CCPT into the approach widely used today. As Landreth's work spread, scholars deepened their theoretical, practical, and empirical understanding of the approach. VanFleet and colleagues (2010) explored theoretical implications, emphasizing the importance of maintaining integrity to Axline's basic theoretical principles regardless of shifts in the practice of CCPT over time. They also identified and explored the four primary theoretical skills of child-centered play therapists: empathic listening, which is the primary communication skill of therapists; child-centered imaginary play, which allows the child to share their world and the therapist to step into their world; limit-setting, which creates a space of physical safety; and structure, which provides the child with a predictable play therapy space with which to interact (VanFleet et al., 2010). Further exploring the practicality of CCPT, Cochran and colleagues (2023) created a guide to CCPT, pairing theoretical beliefs with practical application and including ethical considerations. In 2011, Ray provided a more in-depth description of CCPT for advanced child-centered play therapists, including the CCPT treatment manual and protocol, which created a foundational standardization of CCPT. This set the stage for providing empirical support of CCPT through more rigorous research, earning CCPT recognition as a promising evidence-based mental health intervention by both the Title IV-E Prevention Services Clearinghouse (preventionservices.acf.hhs.gov) and the California Evidence-Based Clearinghouse for Child Welfare (www.cebc4cw.org).

The Therapeutic Relationship in CCPT

Child-centered play therapy emphasizes that "it is the relationship that is the therapy" (Landreth, 2024, p. 76), adding that the role of a CCPT therapist is to be rather than to do. The

therapeutic relationship is at the core of CCPT, as is the theoretical belief that true healing and growth cannot exist unless within such a relationship (Rogers, 1957). As these relational conditions are explored, the emphasis is on the therapist as a whole person, not on the skills used to convey these conditions. The underlying belief of CCPT therapists is that the therapist themselves is wholly in relationship with the child, which facilitates the child's growth and healing (Landreth, 2024); in other words, the healing is not facilitated by the skills that the therapist does, but rather by the way that the therapist is. The attitudinal conditions outlined by Carl Rogers (1957) are both necessary and sufficient, requiring no additional skills or teaching to facilitate healing. The aspects of this therapeutic relationship, then, are crucial to examine, to understand, and to embody.

Empathic understanding is the counselor's ability to experience accurate understanding of the client's world as if it is the therapist's own world yet without forgetting the "as if" quality (Rogers, 1957). In other words, the counselor feels with the client without getting swept up in the emotions (Rogers, 1957). With this deep understanding, the counselor is then able to communicate this understanding to the client, at times putting words to things of which the client themselves is unaware (Rogers, 1957). These descriptions clearly show that being empathic is not a skill or a technique to use, but an attitude of openness and curiosity toward another's experience. A therapist who truly embodies empathy is being empathic, not acting empathically or showing empathy. It is a "complex, demanding, and strong – yet also a subtle and gentle – way of being" (Rogers, 1975, p. 143). Research has shown a positive relationship between a therapist's expression of empathic understanding and a client's outcomes (Elliot et al., 2018). More specifically, client-perceived empathy was a stronger predictor of client

outcomes than observer- or therapist-rated empathy (Elliot et al., 2018). This research contributes to a deeper understanding of Rogers' (1957) final condition for change: the client's perception of the therapist. Unless the attitudinal conditions, including empathy, are communicated to and perceived by the client, the attitudes do not exist (Rogers, 1957).

Unconditional positive regard is the therapist's experiencing of the client as worthy just as they are, embracing a warm acceptance toward all parts of the client with "no 'ifs,' 'buts,' or 'not reallys'" (Rogers, 1957). Over time, unconditional positive regard has been termed as affirmation, respect, nonpossessive warmth, support, validation, and prizing (Farber et al., 2018), all of which are grounded in a warm acceptance of the client as a human with their own values, opinions, and emotions worthy of love and care. Axline (1947) further explored this concept, stating that the therapist must accept the child exactly as they are without any expectation or hope that they change. Unconditional positive regard is foundational in providing the client a relationship within which they feel accepted, allowing them to then accept themselves and experience unconditional positive self-regard. Rogers (1961) puts words to this paradox, stating "when I accept myself as I am, then I change... we cannot change, we cannot move away from what we are, until we thoroughly accept what we are" (p. 17). Research has shown a small but positive relationship between unconditional positive regard and client outcome (Farber et al., 2018).

The counselor's congruence, also known as genuineness, suggests that, within the therapeutic relationship, the counselor is fully and authentically connected with themselves (Rogers, 1957). This attitude exists on a spectrum, as no individual may be realistically congruent all of the time (Rogers, 1957). Congruence can be conceptualized in two facets:

intrapersonal and interpersonal (Kolden et al., 2018). Intrapersonal congruence is characterized by self-awareness and mindful authenticity (Kolden et al., 2018). In other words, the counselor experiences personal congruence, meaning the way that they are within the relationship accurately represents their awareness of self and is fully integrated (Rogers, 1957). Interpersonal congruence, then, is characterized by the ability to communicate one's genuine experience to another with respect and transparency (Kolden et al., 2018). This explains that a counselor's congruence is also impacted by the counselor's discernment in deciding what and how to communicate their authentic self to the client (Rogers, 1957). Therefore, counselor congruence refers to the counselor's self-awareness of their internal experiences as well as the ways in which they communicate that awareness to the client. This is echoed by Ray (2011), who states that congruence appears to be closely related to an individual's own self-awareness and sense of self and therefore seems to be a more advanced therapeutic ability. Counselors cannot communicate their self-awareness if they are not first self-aware. In other words, one must first become internally congruent before one can successfully communicate congruently in session. Research has shown a positive relationship between congruence and client outcomes (Kolden et al., 2018).

Rogers' attitudinal conditions (1957) are echoed in Landreth's four healing messages (2024, p. 232-233): "I am here. I hear you. I understand. I care." A fifth healing message later added is "I delight in you" (Bratton & Landreth, 2020, p. 21). These messages are conveyed to the child through the therapist's attitudinal conditions. "I am here" sends the child the message that the therapist is fully present and genuine in their relationship. It sends the message that the therapist is focused wholly on the child and their experience. "I hear you" sends the

message that the therapist is listening to and taking in what the child is communicating, whether through their words or their play. “I understand” sends the message that the therapist is empathically understanding the child’s story and that the therapist is allowing themselves to be in the child’s shoes to see the world from their eyes. “I care” sends the message of genuine warmth and unconditional positive regard for the child. “I delight in you” sends the message of an authentic and joyful relationship with the child. Altogether, these messages embody the attitudinal conditions that are the pillars of person-centered counseling and provide the child-centered play therapist with guiding values.

The attitudinal conditions underlie the theoretical emphasis on the therapeutic relationship as the healing factor (Landreth, 2024; Rogers, 1957). Rogers lays the groundwork for this philosophical tenet when discussing the 19 propositions (Rogers, 1951), stating that only in a nonthreatening and nonjudgmental environment may an individual move toward an integrated self. This environment is facilitated by the core attitudinal conditions provided by the therapist within the relationship (Rogers, 1951), indicating that growth and healing are done within relationship. In other words, “the relationship is the therapy” (Landreth, 2024, p. 90).

Research in CCPT

With the creation of the CCPT Treatment Manual (Ray, 2011), the Play Therapy Skills Checklist (PTSC; Ray, 2011), and the CCPT Research Integrity Checklist (CCPT-RIC; Ray et al., 2017), CCPT research has become increasingly common and has provided strong support for CCPT with a range of populations, presenting concerns, settings, and more. CCPT has been recognized as a promising evidence-based mental health intervention by both the Title IV-E

Prevention Services Clearinghouse (preventionservices.acf.hhs.gov) and the California Evidence-Based Clearinghouse for Child Welfare (www.cebc4cw.org) with strong research backing to support its effectiveness. Multiple metaanalyses have been completed to summarize overall effectiveness (Lin & Bratton, 2015; Parker et al., 2021; Pester et al., 2019; Ray et al., 2015; Taylor, 2024).

Lin and Bratton (2015) completed a meta-analysis that included 52 studies across presenting problems and settings, demonstrating a statistically significant positive effect with an effect size of .47. Lin and Bratton's (2015) meta-analysis explored the impacts of CCPT on a variety of outcome variables including global behavioral problems, internalizing behavior problems, externalizing behavioral problems, caregiver–child relationship stress, self-efficacy, academic performance, and other presenting issues. Also exploring the effects of CCPT across presenting problems and settings, Pester et al. (2019) completed a meta-analysis that included 11 single-case evaluations that explored the impacts of CCPT on presenting problems including externalizing symptoms, internalizing symptoms, social skills, and self-control and self-regulation. This meta-analysis identified statistically significant moderate effect sizes for externalizing symptoms ($\text{Tau-U} = .43$), internalizing symptoms ($\text{Tau-U} = .51$), and social skills (omnibus $\text{Tau-U} = .33$; Pester et al., 2019). Within the school setting, Ray et al. (2015) completed a meta-analysis that reviewed 23 randomized controlled trials that examined the impacts of CCPT conducted in elementary schools. This meta-analysis resulted in statistically significant effect sizes for externalizing problems ($d = .34$), internalizing problems ($d = .21$), total problems ($d = .34$), self-efficacy ($d = .29$), academic ($d = .36$), and other behaviors ($d = .38$; Ray et al., 2015). Parker and colleagues (2021) completed a meta-analysis exploring the use of CCPT

for 904 children who exhibit behavioral problems, identifying a statistically significant and moderate effect size of .48. Most recently, Taylor (2024) completed a meta-analysis investigating the effect of CCPT on internalizing behaviors, concluding that CCPT had an overall statistically significant impact with small to medium effect ($g = .44$) on the internalizing behaviors of children.

In summary, child-centered play therapy has been shown to have an overall positive effect on a multitude of presenting problems and across a variety of settings, indicating it as an effective intervention to use with children presenting with a range of needs. More specifically, CCPT has been shown to positively impact previously discussed symptomology specifically related to children who have experienced care disruptions, including attachment behaviors, social-emotional competencies, and trauma symptomology.

Child-Centered Play Therapy and Children Who Have Experienced Care Disruptions

Children who experience care disruptions from their primary caregivers experience a substantial relational wound. Research indicates that the loss of their primary attachment figure is a traumatic experience that impacts the way they view themselves, relate to others, and interact with the world around them. Therefore, to best meet the needs of children who have experienced care disruptions, mental health interventions can provide children with a safe space to explore and make sense of their traumatic experiences within a trusting and secure therapeutic relationship. Disruptions in caregiving is characterized by inconsistency, unpredictability, and unreliable relationships. To counteract this, children who have experienced care disruptions may benefit from consistent, predictable, and reliable relationships within which to heal. Child-centered play therapy is a mental health intervention

that utilizes such a therapeutic relationship as the healing mechanism. Simply put, disruptions in caregiving are relational traumas (D'Andrea et al., 2012), and CCPT is a relational intervention (Landreth, 2024). As such, the relational impact of care disruptions may be conceptualized as the foundational concern when working with displaced children. With the relationship as the roots, the resulting behaviors may be conceptualized as the secondary branches. Therefore, it may be asserted that effective intervention may focus on the relationship, or the roots.

Research indicates a connection between the quality of a child's adult relationships and the child's overall wellness, including internalizing and externalizing behaviors, self-esteem and self-concept, and academic functioning (Ray & Edwards, 2010). This is congruent with previously discussed research, which has linked these outcomes with attachment and care disruptions. Upon deeper exploration of children's relationships, Ray and Edwards (2010) provide support for the cyclical nature of relationships, stating that the child's behaviors and emotions, the adult's behaviors and emotions, and the child-adult relationship are all interrelated. In other words, child-adult interactions are reciprocal (Ray & Edwards, 2010). Research has shown support for the assertion that individual child-centered play therapy may disrupt maladaptive reciprocity within child-adult relationships (Ray & Edwards, 2010). Brandt (2001) provided some promising evidence that CCPT may positively impact the parent-child relationship, and Ray (2008) found a statistically significant decrease in parent-child relationship stress following CCPT for children experiencing externalizing concerns. As the concerns facing children experiencing disruptions in caregiving may be conceptualized as primarily relational, research supporting the use of CCPT for relational wellness provides a strong foundation.

Researchers may continue this exploration by specifically investigating the use of CCPT with displaced children.

Children who have experienced disrupted attachments and caregiving experiences have often experienced numerous layered traumatic experiences (Baker et al., 2017; Spinazzola et al., 2021) and present with various posttraumatic symptomology, including intrusive symptoms, avoidance symptoms, arousal symptoms, and negative thoughts or feelings (APA, 2022). Child-centered play therapy has been shown to be effective when working with children who have experienced traumatic events (Ray et al., 2021). Ray et al. (2021) completed the first randomized controlled trial analyzing the effectiveness of CCPT with children who have experienced multiple ACEs and found that CCPT had a statistically significant moderate to large effect on every construct examined, including empathy ($d = .64$), self-regulation ($d = .71$), social competence ($d = .57$), total social-emotional competencies ($d = .77$), and total problems ($d = .32$). Ultimately, Ray and colleagues (2021) supported the effectiveness of CCPT with children who have experiences ACEs, particularly in increasing the children's social-emotional competencies. Providing additional support for the use of CCPT with children who have experienced trauma, Schoonover and Perryman (2022) completed a single case research design with five children who had experienced trauma, finding that the children's externalizing behaviors decreased even following termination of CCPT sessions. Though not the focus of the study, three of the five clients had experienced displacement via adoption (Schoonover & Perryman, 2022), providing some support for CCPT with displaced children. Frawley and Dillman Taylor (2024) examined the biological relational and coregulatory mechanisms of CCPT with children who had experienced trauma, finding that the child-counselor dyad showed consistent

synchrony levels in their heart rates across play therapy sessions, suggesting that even children who have experienced trauma engage in relational coregulation with safe adults. These studies provide a rationale for the use of CCPT with children who have experienced traumatic events, including care disruptions.

Children who have experienced disruptions in caregiving and disrupted attachments have been shown to struggle with internalizing behaviors, including depression, anxiety, and lower self-concept (Baker et al., 2017; Zhao et al., 2021; Goodvin et al., 2008; Madigan et al., 2013; Deneault et al., 2021; Dagan et al., 2022). Research has supported the use of CCPT with internalizing behaviors, including anxious symptoms (Blanco et al., 2015; Fall et al., 2002; Gholamalizadeh et al., 2018; Hateli, 2020; Murphy Jones & Landreth, 2002; Patterson et al., 2018; Salter et al., 2016; Stulmker & Ray, 2015), depressive symptoms (Burgin & Ray, 2022), and other internalizing behaviors (Baggerly & Jenkins, 2009; Ceballos & Bratton, 2010; Cochran & Cochran, 2017; Garze & Bratton, 2005; Muro et al., 2006; Ray, 2008; Ray et al., 2007; Robinson et al., 2017; Tsai & Ray, 2011; Wong et al., 2022). In a meta-analysis analyzing 17 studies, Taylor (2024) found that CCPT had an overall statistically significant impact with small to medium effect ($g = .44$) on the internalizing behaviors of children. Taylor (2024) further asserted that CCPT is a well-matched intervention to decrease maladaptive internalizing behaviors because the relational focus of CCPT creates an environment within which the child is more likely to experience a stronger sense of self leading to increased autonomy, capability, and hopefulness, all of which counteract the worry, fear, and hopelessness that accompany anxiety and depression.

Children who have experienced disrupted attachments and caregiving experiences have been shown to struggle with externalizing behaviors, including arguing, fighting, and impulsivity (Baker et al., 2017; Zhao et al., 2021; Fearon et al., 2022; Deneault et al., 2021; Dagan et al., 2022). Additionally, Ray and colleagues (2020) found that children with more ACEs were identified by their parents as having more behavioral problems than those with less ACEs. Research has supported the use of child-centered play therapy with externalizing behaviors (Parker et al., 2021). In a meta-analysis analyzing 23 studies, Parker et al. (2021) found that CCPT statistically significantly decreased children's externalizing behaviors (Hedge's $g = .34$ compared to no treatment; Hedge's $g = .56$ compared to other treatment), overall behavior problems (Hedge's $g = .48$), and aggressive behaviors (Hedge's $g = .26$).

Children who have experienced disrupted attachments and caregiving experiences have been shown to struggle with social-emotional competencies (Groh et al., 2017). Moreover, adverse childhood experiences, including foster care and other displacement experiences, have been linked to lower social-emotional competencies regardless of age or gender (Ray et al., 2020). Specifically, children with more reported ACEs were reported by their parents to have less social competence, self-regulation, and empathy, all of which are crucial for social-emotional wellness (Ray et al., 2020). In investigating the use of CCPT in increasing social-emotional competencies, Taylor and Ray (2021) found a statistically significant increase in children's empathy and responsibility, characteristics identified as social-emotional competencies, following participation in CCPT. Additionally, Wilson and Ray (2018) found that parents noted a statistically significant increase in self-regulation and empathy in children

following participation in CCPT. These studies provide support for the use of CCPT as a way to address social-emotional competencies.

Conclusion

Child-centered play therapy provides a unique approach that may provide children who have experienced attachment and caregiving disruptions with a new, supportive, consistent relationship within which to begin to learn how to form secure and safe attachments. By embracing person-centered theoretical beliefs, the child-centered play therapist meets the child where they are without expecting the child to change, to attach, or to be different in any way (Landreth, 2024; Axline, 1947), allowing for a space within which the child can safely process what is most pressing to them in that moment without trying to gain acceptance from the counselor. The therapist's conveyance of empathic understanding and genuineness also send the message of being understood to the child while providing the child with a new experience of a safe relationship that they may have not previously had. By utilizing the therapeutic relationship as the healing factor, children who have experienced relational trauma through care disruptions may work toward relational healing, further impacting the behaviors associated with attachment and relational disruptions. These behaviors include trauma-related symptoms (Bederian-Gardner et al., 2018; D'Andrea et al., 2012; Spinazzola et al., 2021; Turner et al., 2020), internalizing and externalizing behaviors (Baker et al., 2017; Zhao et al., 2021), social-emotional concerns (Goodvin et al., 2008; McTavish et al., 2022; Mitchell & Kuczynski, 2010), and attachment difficulties (Lake, 2005; Madigan et al., 2023; Stinehart et al., 2012). Child-centered play therapy has been shown to positively impact these concerns (Frawley & Dillman Taylor, 2024; Lin & Bratton, 2015; Parker et al., 2021; Pester et al., 2019; Ray et al.,

2015; Ray et al., 2021; Schoonover & Perryman, 2022; Taylor, 2024; Taylor & Ray, 2021; Wilson & Ray, 2018), suggesting that CCPT may be an appropriate mental health intervention to use with this population. Additionally, research supports the use of CCPT in improving children's relationships with significant adults in their lives, including their guardians (Brandt, 2001; Ray, 2008). Thus, CCPT may be a well-matched mental health intervention for children who have experienced disruptions in caregiving.

APPENDIX B.
DETAILED METHODOLOGY

The purpose of the current study is to examine the relationships between participation in Child-Centered Play Therapy (CCPT) and the trauma symptoms and social-emotional wellness of children who have experienced disruptions in caregiving. To explore these relationships thoroughly, I conducted a repeated measures, single cohort design. To detail the growth in participants at different stages of their CCPT intervention, I utilized a within-subject design. Specifically, I explored the participants' trauma symptoms and social-emotional competencies before and after participation in 8, 12, and 16 sessions of CCPT in order to understand patterns of change over time in relationship with CCPT intervention.

In this section, I will address the methodology for this study including the research questions, operational definitions, participants, instruments, procedures, analysis of data, and limitations of the study.

Research Questions

This study aimed to answer research questions regarding the impact of CCPT on the trauma symptoms and social-emotional wellness of children who have experienced care disruptions. Therefore, this study addressed the following research questions: (a) What is the relationship between participation in child-centered play therapy over time and report of trauma symptoms for children who have experienced care disruptions? (b) What is the relationship between participation in child-centered play therapy over time and report of social-emotional competencies for children who have experienced care disruptions?

Operational Definitions

To clarify the constructs involved in this study, I have included the definition and measurement of each construct, including care disruptions, trauma symptomology, social-emotional competencies, and CCPT.

Care Disruptions

For this study, care disruptions are operationally defined as the child's separation from their primary caregiver at some point in their life. This may include but is not limited to adoption, foster care, group home placement, institution placement, living with relatives without their biological parent, or living with non-relatives without their biological parent.

Trauma Symptomology

Trauma symptomology includes a variety of thoughts, feelings, and behaviors including intrusive symptoms, avoidance symptoms, arousal symptoms, and negative thoughts or feelings (APA, 2022). Displaced children have been shown to also present with attachment insecurity, maladaptive self-soothing, betrayal-based relational schemas, and impaired interpersonal empathy (D'Andrea et al., 2012). For this study, trauma symptomology is operationally defined based on the Trauma Symptom Checklist for Young Children (TSCYC; Briere, 2005). The TSCYC identifies eight clinical scales related to trauma symptomology as Anxiety, Depression, Anger/Aggression, Posttraumatic Stress – Intrusion, Posttraumatic Stress – Avoidance, Posttraumatic Stress – Arousal, Dissociation, and Sexual Concerns. Specifically, the scores of Posttraumatic Stress – Intrusion, Posttraumatic Stress – Avoidance, and Posttraumatic Stress – Arousal are combined to create the Posttraumatic Stress – Total score. For this study, trauma

symptomology is operationally defined as the Posttraumatic Stress – Total score on the TSCYC assessment.

Social-Emotional Competencies

Social-emotional competencies are defined based on the Social-Emotional Assets and Resilience Scales (SEARS), which identifies these competencies as adaptive characteristics that contribute to a child's assets and resilience and include friendship skills, empathy, interpersonal skills, social support, problem-solving skills, emotional competence, social maturity, self-concept, self-management, social independence, cognitive strategies, and resilience (Merrell, 2011, p. 3). Furthermore, the SEARS includes categories of social-emotional competencies as Self-Regulation, Responsibility, Social Competence, and Empathy. For this study, social-emotional competencies are operationally defined as the total score on the SEARS assessment.

Child-Centered Play Therapy (CCPT)

Landreth (2024) defines CCPT as “a dynamic interpersonal relationship between a child (or person of any age) and a therapist trained in play therapy procedures who provides selected play materials and facilitates the development of a safe relationship for the child (or person of any 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 this study, CCPT is operationally defined in accordance with the CCPT treatment protocol, manualized by Ray (2011).

Participants

Due to the uniqueness of the identified population, I used a purposive sampling approach to recruit participants from three Title-I elementary schools and two university-based

clinics in the southwestern United States. The U.S. Department of Education (2019) defines Title-I schools as schools in which at least 40% of the student population are from economically disadvantaged families thus qualifying to receive federal financial assistance. The two clinics are located on the campus of a large public university and provide mental health services, including play therapy, to all members of the community regardless of socio-economic status, gender identity, age, race, ethnicity, ability, and other identity markers. The clinic counselors include masters-level counselors-in-training as well as doctoral-level counselors with full or provisional counseling licensure. The clinics provide a sliding scale fee, with clients typically paying between \$5 to \$50 per session. Clinic A serves approximately 200 clients, while Clinic B serves approximately 80 clients.

In order to participate in the study, the participant met the following criteria: a) the child must be between ages 5 to 12; b) the child must currently be or have previously been separated from their primary caregiver(s) by circumstances such as foster care, state custodial arrangements, or other guardianship arrangements such as grandparents, kin guardians, or non-kin guardians; c) the child must score in the Possibly Concerning or Clinically Significant range on a subscale of the Trauma Symptom Checklist for Young Children (TSCYC) or in the Tier 2 (At Risk) or Tier 3 (High Risk) range on a subscale of the Social-emotional Assets and Resilience Scales (SEARS); and d) the child must not be receiving play therapy elsewhere during the duration of the study. An a priori power analysis using G*Power determined a sample size of 16 participants is needed to find statistical significance over four measurement points (Faul et al., 2007). The G*Power was calculated using an alpha level of .05, with minimum power at .80, and

a medium treatment effect size for one group with four points of measurement as recommended by Cohen (1988).

In total, 33 children were recommended or recruited; however, six children did not meet the inclusion criteria, two children's caregivers declined to participate, and three children provided consent too late to participate in services and were therefore referred to clinical services elsewhere. At the start of the study, 22 children met criteria for inclusion. Over the course of the study, two children experienced a change in caregivers and relocated during the study, three children's caregivers did not complete data collection procedures, and one child was omitted from analysis due to their active custody dispute and unstable caregiving throughout intervention, resulting in clinically meaningful differences from rest of sample. A total of 16 participants were included in the final study. Participants were aged between 5 years and 12 years ($M = 8.31$, $SD = 2.18$). Caregivers reported participants' gender identities were 62.5% male ($n = 10$) and 37.5% female ($n = 6$). Caregivers reported participants' racial/ethnic identities were 25% Black ($n = 4$), 12.5% Black/White ($n = 2$), 12.5% Hispanic ($n = 2$), 12.5% Hispanic/White ($n = 2$), and 37.5% White ($n = 6$). Participants' demographic characteristics can be seen in Table 1. Caregivers reported between 2 to 9 caregiver placements ($M = 4.5$, $SD = 2.68$), with the average age at first separation from biological parent occurring at age 2.3 years ($SD = 3.03$). Caregivers reported that the child participant had been in their care between one month to 8 years ($M = 2.86$, $SD = 2.82$). Participants' caregiving experiences can be seen in Table 2. Within that, multiple participants experienced caregiving experiences that were difficult to quantify. For example, one child was placed in foster care on five separate occasions, but their current caregiver was unaware of how many placement changes they experienced

during their time in foster care. Additionally, multiple clients experienced repeated caregiving changes between two placements (i.e., biological parent and grandparent). In other words, the provided means may not be representative of the sample as a whole.

Table 1

Parent-identified Demographic Characteristics of Participants (N = 16)

Demographic Characteristics	<i>n</i>	%*
Age		
5	3	18.8
6	1	6.3
7	1	6.3
8	2	12.5
9	4	25
10	3	18.8
11	1	6.3
12	1	6.3
Gender		
Female	6	37.5
Male	10	62.5
Race/ethnicity		
Black	4	25
Black/White	2	12.5
Hispanic	2	12.5
Hispanic/White	2	12.5
White	6	37.5

Note: * percentage rounded up to one decimal

Table 2

Parent-identified Caregiving Experiences of Participants (N = 16)

Caregiving Experiences	<i>n</i>	%*
Earliest age at separation		
Birth	6	37.5
1-24 months	5	31.3
3-4 years	2	12.5
5-9 years	1	6.3
9 years	2	12.5
Time in current placement		
1-12 months	7	43.8
1-4 years	4	25
5-8 years	5	31.3
Total number of caregiver placements		
2	6	37.5
3-6	5	31.3
7-9	5	31.3
History of caregiving experiences**		
Foster care	9	56.3
Adoption	3	18.8
Kinship care	12	75
Group home	1	6.3
Other	2	12.5

Note: * percentage rounded up to one decimal ** experiences are not mutually exclusive and therefore totals may not equal 100%

Instruments

To gather a more holistic understanding of the participants' progress in CCPT over treatment time, I used both a strength-based assessment and a symptomology assessment to collect data from caregivers. Both assessments are standardized. Additionally, I utilized a demographic form to confirm that the participant meets the inclusion criteria of experiencing care disruptions and to gather richer clinical information regarding the participants. Ray (2008) suggested that CCPT may have beneficial outcomes for children around eight to 10 sessions, with statistically significant results manifesting around 11 or more sessions. Therefore, to better understand the participants' progress over time, the standardized assessments were

administered as a pre-test, between the 8th and 9th session, between the 12th and 13th session, and as a post-test.

Demographic Questionnaire

I verbally administered a demographic questionnaire with each guardian (Appendix E). The questionnaire included questions about the guardian's relationship to the child as well as questions about the child's age, gender, ethnicity, and caregiving experiences. Additionally, I gathered information regarding the family's and the child's experiences and circumstances.

Trauma Symptom Checklist for Young Children (TSCYC)

The TSCYC is a 90-item standardized assessment of trauma symptoms for children aged 3 to 12 that allows for the guardian to report on their perspective of their child's concerns (Briere, 2005). The TSCYC is normed separately for males and for females as well as for different ages: 3-4 years, 5-9 years, and 10-12 years (Briere, 2005). The TSCYC includes nine clinical scales to explore the nuances of trauma symptoms, including Anxiety (ANX), Depression (DEP), Anger/Aggression (ANG), Posttraumatic Stress – Intrusion (PTS-I), Posttraumatic Stress – Avoidance (PTS-AV), Posttraumatic Stress – Arousal (PTS-AR), Posttraumatic stress – Total (PTS-TOT), Dissociation (DIS), and Sexual Concerns (SC; Briere, 2005). Examples of items on the TSCYC include “drawing pictures about an upsetting thing that happened to him or her,” “not noticing what he or she was doing,” and “flinching or jumping when someone moved quickly or there was a loud noise.” Items are rated on a four-point scale, from 1 (Not At All) to 4 (Very Often; Briere, 2005). Scores can be interpreted as possibly concerning (*T*-score of 65-69) or clinically significant (*T* greater than or equal to 70). The TSCYC takes approximately 15-20 minutes to complete (Briere, 2005).

The TSCYC reports good overall test-retest reliability, with coefficient alphas ranging from .81 to .93 (Briere, 2005). For the subscales, the coefficient alpha reliabilities are: Anxiety ($\alpha = .86$), Depression ($\alpha = .84$), Anger/Aggression ($\alpha = .91$), Posttraumatic Stress – Intrusion ($\alpha = .87$), Posttraumatic Stress – Avoidance ($\alpha = .82$), Posttraumatic Stress – Arousal ($\alpha = .85$), Posttraumatic Stress – Total ($\alpha = .93$), Dissociation ($\alpha = .91$), and Sexual Concerns ($\alpha = .81$). Additionally, the TSCYC's test-retest reliability, or the stability of scores over time, boasts a median coefficient of .88, with coefficients for the subscales as: Anxiety ($\alpha = .89$), Depression ($\alpha = .90$), Anger/Aggression ($\alpha = .96$), Posttraumatic Stress – Intrusion ($\alpha = .68$), Posttraumatic Stress – Avoidance ($\alpha = .82$), Posttraumatic Stress – Arousal ($\alpha = .91$), Posttraumatic Stress – Total ($\alpha = .87$), Dissociation ($\alpha = .96$) and Sexual Concerns ($\alpha = .96$). For the current sample, the Cronbach's alpha for the total score was calculated at .90.

The TSCYC has been shown to be valid, with studies supporting the assertion that higher scores on the scales correlates with the child's experience of a trauma and leading to support of a diagnosis of posttraumatic stress disorder (Briere, 2005). Additionally, the TSCYC includes two scales to further support the assessor's validity in reporting: the Response Level (RL) scale and the Atypical Response (ATR) scale (Briere, 2005). The Response Level scale reflects the degree to which a caregiver may be underreporting developmentally typical concerning thoughts, feelings, or behaviors, while the Atypical Response scale reflects the degree to which a caregiver may be overreporting the least endorsed or most unusual thoughts, feelings, or behaviors listed on the TSCYC (Briere, 2005). Elevated scores suggest that the overall scores should be interpreted with caution.

The Social-emotional Assets and Resilience Scales™ (SEARS)

The SEARS is a strength-based assessment, which is identified as a measurement of emotional and behavioral competencies, skills, and characteristics that emphasizes and promotes personal accomplishment, satisfying relationships, resiliency, and development. The SEARS defines social-emotional assets and resiliencies as adaptive characteristics that support an individual's success in school, in relationships, and in life, including characteristics such as "friendship skills, empathy, interpersonal skills, social support, problem solving, emotional competence, social maturity, self-concept, self-management, social independence, cognitive strategies, and resilience" (Merrell, 2011, p. 3). The SEARS measures social-emotional competencies and assets for children and adolescents aged 5 to 18 and allows for multiple perspectives, including the parent (SEARS-P), teacher (SEARS-T), and self (SEARS-C for ages 8 to 12 or SEARS-A for ages 13-18). For the purpose of this study, I used the SEARS-P to better understand the perspective of the participants' caregivers. The SEARS-P includes 39 items and results in a total score made up of three domains: Self-Regulation/Responsibility (SR/R), Social Competence (SC), and Empathy (E; Merrell, 2011). Examples of questions on the SEARS-P include "is good at understanding the point of view of other people," "stays in control when he/she gets angry," and "works on chores and projects independently, without help." Items on the SEARS-P are rated on a four-point scale, from 0 (Never) to 3 (Always; Merrell, 2011). The SEARS-P takes approximately 10-12 minutes to complete (Merrell, 2011). Scoring results in placement in Tier 1 (Average to High Functioning), Tier 2 (At Risk), or Tier 3 (High Risk). The cut-off scores for Tier 1 fall between the 21st and 99th percentile. Tier 2 scores fall between the 6th and 20th percentiles. The cut-off scores for Tier 3 fall at or below the 5th percentile.

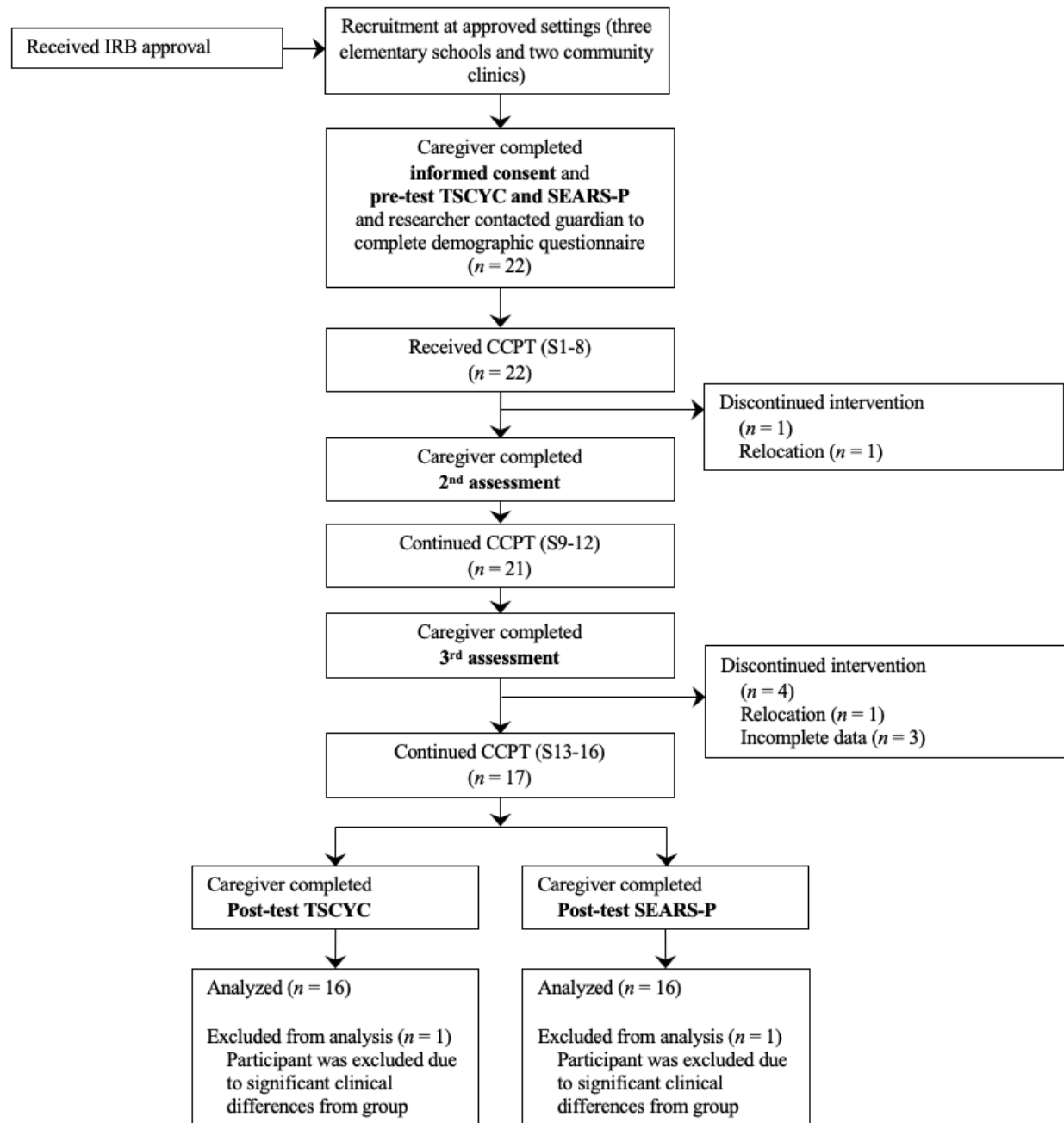
The SEARS-P reports strong internal consistency reliability for the total score at $\alpha = .96$, with coefficients for the subscales as: Self-Regulation/Responsibility ($\alpha = .95$), Social Competence ($\alpha = .89$), and Empathy ($\alpha = .87$; Merrell, 2011). The test-retest reliability, or the stability of scores over time, is considered moderate to strong at $\alpha = .93$, with coefficients for the subscales as: Self-Regulation/Responsibility ($\alpha = .92$), Social Competence ($\alpha = .88$), and Empathy ($\alpha = .90$; Merrell, 2011). For the current sample, the Cronbach's alpha for the total score was calculated at .96.

Procedures

Prior to beginning my study, I obtained approval from the Institutional Review Board (IRB; See Appendix E). Additionally, I contacted the clinical directors of each clinic and the school counselors of each elementary school to explain the parameters of the study as well as the inclusion criteria for the participants. I distributed flyers to the clinic directors and school counselors, and they posted the flyers in areas where parents of potential participants may view (see Appendix E). Confidential packets including an informed consent (see Appendix E), a contact form, and the TSCYC and SEARS-P assessments were then provided to guardians who expressed interest. Once the packet was returned, I contacted the caregivers by phone to answer any questions about the informed consent or the assessments, to confirm eligibility in the study, and to verbally complete the demographic questionnaire. For one parent who did not speak English, I arranged for a translator in order to answer any questions the caregiver had about the study, to complete the demographic form verbally, and to ensure that language differences were not a barrier to receiving services. Additionally, this caregiver was administered the TSCYC – Spanish and the SEARS-P – Spanish.

Children who met all criteria received individual CCPT sessions twice weekly for 30 minutes over 8 weeks for a total of 16 sessions. All play therapy sessions were recorded on a video camera and digitally stored on confidential and encrypted video software used by the clinic to be used for later fidelity checks. The SEARS-P and TSCYC assessments were completed by the guardians prior to beginning services, between the 8th and 9th sessions, between the 12th and 13th sessions, and upon completion of the 16 sessions. To ensure that assessments were completed in the appropriate time frames within the school setting, I worked with the teachers to deliver the assessments to guardians in the child's backpack; if assessments were not returned on time, I called the guardian to administer verbally. For participants receiving clinic services, guardians completed the assessments in the lobby while the child was in their play therapy session. Assessments were deidentified, scored, and entered into the confidential encrypted password protected database. Following the completion of 16 sessions, I met with each interventionist to collaborate on a follow-up care plan to ensure that all participants continued to receive mental health services if needed. Figure 1 illustrates the procedures and treatment of the current study.

Figure 1
Research Procedures and Treatment



Intervention

Children participating in this study received individual CCPT. CCPT is a developmentally appropriate and culturally inclusive mental health intervention that emphasizes the therapeutic relationship as the healing factor (Landreth, 2024; Ray, 2011). The interventionists for this study

followed the CCPT manualized treatment protocol as outlined by Ray (2011). CCPT is based in the belief that play is the child's natural way of communicating and that, by using the therapist's intentionally selected toys, the child can communicate with the play therapist (Landreth, 2024). In CCPT, the play therapist works to create an environment within which the child can feel welcome by setting up the playroom with a carefully selected variety of toys and materials across a variety of categories, including real-life, acting-out aggressive-release, and creative expression and emotional release (Landreth, 2024). Relationally, the therapist embodies the attitudinal conditions of empathic understanding, unconditional positive regard, and congruence (Rogers, 1957) to create a warm and safe relationship. Additionally, the therapist utilizes verbal and nonverbal therapeutic responses congruent with CCPT, including tracking and reflecting content, reflecting feeling and meaning, facilitating decision making and creativity, esteem building and encouragement, and limit setting as well as open and warm body language (Ray, 2011).

For this study, the participants received a total of 16 CCPT sessions twice weekly over 8-10 weeks. Each session lasted 30 minutes in their elementary school or at a community counseling clinic on a university campus. The play therapy rooms in the clinics and schools were designed in accordance with Landreth's (2024) design and recommendations regarding size, location, and set up. Additionally, the inclusion of toys and materials were selected based on Landreth's (2024) historically recommended playroom as well as multicultural playroom recommendations (Chung et al., 2023; Turner, 2024) and were developmentally appropriate for children aged 3 through 12. The play therapy room was intentionally designed to allow for children's expression and exploration of themselves, others, and their environment (Landreth,

2024). Typically, CCPT includes parent consultations once per 3 to 5 child play therapy sessions (Ray, 2011); however, due to the lack of standardization of CCPT parent consultation as well the uniqueness of the participants' various caregiving circumstances, this study did not utilize parent consultations in order to ensure fidelity to the CCPT manualized protocol. Following data collection, a therapy treatment plan was developed for each child to determine the need for and type of clinical services.

The interventionists for this study included two doctoral-level play therapists as well as six play therapists currently pursuing a doctoral degree. All play therapists had completed at least four graduate-level play therapy courses and were trained in CCPT. The play therapists self-identified as the following: a White cisgender female, a cisgender Jamaican-American Black female adoptee, an Indigenous Latina cisgender female, a Hispanic queer transgender man, a Pakistani cisgender female, a Filipino-American cisgender female, a White cisgender female, and a Black cisgender female.

To ensure fidelity to CCPT, all sessions were recorded, and two randomly selected session recordings per child were reviewed to check for fidelity in accordance with the CCPT protocol (Ray, 2011) by utilizing the Child-Centered Play Therapy – Research Integrity Checklist (CCPT-RIC; Ray et al., 2017). Protocol fidelity was defined as being at or above 90% adherence to CCPT verbal responses per the recommendations of Ray et al. (2017). The fidelity checks were carried out by a trained auditor who identifies as a White cisgender female. The auditor was a master's student who was in her internship experience, had taken three graduate play therapy courses, and was trained in utilizing the CCPT-RIC. For the current study, protocol adherence was calculated at .98, confirming that CCPT protocol was followed. In order to test

the effects of the intervention as directly provided to children, therapists did not hold parent consultations nor engage with parents in conversation or discussion beyond scheduling.

Analysis of Data

In order to answer the primary research questions, I completed a one-way repeated measures ANOVA analysis using the TSCYC Posttraumatic Stress – Total score and the SEARS-P Total score to understand the relationship between CCPT sessions and assessment scores over time and throughout intervention. I conducted planned post hoc pairwise comparison analyses to determine the time of measurement for which significant changes occurred. Prior to running the analyses, I ensured that the assumptions necessary for running an ANOVA were met, including normal distribution, homogeneity of variance, and sphericity (Pallant, 2020). The assumption of normal distribution means that the populations from which the sample comes have scores that are normally distributed (Pallant, 2020); normal distribution was confirmed by using histograms per Pallant's suggestion (2020). Finally, the assumption of homogeneity of variance means that the variance of scores for the groups is similar (Pallant, 2020); homogeneity was confirmed by examining the Levene's Test of Equality of Variances and confirming non-significance per Pallant's suggestion (2020). All of these assumptions were met in this study's analysis. The assumption of sphericity means that the variance of population difference scores for any two conditions is the same as the variance of the population difference scores for any other two conditions and is assessed by Mauchley's Test of Sphericity (Pallant, 2020). This assumption was not met; however, multivariate statistics do not require sphericity (Pallant, 2020); hence the multivariate coefficient was reported.

Regarding interpretation of analyses, alpha was set at .05, meaning statistical significance was defined as a p value less than or equal to .05. Practical significance was measured using a multivariate partial eta squared (η_p^2) with a score of .01 being identified as small, .06 as moderate, and .14 as large (Cohen, 1988). I decided that if statistical significance or meaningful practical significance was found for the main analyses, I would explore the subscale data with exploratory analyses that should be interpreted with caution due to higher possibility of Type 1 error based on multiple analyses with a small sample. The clinical significance was explored by noting how many participants' trauma symptomology decreased from the possibly concerning or clinically significant ranges to the normal range.

APPENDIX C.
UNABRIDGED RESULTS

The following results aim to answer the current study's two research questions. The first research question is: What is the relationship between participation in child-centered play therapy over time and trauma symptoms for children who have experienced care disruptions? The second research question is: What is the relationship between participation in child-centered play therapy over time and the social-emotional competencies for children who have experienced care disruptions? I will present results of the data analysis, including report of statistical, practical, and clinical significance.

Trauma Symptoms

A repeated measures ANOVA was conducted to explore the impact of CCPT on participants' total trauma scores across time as reported by parents on the Trauma Symptom Checklist for Young Children (TSCYC; See Table 1). Results of repeated measures ANOVA indicated a statistically significant difference at the $p \leq .05$ for time, Wilks' $\lambda = .444$, $F(3, 13) = 5.42$, $p = .01$, $\eta_p^2 = .56$. Thus, there was a statistically significant correlation between time and parent-reported improvement in participants' total posttraumatic stress symptoms, and 56% of the variance in outcome could be explained by increased time in CCPT. Figure 1 provides a graph of the four data points. Because a statistically significant result was obtained, post-hoc pairwise comparison analyses utilizing the Bonferroni method were completed to determine where the difference in scores occurred (see Table 2). Statistically significant differences were found between time points 1 and 3 and time points 1 and 4. In subsequent paired samples t-test analyses, between points 1 and 3 results indicated a statistically significant effect with large effect size ($p < .01$, $d = .88$) and between points 1 and 4 results indicated a statistically significant effect with large effect size ($p < .01$, $d = .88$). In summary, participants demonstrated

statistically significant improvement with large effects after 16 sessions of CCPT. Due to statistically significant results with a large effect size, I decided to conduct exploratory analyses on the TSCYC subscales.

Table 1

One-Way Repeated Measures ANOVA Comparing TSCYC Scores Across Time (N = 16)

Dependent Variable		<i>M</i>	<i>SD</i>	<i>df</i>	<i>F</i>	<i>p</i>	η_p^2
Posttraumatic Stress – Total	Intake	70.56	21.84	3, 13	5.42	.01*	.56
	Session 8	59.94	11.52				
	Session 12	55.44	12.89				
	Session 16	56.13	10.81				
Anxiety	Intake	60.06	14.88	3, 13	7.73	<.01*	.64
	Session 8	52.94	10.42				
	Session 12	52.31	12.32				
	Session 16	53.44	11.63				
Depression	Intake	61.25	17.55	3, 13	2.78	.08	.39
	Session 8	54.50	11.78				
	Session 12	52.63	10.05				
	Session 16	53.94	12.74				
Anger	Intake	64.81	18.91	3, 13	8.33	<.01*	.66
	Session 8	56.69	15.52				
	Session 12	54.63	16.31				
	Session 16	54.25	13.43				
Posttraumatic Stress – Intrusion	Intake	66.56	24.71	3, 13	3.55	.05*	.45
	Session 8	56.69	14.35				
	Session 12	50.88	10.34				
	Session 16	53.31	10.39				
Posttraumatic Stress – Avoidance	Intake	73.00	26.99	3, 13	4.86	.02*	.53
	Session 8	63.69	21.21				
	Session 12	54.94	12.93				
	Session 16	57.75	17.28				
Posttraumatic Stress – Arousal	Intake	65.44	18.55	3, 13	3.40	.05*	.44
	Session 8	55.37	10.22				
	Session 12	56.81	17.86				
	Session 16	55.38	12.16				
Dissociation	Intake	62.56	17.71	3, 13	2.98	.07	.41
	Session 8	55.31	13.67				
	Session 12	52.50	8.75				
	Session 16	52.69	11.81				
Sexual Concerns	Intake	56.69	22.04	3, 13	2.30	.13	.35
	Session 8	52.63	10.63				
	Session 12	50.06	9.57				
	Session 16	49.25	9.18				

Note: M = Mean, SD = Standard Deviation, * indicates statistical significance at $p \leq .05$

Figure 1

Mean Scores Over Time on TSCYC Posttraumatic Stress – Total Scores

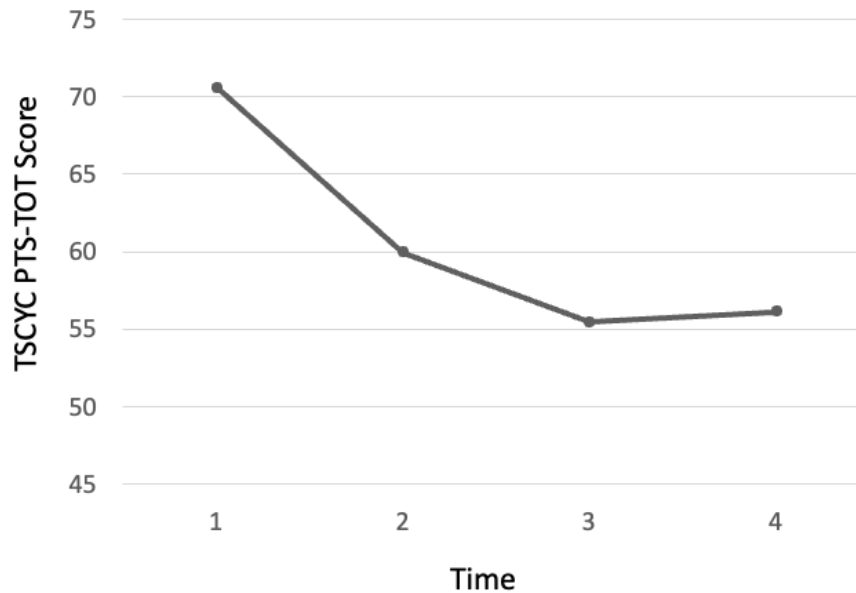


Table 2

Pairwise Comparisons for TSCYC Posttraumatic Stress – Total Scores (N = 16)

Time (I)	Time (J)	Mean Difference (I-J)	Std. Error	Sig.
1	2	10.63	4.55	.20
	3	15.13	4.32	.02*
	4	14.44	4.10	.02*
2	1	-10.63	4.55	.20
	3	4.50	1.87	.18
	4	3.81	2.34	.75
3	1	-15.13	4.32	.02*
	2	-4.5	1.87	.18
	4	-.69	1.97	1.00
4	1	-14.44	4.10	.02*
	2	-3.81	2.34	.75
	3	.69	1.97	1.00

Note: * indicates statistical significance at $p \leq .05$

TSCYC Anxiety (ANX) Subscale

A repeated measures ANOVA was conducted to explore the impact of CCPT on participants'

Anxiety (ANX) scores across time as reported by parents. Results of repeated measures ANOVA

indicated a statistically significant difference at the $p \leq .05$ for time, Wilks' $\lambda = .359$, $F(3, 13) =$

7.73, $p < .01$, $\eta_p^2 = .64$. Thus, there was a statistically significant correlation between time and parent-reported improvement in participants' anxiety, and 64% of the variance in outcome could be explained by increased time in CCPT. In summary, participants demonstrated statistically significant improvement with a very large effect over 16 sessions of CCPT.

TSCYC Depression (DEP) Subscale

A repeated measures ANOVA was conducted to explore the impact of CCPT on participants' Depression (DEP) scores across time as reported by parents. Results of repeated measures ANOVA indicated no statistically significant difference at the $p \leq .05$ for time, Wilks' $\lambda = .609$, $F(3, 13) = 2.78$, $p = .08$, $\eta_p^2 = .39$. However, the partial eta squared indicated a very large effect size as interpreted by Cohen's (1988) criteria.

TSCYC Anger (ANG) Subscale

A repeated measures ANOVA was conducted to explore the impact of CCPT on participants' Anger (ANG) scores across time as reported by parents. Results of repeated measures ANOVA indicated a statistically significant difference at the $p \leq .05$ for time, Wilks' $\lambda = .342$, $F(3, 13) = 8.33$, $p < .01$, $\eta_p^2 = .66$. Thus, there was a statistically significant correlation between time and parent-reported improvement in participants' anger, and 66% of the variance in outcome could be explained by increased time in CCPT. In summary, participants demonstrated statistically significant improvement with a very large effect over 16 sessions of CCPT.

TSCYC Posttraumatic Stress – Intrusion (PTS-I) Subscale

A repeated measures ANOVA was conducted to explore the impact of CCPT on participants' Posttraumatic Stress – Intrusion (PTS-I) scores across time as reported by parents.

Results of repeated measures ANOVA indicated a statistically significant difference at the $p \leq .05$ for time, Wilks' $\lambda = .550$, $F(3, 13) = 3.55$, $p = .05$, $\eta_p^2 = .45$. Thus, there was a statistically significant correlation between time and parent-reported improvement in participants' posttraumatic intrusion, including nightmares and trauma reenactment, and 45% of the variance in outcome could be explained by increased time in CCPT. In summary, participants demonstrated statistically significant improvement with a very large effect over 16 sessions of CCPT.

TSCYC Posttraumatic Stress – Avoidance (PTS-AV) Subscale

A repeated measures ANOVA was conducted to explore the impact of CCPT on participants' Posttraumatic Stress – Avoidance (PTS-AV) scores across time as reported by parents. Results of repeated measures ANOVA indicated a statistically significant difference at the $p \leq .05$ for time, Wilks' $\lambda = .471$, $F(3, 13) = 4.86$, $p = .02$, $\eta_p^2 = .53$. Thus, there was a statistically significant correlation between time and parent-reported improvement in participants' posttraumatic avoidance, including inability to think about, talk about, or engage in activities related to traumatic experiences, and 53% of variance in outcome could be explained by increased time in CCPT. In summary, participants demonstrated statistically significant improvement with a very large effect over 16 sessions of CCPT.

TSCYC Posttraumatic Stress – Arousal (PTS-AR) Subscale

A repeated measures ANOVA was conducted to explore the impact of CCPT on participants' Posttraumatic Stress – Arousal (PTS-AR) scores across time as reported by parents. Results of repeated measures ANOVA indicated a statistically significant difference at the $p \leq .05$ for time, Wilks' $\lambda = .560$, $F(3, 13) = 3.40$, $p = .05$, $\eta_p^2 = .44$. Thus, there was a statistically

significant correlation between time and parent-reported improvement in participants' posttraumatic arousal, including jumping or flinching, difficulty paying attention, and hypervigilance to safety, and 44% of the variance in outcome could be explained by increased time in CCPT. In summary, participants demonstrated statistically significant improvement with a very large effect over 16 sessions of CCPT.

TSCYC Dissociation (DIS) Subscale

A repeated measures ANOVA was conducted to explore the impact of CCPT on participants' Dissociation (DIS) scores across time as reported by parents. Results of repeated measures ANOVA indicated no statistically significant difference at the $p \leq .05$ for time, Wilks' $\lambda = .592$, $F(3, 13) = 2.98$, $p = .07$, $\eta_p^2 = .41$. However, the partial eta squared indicated a very large effect size as interpreted by Cohen's (1988) criteria indicating improvement in participants' dissociation, including seeming to be in a daze, in a trance, or in a fantasy world.

TSCYC Sexual Concerns (SC) Subscale

A repeated measures ANOVA was conducted to explore the impact of CCPT on participants' Sexual Concerns (SC) scores across time as reported by parents. Results of repeated measures ANOVA indicated no statistically significant difference at the $p \leq .05$ for time, Wilks' $\lambda = .653$, $F(3, 13) = 2.30$, $p = .13$, $\eta_p^2 = .35$. However, the partial eta squared indicated a very large effect size as interpreted by Cohen's (1988) criteria.

Social-emotional Competencies

A repeated measures ANOVA was conducted to explore the impact of CCPT on participants' total social-emotional competencies across time as reported by parents on the Social-emotional Assets and Resilience Scales (SEARS; See Table 3 and Figure 2). Results of

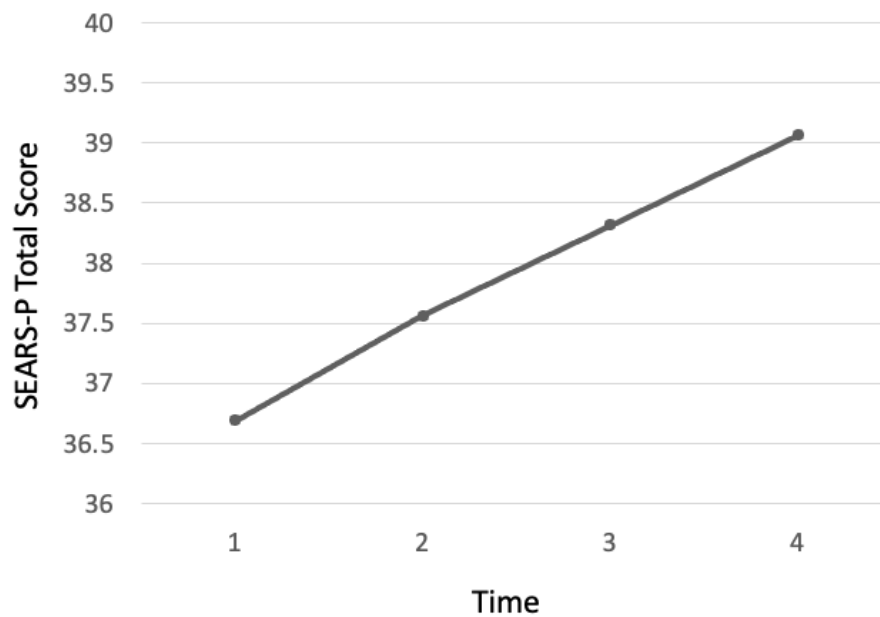
repeated measures ANOVA indicated no statistically significant difference at the $p \leq .05$ for time, Wilks' $\lambda = .886$, $F(3, 13) = .560$, $p = .651$, $\eta_p^2 = .11$. However, the partial eta squared indicated a medium to large effect size as interpreted by Cohen's (1988) criteria. Pairwise comparisons were not analyzed due to lack of statistical significance on the total score. Due to the meaningful effect size on the total score, further analyses were conducted on SEARS subscales for deeper understanding.

Table 3
Mean Scores of SEARS-P Scores Across Time (N = 16)

Dependent Variable		<i>M</i>	<i>SD</i>	<i>df</i>	<i>F</i>	<i>p</i>	η_p^2
Total	Intake	36.69	10.88	3, 13	.56	.65	.11
	Session 8	37.56	10.53				
	Session 12	38.31	10.71				
	Session 16	39.06	12.49				
Self-Regulation/ Responsibility	Intake	35.44	11.78	3, 13	1.28	.32	.23
	Session 8	37.31	9.80				
	Session 12	39.31	10.45				
	Session 16	39.31	11.92				
Social Competence	Intake	39.75	9.77	3, 13	.52	.68	.11
	Session 8	41.38	10.97				
	Session 12	40.50	10.46				
	Session 16	41.75	12.10				
Empathy	Intake	40.13	13.04	3, 13	.51	.68	.11
	Session 8	40.88	12.26				
	Session 12	39.12	11.62				
	Session 16	41.31	12.79				

Note: M = Mean, SD = Standard Deviation

Figure 2
Mean Scores Over Time on SEARS-P Total Scores



SEARS Self-Regulation/Responsibility (SR/R) Subscale

A repeated measures ANOVA was conducted to explore the impact of CCPT on participants' Self-Regulation/Responsibility (SR/R) scores across time as reported by parents. Results of repeated measures ANOVA indicated no statistically significant difference at the $p \leq .05$ for time, Wilks' $\lambda = .772$, $F(3, 13) = 1.28$, $p = .32$, $\eta_p^2 = .23$. However, the partial eta squared indicated a large effect size as interpreted by Cohen's (1988) criteria.

SEARS Social Competence (SC) Subscale

A repeated measures ANOVA was conducted to explore the impact of CCPT on participants' Social Competence (SC) scores across time as reported by parents. Results of repeated measures ANOVA indicated no statistically significant difference at the $p \leq .05$ for

time, Wilks' $\lambda = .893$, $F(3, 13) = .518$, $p = .68$, $\eta_p^2 = .11$. However, the partial eta squared indicated a medium to large effect size as interpreted by Cohen's (1988) criteria.

SEARS Empathy (EM) Subscale

A repeated measures ANOVA was conducted to explore the impact of CCPT on participants' Empathy (EM) scores across time as reported by parents. Results of repeated measures ANOVA indicated no statistically significant difference at the $p \leq .05$ for time, Wilks' $\lambda = .894$, $F(3, 13) = .512$, $p = .68$, $\eta_p^2 = .11$. However, the partial eta squared indicated a medium to large effect size as interpreted by Cohen's (1988) criteria.

Clinical Significance

To address the clinical significance of the results, I explored the participants' clinical scores on the TSCYC Posttraumatic Stress – Total (PTS-TOT) subscale to determine meaningful clinical progress for participants. Of the 16 participants, seven participants' TSCYC PTS-TOT intake scores indicated clinically significant or concerning levels of posttraumatic symptomology at pretest. Of those seven, five progressed to lesser concerning categories at the completion of 16 CCPT sessions. Of those, three went from significantly clinical scores at intake to average scores at completion of 16 sessions. Two went from significantly clinical scores at intake to the lesser concerning category. One went from concerning scores at intake to average category at the final rating. Of all 16 participants, no participants were reported to have had worsening PTS-TOT scores from intake to completion of sessions.

APPENDIX D.
EXTENDED DISCUSSION

In this study, I examined the impact of Child-Centered Play Therapy (CCPT) on the trauma symptoms and social-emotional competencies of children who have experienced care disruptions. By utilizing a within-subject single cohort design, I investigated changes in the participants' scores on the TSCYC and SEARS-P across four points of measure throughout their participation in CCPT, allowing for a deeper exploration of the relationship between trauma symptoms and social-emotional competencies over time in CCPT. Caregivers reported statistically significant improvements in trauma symptoms following participation in CCPT. Trauma symptoms included posttraumatic intrusion, avoidance, and arousal (Briere, 2005). To provide a more holistic perspective, subscales of behaviors commonly exhibited by traumatized children were also explored, including anxiety, depression, anger and aggression, dissociation, and sexual concerns (Briere, 2005). Caregivers reported meaningful improvements in all the associated concerning behaviors. Additionally, caregivers reported practically significant improvements in social-emotional competencies following participation in CCPT. Social-emotional competencies included self-regulation and responsibility, social competence, and empathy. Overall, results indicated the beneficial effects of CCPT over time for children who have experienced disruptions in care in reducing their trauma symptoms and improving their social-emotional competencies.

Impact of CCPT with Children Who Have Experienced Disruptions in Care

This study is the first study to explore the impact of CCPT individual intervention delivered directly to children who have experienced caregiving disruptions, including children in the foster system, children who have been adopted, and children who are otherwise being raised away from their biological parents. This study implemented the Trauma Symptom

Checklist for Young Children (TSCYC), an evidence-based assessment that is used across disciplines and is considered reliable and valid (Briere, 2005), and the Social-emotional Assets and Resilience Scales (SEARS), a strength-based assessment with strong reliability (Merrell, 2011). Additionally, by utilizing a repeated measures design, this study provided the opportunity to engage in deeper exploration of the impacts of CCPT over time with these children. The results of this study provide the first look into the impacts of a meaningful therapeutic intervention for children with disruptive care experiences.

Trauma and CCPT

Children who have experienced disruptions in caregiving often experience a layered trauma experience. Trauma, which is defined as an event or circumstance resulting in physical, emotional, or life-threatening harm that may have long-term impacts on an individual's mental, physical, emotional, social, and spiritual well-being (Substance Abuse and Mental Health Services Administration, 2024). Disruptions in the child's caregiving experiences impact the child's attachment bonding with their primary caregiver, which is conceptualized by D'Andrea et al. (2012) as a primary developmental trauma and results in a higher likelihood of attachment insecurity (Madigan et al., 2023). Attachment refers to the ways individuals respond relationally to others (Bowlby, 1969) and impact, even in infancy, the way in which the infant interacts with and connects to adults (Ainsworth et al., 1978). Early disruptions in the child's relational attachments may therefore impact the way that the child relates to the world as they grow. In addition to attachment trauma, the care disruption is often preceded by a separate traumatic experience, such as abuse or neglect (Baker et al., 2017), which have far-reaching emotional, physical, and mental impacts on the children they impact (Burke et al.,

2011; Felitti et al., 1998; Hughes et al., 2017). Because CCPT prioritizes the therapeutic relationship as the healing factor in play therapy, the intervention appeared well-suited to address the attachment trauma experienced by children with care disruptions.

Past exploration of therapeutic interventions with children who have experienced care disruptions has provided some insight into the benefits of counseling as well as the unique factors counselors may need to consider. Firstly, conceptualization of an “attachment network” suggests that children may develop unique attachment relationships with the various adults in their lives (Denault et al., 2021), and that these attachments to non-caregiver adults may have a cumulative impact on the child’s well-being (Bethell et al., 2019; Denault et al., 2021). Research has also continued to show the long-term impacts (Spinazzola et al., 2021) and cyclical nature of attachment disruptions (Vreeland et al., 2020). In other words, disruptions in caregiving may result in increased externalizing behaviors which then may result in another caregiver placement and attachment disruptions which then may result in even more externalizing behaviors and so forth. This suggests the need for early intervention to attempt to intervene and disrupt the cycle. In the current study, the mean age of participants was eight years old, allowing for intervention at an early age to address disruptions prior to worsening of behaviors. Results indicated that participation in CCPT over time resulted in reduced problem symptoms highlighted in the symptom checklist.

As part of this study, CCPT highlighted the direct therapeutic relationship between child and therapist as the primary factor of healing. For this particular population, inconsistent caregivers provide a unique challenge when considering adding a parenting component to the counseling intervention. Providing a non-permanent caregiver with therapeutic intervention

may not appropriately equip the child themselves with the internal strengths and skills they need as they navigate a potential future caregiving experience, whether that be a new placement or a return to biological parents. A final consideration for counseling interventions with children who have experienced care disruptions is the duration of intervention.

Exploration of this population repeatedly suggests long-term therapy services may be most beneficial, with Clausen et al. (2012) stating that in working with foster children, they received an average of 3 years of services, with some kids receiving services for as long as 7 years.

Literature on need for long-term therapy was of particular interest for the current study, and I sought to explore how a shorter term therapy might impact a sample of this population.

Overall, results of this study indicated that CCPT may be a well-matched therapeutic intervention for children who have experienced care disruptions to decrease their trauma symptoms. Though previous CCPT research has not specifically explored the impacts CCPT has on trauma symptomology, previous research has explored the impacts of the intervention of children who have experienced trauma (Frawley & Dillman Taylor, 2024; Ray et al., 2021; Schoonover & Perryman, 2022). These studies concluded that utilizing CCPT with children who have experienced adverse childhood experiences may result in improved social-emotional competencies (Ray et al., 2021) and decreased externalizing behaviors (Ray et al., 2021; Schoonover & Perryman, 2022). Additionally, Frawley and Dillman Taylor (2024) suggested that children who have experienced trauma experience relational coregulation with the therapist during CCPT, suggesting that the therapist may be serving as a secure attachment figure during therapeutic moments. Though these studies explored the experiences of traumatized children, no previous studies have empirically explored the use of CCPT with children who have

experienced care disruptions. Therefore, this study takes a narrower look specifically at the posttraumatic symptomology displayed by children who have had disruptions in their caregiving and have potentially experienced resulting attachment trauma.

Disruptions in caregiving can be experienced by a child as traumatic (D'Andrea et al., 2012; Spinazzola et al., 2021), and therefore these children may present with posttraumatic symptoms. The TSCYC measures posttraumatic symptoms as an accumulation of intrusive, avoidant, and aroused thoughts and behaviors as well as by externalizing and internalizing behaviors often experienced by traumatized children including anxiety, depression, anger and aggression, dissociation, and sexual concerns (Briere, 2005). Posttraumatic intrusion includes maladaptive and unexpected memories related to the traumatic experience and can include nightmares and trauma reenactment (Briere, 2005). Posttraumatic avoidance includes the child's attempt to ignore or avoid trauma reminders, triggers, or memories and can include declining to talk about their experiences or avoiding places or people that remind them of their trauma experiences (Briere, 2005). Posttraumatic arousal includes hypervigilance to a lack of felt safety and can include jumping or flinching (Briere, 2005). The TSCYC combines these posttraumatic subscales to create a total, holistic perspective of trauma symptoms. Additionally, the TSCYC separately explores symptoms commonly exhibited by traumatized children, including anxiety, depression, anger/aggression, dissociation, and sexual concerns (Briere, 2005).

Results of the current study indicated statistically significant improvements in the overall posttraumatic symptoms of the participants following participation in CCPT with very large effect sizes. In other words, this study suggests that participation in CCPT may decrease

the intrusive, avoidant, and arousal symptoms of children who have experienced disruptions in caregiving. These behaviors were commonly seen in CCPT sessions. For example, one child displayed high levels of posttraumatic avoidance by completely shutting down and sitting in silence for entire sessions following visits with her biological parents. CCPT honors the pace of the child (Landreth, 2024; Ray, 2011), and by following the child's lead, CCPT provided this child with the autonomy to self-titrate her exposure and processing of her own traumatic experiencing. Through facilitation of the therapist providing an ongoing experience of being with the child through both nonverbal and verbal responsiveness, the child was able to build trust with the therapist and within herself. Over time, this child's avoidance of trauma reminders decreased.

Another child engaged in repetitive, intrusive posttraumatic play, playing out reenactments of his traumatic care disruptions as well as other traumatic events he had experienced and witnessed. CCPT trusts in the child's ability to process their experiences and believes that children bring to the play therapy room the experiences that are most pertinent to them (Landreth, 2024; Ray, 2011). By providing a regulated and grounded presence and engaging in empathetic reflections, the counselor was able to convey a safe and trusting relationship defined by the four healing messages: "I am here. I hear you. I understand. I care" (Landreth, 2024, p. 232-233). These messages are particularly vital during moments of intrusive posttraumatic play, as they provide a safe relationship within which the child can process through their trauma experiences. Rather than being alone in their play and possibly re-experiencing the trauma, the child is accompanied by the therapist to engage in healing play. CCPT prioritizes the child's lead whereas if the therapist were to redirect the child, the therapist

may have unintentionally conveyed the opposite of the healing messages: “I don’t want to hear you in this moment. I don’t understand the importance of the play you are engaging in right now. I don’t trust that you can handle this, and it is my job to stop you and fix your pain.”

Instead, CCPT provided the space for the child to work through these painful experiences as a safe, secure adult reflected on the emotional experience and deeper meanings of the play to help facilitate the child’s trauma processing. By engaging in this posttraumatic play, this child was able to communicate to the therapist his feelings of powerlessness and grief during these experiences that happened to him. The therapist utilized empathic understanding and communicated her experience of being with the child as he processed, helping him to feel heard. Over time, this child discontinued his repetitive play surrounding themes of instability and powerlessness related to his changing of caregivers, suggesting that he had processed this experience through his play and was ready to move on and process the next content that was most important to him.

Posttraumatic arousal was also seen in multiple participants’ sessions. For example, one child experienced an abrupt play disruption after engaging in intense play and verbalized to counselor “are you mad?”, suggesting his hypervigilance to relational safety. In this moment, it appeared as though this child had been sent the message that engaging in intense power and control play was considered unacceptable and would impact the other person’s acceptance of him. Though the counselor had not set a limit and was internally experiencing unconditional positive regard for the child, the child’s sensitivity to the relationship and hypervigilance due to past, dangerous relationships seemed to result in sudden high anxiety related to his relational security and safety with the counselor. CCPT provides opportunities for the counselor to

genuinely reflect on these experiences in the counseling room. In this moment, the counselor utilized empathic understanding to reflect the child's fear that she was angry at him as well as genuineness in her warmth toward him, sending the message both verbally and nonverbally that she accepted him regardless of his behaviors. In summary, CCPT appeared to provide a space where each child could process through their traumatic attachment disruptions in a safe therapeutic relationship even when engaging in avoidant, intrusive, or aroused posttraumatic behaviors. Quantitative results support that children were able to use their CCPT experiences to reduce their disruptive traumatic symptoms.

A unique consideration with children who have experienced care disruptions and traumatic attachment disruptions is that the child's trauma is based in relationship. As such, posttraumatic symptomology may also be based in relationship. For children who have experienced disruptions in caregiving, the child's trauma is based in relationship and, therefore, the child's trauma reminder may be relationships. Children who have experienced traumatic attachment disruptions have often experienced hurt by the people who they love and trust (Baker et al., 2017; United States Children's Bureau, 2022), and their trauma experience revolves around the relationships they are in. Hence, the way they show up in relationships may be embedded with posttraumatic behaviors (Spinazzola et al., 2021). They might avoid relationships (APA, 2022; Briere, 2005), as they believe that all relationships will be reminiscent of their traumatic relationship disruption. They may constantly be bombarded by negative intrusive thoughts about relationships (APA, 2022; Briere, 2005), telling themselves that relationships are unsafe and scary and harmful and impermanent. They might even be on high alert when engaging in relationships (APA, 2022; Briere, 2005), overly tense and fearful at the

slightest hint of instability or unpredictability. Additionally, the child may engage in posttraumatic reenactment (APA, 2022). In children who have experienced relational trauma, this may appear as though the child is choosing to seek out further traumatizing relationships. However, when conceptualized through the lens of posttraumatic reenactment of relational trauma, it becomes clear that the child is attempting to process and heal from this experience.

CCPT views the relationship as the therapeutic factor (Landreth, 2024), which may provide a unique and healing relationship within which the child can begin to process this relational trauma. Additionally, the CCPT therapist trusts the child's process and meets them where they are in their healing journey. As the child experiences such a relationship with their therapist, they experience a safe and predictable relationship for, perhaps, the first time. CCPT aims to create a safe relationship that is characterized by empathy and warmth, understanding and acceptance, and authenticity. These conditions may serve to counteract the coldness, expectation, and duplicitousness the child may have experienced in their traumatic relationships. Within the CCPT relationship, the traumatized child is able to work through their experiences with the support and understanding of the therapist. By embodying the tenets of CCPT, the therapist seeks to form a secure attachment with the child and act as a secure base and a safe haven (Bowlby, 1982). As a secure base, the therapist conveys trust in the child's pace and direction, allowing them to explore the experiences most pertinent to them. As a safe haven, the therapist serves as a connection during painful moments with whom the child can seek comfort when feeling distressed. As CCPT emphasizes a warm and empathic relationship, the CCPT therapist is able to create a real and genuine relationship with the child and act as a secure attachment figure from within which the child is able to fully explore themselves and

their experience and express their innermost thoughts and feelings. Hence, utilizing CCPT with children who have experienced care disruptions is a well-matched intervention that is able to meet the child where they are and walk with them through their processing. This study suggests that CCPT is a well-matched relational intervention. Care disruptions are characterized by inconsistency, unpredictability, and unreliable relationships, and CCPT provides a consistent, predictable, and reliable therapeutic relationship within which the child can work toward healing.

Symptoms Associated with Trauma

Symptoms that comprise trauma presentation include symptoms that are often unique to trauma, such as accumulation of intrusive, avoidant, and aroused thoughts and behaviors, as well as symptoms that are often comorbid with trauma symptoms, such as anxiety, depression, and aggression. In this study, I explored the range of trauma symptoms by analyzing subscales of the TSCYC. Although analyses on the subscales should be interpreted with caution, progress on subscales on the TSCYC showed very large effect sizes and therefore warrant further discussion. This study suggests that CCPT may be impactful with symptoms commonly exhibited by traumatized children, including anxiety, depression, anger and aggression, dissociation, and sexual concerns. Children who have care disruptions have been shown to experience higher levels of many of these concerns. Baker et al. (2017) found that, in a sample of 156 foster children, 39% of foster children receiving counseling identified depression and anxiety as a primary concern and that 36.5% identified externalizing behaviors as a primary concern. Additionally, Zhao et al. (2021) found that children who have experienced 12 or more months separated from their biological parents exhibit higher levels of anxiety and depression as well as

anger and aggression. Though no research has connected care disruptions with dissociation or sexual concerns, dissociation and sexual concerns have been associated with experiencing trauma (Briere, 2005), which is commonly experienced by children who have had care disruptions (Baker et al., 2017; D’Andrea et al., 2012).

Baker et al. (2017) suggested a multitude of risk factors that may contribute to the higher levels of anxiety and depression often seen in children with disruptive care histories, including the maltreatment that preceded the displacement as well as the separation from their biological parents. These experiences often compound the trauma experienced by these children (Baker et al., 2017). CCPT provides a space within which the child can focus on processing the experiences most hurtful to them, whether that be the grief and loss of their biological parents, the difficulties with adjusting to a new family, the fear and pain of past traumas, or other concerns that are most pertinent to them. In fact, past research has supported the use of CCPT in decreasing internalizing behaviors including anxiety (Blanco et al., 2015; Gholamalizadeh et al., 2018; Hateli, 2020; Patterson et al., 2018; Salter et al., 2016; Stulmmaker & Ray, 2015) and depression (Burgin & Ray, 2022). This study further supports the use of CCPT with anxiety and depression, specifically with children who have experienced care disruptions. Taylor (2024) asserted that CCPT is well-matched for such internalizing behaviors because the relational focus of CCPT creates an environment within which the child is more likely to experience a stronger sense of self leading to increased autonomy, capability, and hopefulness, all of which counteract the worry, fear, and hopelessness that accompany anxiety and depression. This is particularly salient for children with disruptive care histories. Children who have experienced caregiving disruptions do not have control in these experiences, which

may make the self-directed nature of CCPT especially empowering for these children. This study provided support for this, as the participants' anxiety scores decreased with statistical significance and participants' depression scores, though not statistically significant, decreased meaningfully with a large effect size.

Children who have experienced disruptions in caregiving have been shown to exhibit higher levels of externalizing behaviors, including fighting, arguing, acting impulsively, and feeling angry (Zhao et al., 2021). For example, in this study, one child repeatedly expressed anger toward her biological parents for her trauma experiences while in their care, using the therapeutic relationship as a space to process this anger. CCPT provided the unconditional positive regard necessary for the child to experience unconditional positive self-regard, giving herself the space to express these feelings without self-judgement. This child's anger served as a way to advocate for herself, for her stability with her new guardian, and for her safety. Past metanalytic research has supported the use of CCPT with children experiencing anger and aggression (Parker et al., 2021), which is further supported by the results of this study. In fact, one parent specifically stated that, after 16 sessions, their child was able to "manage his anger and frustration easier than before." CCPT provides structure, which reinforces the predictability of the space and hence the safety of the child, which is supported by limit-setting, allowing for the child to increase their own self-regulation and self-control (Landreth, 2024). By creating predictability and setting consistent limits, the CCPT therapist is able to create an environment that facilitates frustration tolerance through the building of the child's self-control and new coping skills.

Social-emotional Competencies

Children who have experienced disruptions in caregiving may experience difficulties in their social-emotional strengths (Groh et al., 2017; Ray et al., 2020). In fact, the unique nature of care disruptions and confounding traumatic experiences poses a unique risk, as Ray et al. (2020) found that more reported adverse childhood experiences correlated with lower social-emotional competencies, including self-regulation, social competence, and empathy. When specifically exploring the social-emotional strengths of children with care disruptions, Mitchell and Kuczynski (2010) found that initial removal from biological parents resulted in impeded ability to understand the world, relate to others, and predict how others will respond to them. McTavish et al. (2022) found that children with disruptive caregiving experiences desire meaningful and supportive adult relationships; however, due to the often unstable and unpredictable futures of children with a history of care disruptions, children may struggle to identify such relationships. This is particularly salient, as social support has been shown repeatedly to act as a protective factor for traumatized children (Bethell et al., 2019; Blodgett & Lanigan, 2018). Zhao et al. (2021) and Goodvin et al. (2008) found decreased self-esteem and self-concept in children with care disruptions indicating a need for intervention that targets the building of strengths.

Though not statistically significant, results of this study show moderate to large effect sizes with social-emotional assets, suggesting that CCPT may positively impact the self-regulation and responsibility, social competence, and empathy of children who have experienced care disruptions. It appeared as though participation in CCPT may have provided a space within which the children could build upon these strengths. This supports past research,

which has shown support for the use of CCPT to promote children's social-emotional competencies (Taylor & Ray, 2021; Wilson & Ray, 2018). CCPT therapist responses including reflections of content and feeling, encouragement, and facilitating creativity affirm the child's sense of self-worth and capability. As the child experiences a stronger sense of self-concept, they are able to access strengths such as self-responsibility, self-regulation, and relational abilities.

Impact of Time and Number of Sessions in CCPT

This study utilized a within-subjects single cohort design, allowing for a deeper exploration into the impacts of CCPT over time. The results of this study showed statistically significant improvements in the participants' trauma symptoms and meaningful improvement in the participants' social-emotional strengths following 12 sessions, with continued improvement at 16 sessions. Improving means between sessions one and eight indicated a positive directional trend while the progress from sessions one to twelve demonstrated statistical significance with large effect for total trauma symptoms. These results indicate that short-term participation in CCPT (12 sessions over approximately 6 weeks) was correlated with noticeable reduction in trauma symptoms. In regard to trauma symptoms, six of the eight participants rated in clinical categories on the TSCYC showed clinically significant progress on the reduction of trauma symptoms while two participants did not appear to improve based on their clinical cut off scores. Yet, both of these participants were rated with improved trauma scores from pre-test to post-test even though they did not move out of clinically concerning scores. This suggests that CCPT was, in fact, making a positive impact on the children yet perhaps needed more time to show significant changes. This highlights consideration of the

importance of long-term counseling for children who have experience care disruptions.

Previous research has supported the use of long-term, relationship-based counseling services for children from disruptive caregiving backgrounds (Baker et al., 2017; Clausen et al., 2012).

Although interpretation is difficult regarding length of treatment for this sample, results appeared to indicate that short-term CCPT may be a substantive intervention; however, some children will benefit from a longer-term treatment.

Research has provided guidance regarding treatment duration for children with caregiving disruptions. In exploring the therapeutic interventions of 20 children with experience in the foster care system, Clausen et al. (2012) found that the children remained with their counselors for an average of three years, with the longest duration being seven years.

Conversely, Frawley and Dillman Taylor (2024) found that children who have been exposed to adverse childhood experiences experience relational attunement with the CCPT therapist, suggesting that exposure to potentially traumatic events does not necessarily diminish the child's relational resilience. Considering the research of both Clausen et al. (2012) and Frawley and Dillman Taylor (2024), children who have experienced care disruptions may have the capacity to engage in secure relationship with the CCPT therapist yet may still need a longer duration of therapeutic intervention to process their layered experiences. This study provided support for both of these assertions. On one hand, the participants showed statistically significant improvements with their trauma symptoms and meaningful improvements with their social-emotional competencies. As "the relationship is the therapy" (Landreth, 2024, p. 90), this suggests that the children were able to engage in safe and secure relationship with their therapists. On the other hand, the participants' social-emotional strengths did not

improve as quickly as their trauma symptoms, suggesting the need for a longer duration of therapy to reach more holistic overall growth. In other words, this study provided support for the use of CCPT with children who have experienced care disruptions while also highlighted the helpfulness of continuing therapeutic services past 16 sessions. Subjectively, all participants were recommended to continue services. Most participants ($n = 14$) continued receiving weekly services from their therapist following the data collection for this study, with the other two participants being referred to another counselor due to the therapist's relocation.

Trauma Symptoms and Social-emotional Competencies

This study also provides a unique perspective on the relationship between trauma symptoms and social-emotional competencies of children with care disruptions. In summary, children in this study showed significant improvements in their trauma symptoms and meaningful improvements in their social-emotional competencies. However, reduction of trauma symptoms was noticeably stronger than the demonstration of social-emotional competencies. Past research supports the use of CCPT with social-emotional competencies (Taylor & Ray, 2021; Wilson & Ray, 2018), even when the children have experienced trauma (Ray et al., 2021). This study showed progress in the participants' social-emotional competencies, albeit slower than progress in trauma symptoms. This suggests that, for children who have experienced disruptions in care, counseling may first address negative trauma symptomology prior to building on positive social-emotional strengths. In other words, acute trauma symptoms such as intrusion, avoidance, and arousal may first need to be decreased before the child is able to build their self-regulation, social competence, and empathy skills. Results of the current study are supported by Weiner et al. (2009), who found that foster youth

who received counseling intervention showed significant decreases in their posttraumatic stress symptoms. Furthermore, Deblinger et al. (1996) found that foster children's engagement in counseling intervention, even without parent involvement, resulted in improved posttraumatic stress symptoms but did not significantly decrease behavioral concerns. It appears as though children who have experienced trauma often present with acute symptomology, including "prominent personality changes" (Stover & Berkowitz, 2005), developmentally regressed behaviors (Schaefer, 1994; Stover & Berkowitz, 2005) including encopresis and enuresis, posttraumatic play and/or reenactment (APA, 2022), relational difficulties including attachment insecurity/disorganization and betrayal-based relational schemas as well as decreased interpersonal empathy (Spinazzola et al., 2021), and extreme externalizing behaviors such as intense temper tantrums (APA, 2022). Such acute symptoms may need to first be addressed before noticeable strengths can be built and observed. In this current study, it appears as though utilizing CCPT followed this pattern, as trauma symptoms significantly decreased and social-emotional strengths increased at a slower rate. It may be possible that, with time and continued trauma symptom decreases, social-emotional competencies would have continued to increase with continued participation in CCPT.

In this current study, the average social-emotional competencies scores were gradually building over time in CCPT, and with more time may have continued to increase. To better understand this phenomenon, one may take a deeper look at the subscales used to measure the participants' social-emotional strengths. Two of the subscales explored characteristics related to the children's relationships: social competence and empathy. As the participants' foundational concern is rooted in their relational experiences, these two subscales may be

conceptualized to be most intrinsically interrelated to their caregiving experiences. Hence, it may be suggested that the children's relational strengths may have taken more time to be observable to their caregivers due to the way the child may engage in relationships in posttraumatic patterns of intrusion, avoidance, or arousal. The final subscale, Self-Regulation/Responsibility, may be understood as an observable manifestation of a child's Posttraumatic Stress – Arousal or even Anger/Aggression. Hence, the therapeutic intervention may need to first address the roots of the matter in order to observe meaningful externalizing changes, perhaps explaining the fact that in this study, the posttraumatic symptomology decreased more significantly over time than the social-emotional strengths.

Involvement of Parents/Caregivers

Children with a history of disruptive caregiving experiences often exist in “contextual uncertainty” (Heineman et al., 2013, p. xvi), meaning their experiences with chronic abandonment, ambiguous loss, and instability in caregiving placement may make effective therapeutic treatment more difficult. Most of the time, CCPT is delivered with regular parent consultations and parent support (Ray, 2011). However, the uncertainty in caregivers for this population poses a particular challenge regarding the implementation of parent consultations. In fact, in this current study, four of the 22 initially recruited participants changed caregivers either during or immediately after intervention and an additional seven had been placed with their current caregiver less than 6 months prior to beginning intervention. To address the instability of caregiving and uncertainty of future placements, this study provided individual counseling services without integrating parent consultations. By providing individual CCPT without parent consultations, this study explored the resilience of the children and appeared to

show the child's ability to grow and heal independent of caregiver involvement. Past CCPT research has repeatedly shown the efficacy of CCPT without the use of parent consultations (Ray et al., 2022), providing support for the methodology of this study. Axline (1947) states it succinctly: "it is not necessary for the adults to be helped in order to insure successful play-therapy results" (p. 68). Children have within themselves that which is needed to more insightful, more self-understanding, and more mature (Axline, 1947). In fact, Axline (1947) suggests that the child's self-directed growth may in fact impact the family system, as the child's growth may impact the parent-child relationship positively, further supported by Ray and Edwards' (2010) exploration of the reciprocity within the parent-child relationship. As the child heals, the parent is able to experience less relational stress and is able to engage more regulated and genuinely with the child, and the child is able to experience more stable parent support (Ray & Edwards, 2010).

Theoretically, CCPT provides the necessary conditions with which the child self-actualizes, with or without parent support. Rogers (1951) explored this phenomenon in his 19 propositions, stating that all individuals have a naturally positive and self-directed movement toward healing and growth. When extending this belief to children, one may then assert that, with or without parent support, every child has the capacity to grow toward fulfillment even in a less-than-ideal environment (Landreth, 2024). This trust in the child's innate positive striving underlies the philosophical application of CCPT. In this study, the CCPT therapist was able to build upon the child's attachment network (Denault et al., 2021) by acting as a secure attachment figure while also providing the child with the opportunity to process their

experiences and impact the world around them in their own way. This study provided support that, even with inconsistent or uncertain caregivers, children can heal.

Although theoretical rationale supports the use of CCPT intervention directed toward children and without caregiver involvement, research demonstrates that play therapy with involvement of parents/caregivers results in stronger outcomes (Lin & Bratton, 2015). Comparison of caregiver involvement was beyond the scope of this study but may have resulted in even stronger findings if caregivers had been involved. As discussed, the reality of working with children with care disruptions may impede the inclusion of caregivers which provided the rationale for not offering a consultation component to the current study. Yet, it should be noted that CCPT literature supports the need for involving caregivers in all aspects of the child's therapy (Landreth, 2024; Ray, 2011).

CCPT Therapist As A Secure Attachment Figure

Secure attachments have been shown to be vital to a child's well-being and healthy development (Dagan et al., 2022; Denault et al., 2021; Fearon et al., 2010; Groh et al., 2017; Madigan et al., 2013; Madigan et al., 2023; van IJzendoorn et al., 1999), and the protectiveness of a vast attachment network consisting of multiple attachment figures has promising implications for the use of non-caregivers as attachment figures (Bethell et al., 2019; Denault et al., 2021). Secure attachments can improve a child's ability to connect relationally, to cope with distress, and to explore new spaces with courage and comfort (Ainsworth et al., 1978). In other words, the child uses their secure attachment figure as both a safe haven from which to seek comfort during distress and a secure base from which to explore independently (Bowlby, 1982). Creating a network of secure attachment figures may have a cumulative impact on a child's

well-being (Bethell et al., 2019; Denault et al., 2021), providing the therapist with a unique opportunity to act as a secure attachment figure.

From a child-centered perspective, the therapist may utilize empathic understanding, unconditional positive regard, and genuineness to create a secure attachment with the child. As the therapist experiences empathy for the child's experience, the child may feel seen and understood. Feeling understood in such a way may increase the child's felt safety within relationship, which is particularly vital for children who have experienced unsafe relationships. When feeling safe in relationship with the therapist, the child may be more inclined to seek comfort from the therapist, as such utilizing the therapist as a safe haven. The therapist's use of unconditional positive regard may convey a warm, accepting support for the child as they are without expectation that they change in some way (Axline, 1947), ultimately providing the foundation for the child's own unconditional positive self-regard. As the child experiences this nonjudgemental acceptance, the child may feel more empowered to engage in autonomous, self-trusting behaviors, therefore treating the therapist as a secure base. Finally, the therapist's congruence in relationship allows the therapist and the child to create a genuine and authentic interpersonal relationship. As the therapist grows in their own self-awareness and in their ability to therapeutically communicate themselves to the child, the child experiences a secure attachment within the therapeutic relationship. As CCPT emphasizes these attitudinal conditions as the relational healing factors, the CCPT therapist is uniquely situated to provide children who have experienced care disruptions with a healing and restorative relational experience. Although this study did not explicitly explore the dynamics of the relationship between child and therapist, outcomes indicate that the child established a positive therapeutic

relationship that resulted in the reduction of problematic symptoms and building of social-emotional strengths.

Limitations of the Study

Findings from the current study allow a deeper understanding of outcomes related to participation in CCPT. However, there were several limitations to this project. The current study employed a repeated measures single cohort design, which does not employ randomization or a control group. This limits the ability to control for extraneous variables, including history, maturation, and regression to the mean. Therefore, I am limited in attributing outcomes purely to CCPT participation. Additionally, though the number of participants ($N = 16$) met G*Power's a priori power analysis, the small sample size limits the ability to generalize the results. Finally, the research design relied only on parent report when exploring the participants' outcomes and changes which may have been impacted by the caregivers' hopefulness regarding intervention. Other limitations include discussion points regarding the lack of a caregiver component to intervention, study limitations on session number, and possible researcher bias due to the researcher's role as an interventionist in this study.

Implications

The findings of the current study provide implications for both clinical practice and research regarding CCPT with children who have experienced care disruptions. Clinicians may consider utilizing CCPT with this population, as utilizing the relationship as the therapeutic change agent aligns well with the relational trauma often experienced by children with care disruptions.

Clinical Implications

This study demonstrated the importance of approaching relational trauma with a relational intervention. CCPT may be a developmentally appropriate intervention to implement when working with children who have experienced disruptions in their caregiving experiences. CCPT appeared to facilitate the addition of a new, secure attachment relationship to the child's attachment network, allowing for the opportunity for the child to feel safe and supported as they processed the experiences they have encountered and moved toward growth and healing. Within the therapeutic relationship, the children were able to express themselves fully, experience a feeling of control over their circumstances, and experience the feeling of being in a safe and trusting relationship.

While children with disruptive caregiving histories often present with a high level of mental health needs (Dagan et al., 2022; Denault et al., 2021; Fearon et al., 2010; Groh et al., 2017; Madigan et al., 2013; Madigan et al., 2023; van IJzendoorn et al., 1999), mental health support is often identified as the largest unmet need for children in the foster care system (American Academy of Pediatrics, 2021). On top of that, mental health services, even when administered, are often inadequate and inconsistent due to systemic barriers including lack of resources and high turnover in agencies often available to foster families (Clausen et al., 2012). Perhaps most pertinent, inconsistent therapeutic relationships provide the child with additional support to their growing belief that relationships are temporary (Clausen et al., 2012). Therefore, when working with this population, clinicians should be cognizant of the long-term commitments of creating a relationship with a child with relational trauma. In this current study, in fact, all but two children continued receiving weekly services from their therapist

following the data collection for this study due to continued therapeutic need. CCPT therapists honor the relationship as the healing factor.

CCPT provides a unique perspective when working with children who have experienced care disruptions. As the relationship is the therapy (Landreth, 2024), the relationship between the therapist and the child is worthy of deeper exploration. Multiple interventionists in this study reflected on the uniqueness of this particular relationship, with one clinician identifying her relationship with her client as “one of the most impactful cases of my career” and another stating the relationship “will follow me for the rest of my life.” It appears as though acting as the child’s secure attachment and safe relationship, particularly when they may have not experienced such a relationship with other adults in their life, is particularly impactful for the therapist themselves. Additionally, many therapists reported feeling confused with the client’s presentation within relationship and as though the child was testing the relational trust, emphasizing the difficulty in creating a relationship with children who have experienced relational instability and therefore may be navigating relationship using a betrayal-based schema (Spinazzola et al., 2021). As such, clinicians may consider emphasizing the attitudinal condition of genuineness when creating relationships with children who have experienced care disruptions. It appears as though genuineness is particularly pertinent to these children as they test the safety in their new relationships. Additionally, multiple interventionists commented on the confusion they often felt in session as well as the fact that many children seemed to begin more thematic processing toward the end of the 16-session intervention. This suggests that children with care disruptions may require longer-term services to fully process their experiences, as supported by past research (Clausen et al., 2012).

Though this study provided support for engaging in CCPT without parent support, research has regularly shown that parent involvement leads to increased improvements in children receiving CCPT (Lin & Bratton, 2015). In this current study, many of the caregivers presented with a high need for support and psychoeducation. Though CCPT appeared to have significant positive effects without parent consultations, the parents of these children would have benefitted from support throughout services and, by proxy, the children may have shown even more improvements. Because of this, clinicians working with children who have had care disruptions may consider ways to balance the importance of trusting the child and facilitating a secure therapeutic relationship with also providing the parent/caregiver with emotional support, trauma-informed psychoeducation, and parent skill building, especially when the child is presenting with high needs. For example, at the conclusion of the current study, one clinician began providing parent consultations every other week as opposed to the recommended once every 3 to 5 sessions (Ray, 2011), one clinician planned to implement family therapy, and one clinician organized and led a parent support group for caregivers of non-biological children. These play therapists chose to do so in order to provide more systemic support for the family system, a consideration for all clinicians working with this population.

Beyond provision of CCPT and working with caregivers, one implication of this study involved creating a deeper understanding of the child's experiences for the therapist, and possibly, caregiver. When engaging in the demographic interview with caregivers, I worked collaboratively to create a caregiving timeline. As the children's caregiving experiences are often complex and unclear, the creation of a concrete timeline allowed for the therapist's deeper understanding of the child's experience. Additionally, in this current study, it appeared

as though the collaborative creation of the caregiving timeline allowed for the caregiver's increased awareness of the child's experiences. For example, while creating the timeline with the therapist, one parent expressed confusion with their child's timeline and surprise at the amount of disruptions in placements he had faced. In that moment, the parents may have had the opportunity for increased empathic understanding of their child's history and resulting behaviors.

Research Implications

The current study was the first to explore individual CCPT directly provided to children who have experienced care disruptions. Utilizing a repeated measures single cohort design allowed for a deeper exploration into the effects of the mental health intervention over time. The current study provided support for CCPT as a developmentally appropriate and well matched intervention for children with disruptions in their caregiving experiences. However, it is necessary to continue research efforts with this population to replicate the results and strengthen the empirical evidence supporting CCPT with children with care disruptions. Future researchers may utilize a randomized controlled trial that compares CCPT to a control group in order to control for extraneous variables. A larger sample may allow for generalization of results. Conversely, future researchers may consider engaging in case study research to provide a deeper exploration of a child's CCPT experience or a qualitative exploration of the experiences of CCPT therapists working with children who have experienced care disruptions. Additionally, future researchers may consider utilizing multiple reporters, such as teachers, to measure changes across settings. Finally, though this study focused on exploring the internal resources and resilience of children with care disruptions, future research may consider

including parent consultations in order to gain a deeper understanding of the impact of caregiver support with this population.

Conclusion

The current study serves as the first study exploring the impacts of CCPT on the trauma symptoms and social-emotional competencies of children who have experienced care disruptions. Utilizing a repeated measures single cohort design allowed me to identify the change process over time. Statistical results suggest that children with care disruptions showed significant decreases in trauma symptoms by 12 sessions, which continued to decrease at 16 sessions. Additionally, though not as pronounced, the children's social-emotional competencies steadily increased over time in CCPT. This study provides strong support for the use of CCPT with children who have experienced care disruptions. Results of this study indicated that CCPT may be a well-matched therapeutic intervention for children who have experienced care disruptions to decrease their trauma symptoms. CCPT honors the pace of the child (Landreth, 2004; Ray, 2011), and by following the child's lead, CCPT provides children with the autonomy to self-titrate their exposure and processing of their own traumatic experiences. Additionally, CCPT trusts in the child's ability to process their experiences and believes that children bring to the play therapy room the experiences that are most pertinent to them (Landreth, 2024; Ray, 2011). By providing a regulated and grounded presence and engaging in empathetic reflections, the counselor is able to convey a safe and trusting relationship. In summary, the emphasis that CCPT places on the relationship as the therapeutic factor provides a unique, healing experience for children who have experienced care disruptions.

APPENDIX E.

ADDITIONAL MATERIALS

IRB Approval Letter



August 7, 2024

PI: Deanne Ray

Study Title: Child-Centered Play Therapy: Impact on Children in Schools Who Have Experienced Disruptions in Care

IRB # IRB-24-368

Dear Dr. Deanne Ray:

As permitted by federal law and regulations governing the use of human subjects in research projects (45 CFR 46), the UNT Institutional Review Board has reviewed your proposed project titled "Child-Centered Play Therapy: Impact on Children in Schools Who Have Experienced Disruptions in Care." The submitted protocol is hereby approved for the use of human subjects in this study.

Attached to your Cayuse application in the Study Detail section, under the Attachments tab, are the consent documents (if applicable to your study) with the stamped IRB approval. Please use the approved consent copy for your study subjects.

Any and all changes to an approved research study must be submitted for review and approval prior to implementing the change(s) into the research study.

Please contact the Office of Research Integrity and Compliance at 940-565-4643, if you wish to make changes or need additional information.

Note: Please do not reply to this email. Please direct all questions to untirb@unt.edu

Sincerely,

A handwritten signature in black ink, appearing to read "Gabe Ignatow".

Gabe Ignatow, Ph.D.
Professor
Chair, Institutional Review Board

GI:jsp

Recruitment Flyer



Center for
Play Therapy
UNIVERSITY OF NORTH TEXAS

The University of North Texas
Department of Counseling
is conducting a research study on the

CHILD-CENTERED PLAY THERAPY: IMPACT ON CHILDREN IN SCHOOLS WHO HAVE EXPERIENCED DISRUPTIONS IN CARE

at the [ENTER NAME OF SETTING HERE].

Your child may be eligible to participate in these CCPT sessions with a trained play therapist if they:

- are between 5 and 12 years old
- have currently or previously been placed in foster care, state custody, or other guardianship arrangements such as grandparents, kin guardians, or non-kin guardians
- agree to be clients at one of the previously mentioned locations

Total participation is decided upon by therapist and guardian and is based on child's therapeutic needs with a maximum sixteen (16) 30 - minute sessions or eight participation hours. Additionally, guardians will be expected to complete two assessments four times each and a demographic questionnaire, totaling approximately 2 hours over the course of the study.

No compensation is offered for this study.

Primary Investigator: Dee C. Ray, Ph.D., LPC-S, NCC, RPT-S,
940 - 565- 3864, dee.ray@unt.edu

You may qualify to participate in a research study examining the effects of CCPT on the social-emotional strengths and trauma symptoms with children who have experienced displacement from their primary caregivers.

**For more information, please contact Amber-Lea Martinez at
Amber-LeaFiedler@my.unt.edu**

Informed Consent



Informed Consent for Parents with Minor Children

TITLE OF RESEARCH STUDY: Child-Centered Play Therapy: Impact on Children in Schools Who Have Experienced Disruptions in Care

RESEARCH TEAM: Dr. Dee C. Ray, (940) 565-3864, dee.ray@unt.edu; Amber-Lea Martinez; Elizabeth Aguilar; Krystal Turner; Kaleb Thompson; Marium Sadiq; Katelyn Lee; Karina Crescini; Erin Malcom; Nekiya Jackson; University of North Texas (UNT) Department of Counseling and Higher Education

Dr. Ray, the Principal Investigator for this study, and members of the research team have worked at the facilities where research activity is occurring and have a working relationship with the staff at these facilities. Your eligibility for current or future services received at these facilities will not be affected by your decision to take part in this study.

You and your child are being asked to participate in a research study. Taking part in this study is voluntary. The investigators will explain the study to you and will answer any questions you might have. It is your choice whether or not you allow you or your child to take part in this study. If you agree to have you or your child participate, and then choose to withdraw you or your child from the study, that is your right, and your decision will not be held against you.

You and your child are being asked to take part in a research study about determining if child-centered play therapy is effective in improving social-emotional competencies and reducing trauma symptoms in children who have experienced displacement from their primary caregivers.

Participation in this research study involves your child participating in play therapy twice weekly for a maximum of 16 30-minute sessions. Additionally, you will be given a paper demographic questionnaire to complete to gather preliminary background information about your child as well as two paper assessments to complete regarding your child's social-emotional competencies and trauma symptoms. The two paper assessments will be completed a total of 4 times (once at the beginning and after sessions 8, 12, and 16). The assessments take approximately 10-15 minutes to complete, totaling approximately 2 hours over the course of the study. More details will be provided in the next section.

You might want to participate in this study if you believe your child may benefit from play therapy services. We expect that children participating in play therapy will be increasingly aware of their own and others' feelings, thoughts, and needs; learn to interact in an accepting

Consent for Parents with Minor Children
Version: January 2019

and supportive way; increase ability to develop self-responsibility and self-regulation; form and maintain relationships; explore and process past experiences; and exhibit less disruptive behaviors and other interpersonal difficulties. The results of this study may further provide play therapists across the nation with knowledge regarding best practices interventions with children who have experienced displacement from their caregivers. However, you might not want to participate in this study if you or your child does not have the time or if you believe you may be uncomfortable answering some of the personal questions.

You may choose to participate in this research study if you are 18 years of age or older and you have a child aged five to twelve who you believe may benefit from play therapy services and who has currently or previously been placed in foster care, state custody, or other guardianship arrangements such as grandparents, kin guardians, or non-kin guardians.

The reasonable foreseeable risks or discomforts to you and your child is the potential for loss of confidentiality and also for your child if you choose to allow him/her to take part is: possible discomfort when exploring emotions in play therapy, which you can compare to the possible benefit of your child increasing their ability to develop self-responsibility and self-regulation; form and maintain relationships; explore and process past experiences, and exhibit less disruptive behaviors and other interpersonal difficulties. These possible positive outcomes may ultimately contribute to their improvement in empathy and emotional regulation. You and your child will not receive compensation for participation.

DETAILED INFORMATION ABOUT THIS RESEARCH STUDY: The following is more detailed information about this study, in addition to the information listed above.

PURPOSE OF THE STUDY: Child-centered play therapy (CCPT) is an intervention that utilizes the therapeutic relationship as the healing factor (Axline, 1947; Landreth, 2024; Ray, 2011) and, as displacement is a relational trauma, is a well-matched intervention for children who have experienced displacement from their primary caregivers. The CCPT therapist utilizes the sufficient attitudinal conditions of empathic understanding, unconditional positive regard, and genuineness (Rogers, 1957) to facilitate the child's relational healing. The primary goal of this study is to explore the effectiveness of child-centered play therapy with children who have experienced displacement from primary caregivers. Specifically, the proposed study will measure the social emotional competencies and trauma symptomology of children over time during their participation in 16 sessions of child-centered play therapy. Therefore, this study will address the following research questions: (a) What is the relationship between participation in child-centered play therapy over time and the social emotional competencies for children who have experienced displacement from their primary caregivers? (b) What is the relationship between participation in child-centered play therapy over time and trauma symptoms for children who have experienced displacement from their primary caregivers?

TIME COMMITMENT: Your child will participate in 30-minute play sessions, twice per week, for a maximum of 16 sessions, totaling 16 hours. It is anticipated the intervention will take

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approximately eight weeks to complete, though your child's play therapy may not be limited to 16 sessions if you and your child's play therapist decide to continue. You will be asked to complete a brief paper demographic questionnaire which requires approximately 10 minutes at the beginning of your child's play therapy experience. The Social Emotional Assets and Resilience Scales™ - Parent (SEARS-P) and Trauma Symptom Checklist for Young Children (TSCYC) will be administered to you four times over the course of the project and will take approximately 15 minutes for each administration. In total, your time commitment will be approximately two hours for the entire study. The Social Emotional Assets and Resilience Scales™ - Teacher (SEARS-T) will be administered to your child's teacher four times over the course of the project and will take approximately 15 minutes to administer totaling one hour for the entire study.

STUDY PROCEDURES: Allowing your child and yourself to participate in this research study will include this list of actions that we will ask you and your child to consider before engaging in the research:

1. Please read carefully the parental informed consent and child assent and contact the research team with any questions or concerns you may have.
2. If you grant permission for your child's participation, your child will be scheduled for play therapy services as soon as possible. The play sessions will occur twice weekly for 30 minutes each. Play therapy is designed for children to express themselves in their natural way of playing with toys. Some elementary-age children have difficulty working through problems with words, so play therapy can help facilitate the process by providing a play environment from which they can work through those issues that may limit their identity exploration progress. Through interactions with the therapist, we hope your child will become increasingly aware of his or her own and others' feelings, thoughts, and needs, as well as learn to interact in socially appropriate ways. Your child decides what materials to play with and what to discuss in play therapy. Your child will not be asked any questions that are not intended to facilitate his/her awareness or growth. Your child will not be forced to play. The play sessions will be video recorded. The research team will observe the recordings to ensure the quality of play therapy services and the integrity of the study.
3. A member of the research team will ask you to complete the demographic questionnaire which requires approximately 10 minutes to complete. The questionnaire will be provided for you to complete during your child's regularly scheduled play therapy sessions. The questionnaire will need to be completed at only one point in the study, the beginning of the 16 sessions. You may choose to skip or discuss with researcher any question that makes you uncomfortable.
4. A member of the research team will ask you to complete the SEARS-P and the TSCYC at the beginning of your child's play therapy sessions as well as following sessions 8, 12, and 16. Additionally, your child's teacher will be asked to complete the SEARS-T at the beginning of your child's play therapy sessions as well as following sessions 8, 12, and

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16. All information collected will be kept confidential in a secure location. Only the primary researchers will have access to the list of participants' names.

AUDIO/VIDEO: The play sessions will be video/audio-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 video recordings are shown in educational settings, your child's face can be seen which means we cannot guarantee confidentiality. Pseudonyms that have no sound similarity to your child's name will be selected in place of your child's name. You may choose to withdraw your consent at any time and the video recordings of your child will not be used.

☐ **I agree** to have my child video/audio recorded during the research study.

☐ **I agree** that the video/audio recording can be shown in professional presentations for educational purposes.

☐ **I do not agree** that the video/audio recording can be shown in professional presentations for educational purposes.

☐ **I do not agree** to have my child video/audio recorded during the research study.

Your child may not participate in the research study if you do not agree for your child to be video/audio recorded. Your child may participate in the research study if you do not agree for your child's video/audio recordings to be shown in professional presentations for educational purposes.

The recordings will be kept with other electronic data in a secure UNT server for the duration of the study.

POSSIBLE BENEFITS: We expect that children participating in play therapy will be increasingly aware of their own and others' feelings, thoughts, and needs; learn to interact in an accepting and supportive way; increase ability to develop self-responsibility and self-regulation; form and maintain relationships; explore and process past experiences; and exhibit less disruptive behaviors and other interpersonal difficulties. These possible positive outcomes may ultimately contribute to their improvement in understanding their own behaviors as well as their identity. The results of this study may further provide play therapist across the nation with knowledge regarding methods of best practice with children who have experienced displacement from their primary caregivers.

POSSIBLE RISKS/DISCOMFORTS: Children may experience discomfort during the regular course of therapy. Play therapists will facilitate appropriate expression of emotions and support for

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any discomfort. Your participation is completely voluntary. You may discontinue participation at any time while completing the assessments. Remember that you and your child have the right to withdraw any study procedures at any time without penalty and may do so by informing the research team.

Participating in research may involve a loss of privacy and the potential for a breach in confidentiality. Study data will be physically and electronically secured by the research team. As with any use of electronic means to store data, there is a risk of breach of data security.

If you or your child experience excessive discomfort when completing the research activity, you may choose to stop participating at any time without penalty. The researchers will try to prevent any problem that could happen, but the study may involve risks to the participant, which are currently unforeseeable. UNT does not provide medical services or financial assistance for emotional distress or injuries that might happen from participating in this research. If you need to discuss your discomfort further, please contact a mental health provider, or you may contact the researcher who will refer you to appropriate services. If your need is urgent, helpful resources include contacting the primary investigator for referrals for emotional support or call Denton County MHMR 24-hour crisis hotline at 940-387-5555, or the Suicide and Crisis Lifeline at 988.

COMPENSATION: There is no compensation for participation in this study.

CONFIDENTIALITY: Efforts will be made by the research team to keep you and your child's personal information private, including research study records, and disclosure will be limited to people who have a need to review this information. All paper and electronic data collected from this study will be stored in a secure location on the UNT campus and/or a secure UNT server for at least three (3) years past the end of this research confidential in a locked cabinet in the Center for Play Therapy of the Counseling Program at the University of North Texas. Research records will be labeled with a code and the master key linking names with codes will be maintained in a separate and secure location.

The results of this study may be published and/or presented without naming you as a participant. The data collected about your child for this study may be used for future research studies that are not described in this consent form. If that occurs, an IRB would first evaluate the use of any information that is identifiable to you, and confidentiality protection would be maintained.

While absolute confidentiality cannot be guaranteed, the research team will make every effort to protect the confidentiality of your records, as described here and to the extent permitted by law. In addition to the research team, the following entities may have access to your records, but only on a need-to-know basis: the U.S. Department of Health and Human Services, the FDA (federal regulating agencies), the reviewing IRB, and sponsors of the study.

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CONTACT INFORMATION FOR QUESTIONS ABOUT THE STUDY: If you have any questions about the study, you may contact Dr. Dee Ray at 940-565-3864. Any questions you have regarding your rights as a research subject, or complaints about the research may be directed to the Office of Research Integrity and Compliance at 940-565-4643, or by email at untirb@unt.edu.

CONSENT:

- Your signature below indicates that you have read or have had read to you all of the above.
- You confirm that you have been told the possible benefits, risks, and/or discomforts of the study.
- You understand that you or your child does not have to take part in this study, and your refusal to allow participation, or your decision to withdraw will involve no penalty or loss of rights or benefits.
- You understand you and your child's rights as a research participant, and you voluntarily consent to allow your child to participate in this study; you also understand that the study personnel may choose to stop your child's participation at any time.
- By signing, you are not waiving any of [you and] your child's legal rights.

Please sign below if you are at least 18 years of age and voluntarily agree to participate in this study.

SIGNATURE OF PARTICIPANT OR GUARDIAN

DATE

***If you agree to participate, please provide a signed copy of this form to the researcher team. They will provide you with a copy to keep for your records.**

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Informed Consent for Parents with Minor Children

My name is...

I am doing a research study and would like to ask you to be a part of my study. Research studies help us to learn and test new ideas. I am going to give you a paper to read that will tell you all about our research study. You can ask me questions at any time.

We want to include you in this research study because we are trying to learn more about whether play therapy is helpful to you. Play therapy is a time when you will come to a playroom either by yourself or with one other child, and a counselor will ask you to play with the toys in lots of the ways you like. Sometimes for children it is hard to share feelings with words and it helps to play with toys to express how you feel.

You can decide if you want to be part of this research study. I will tell you more to help you to decide.

If you say yes to be included in this study you will be asked to come to play therapy two times a week for up to 16 weeks, which will take about 30 minutes per week.

Sometimes in play therapy you may feel sad, frustrated, or angry. But, play therapy may help you feel better and help you understand important parts about who you are.

Please talk with your parents or guardian about your decision. We will also check with them to see if it is okay for you to be included in this study. Even if your parents or guardian say yes, you can still at any time decide not to be included.

If you decide not to be in this study, you do not have to. Being in this study is up to you and no one will be mad or upset even if you choose later not to continue and stop before you are finished. That is okay.

You can ask me questions that you have about the study now. If you have a question later that you did not ask now, you or your parents can call or email me, or you can ask me when I see you next time.

Would you like to be in this research study? If you say "yes" then you agree to be in this study.

If you would like to be part of this study, please sign your name below.

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Printed Name of Child

Signature of Child

Date

Signature of Guardian

Date

Signature of Investigator

Date

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Demographic Interview

Guardian information

- What is your full name?
- What is your gender?
- What is your race or ethnicity?
- What is the best way to contact you?
 - Phone or email?
 - Time of day?
- Are you this child's biological parent?
 - If no: What is your relationship to this child?

Child information

- What is the child's full name?
- How old are they?
- What grade are they in?
- What is their gender?
- What is their race or ethnicity?
- Has the child ever received mental health services?

Can you tell me a little about this child and how they came into your care?

- Since birth, how many guardian placements has this child had? With whom?
- At what age was this child initially displaced?
- What circumstances led to this child's initial (and continuing) displacements?
- Has this child ever been in foster care? State custody? Group home? Institutional care? Has CPS been involved? If so, for what?
- How long has this child been in your care?
- What is this child's current caregiving circumstances? (ex. do they have contact with bio parent, do they split custody with another adult, etc.?)
- For how long has this child been displaced from their biological parent?
- Who currently lives in your household? (Seek further household info as needed.)

What concerns do you have about this child? At home? At school? With you? With others?
What other information might be helpful in understanding your family?

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