THE EFFECTS OF CHILD TEACHER RELATIONSHIP TRAINING (CTRT) ON RESIDENTIAL CARE WORKERS: A MIXED METHODS STUDY

by

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ABSTRACT

EMILY JEANNE DONALD. The effects of child teacher relationship training (ctrt) on residential care workers: a mixed methods study. (Under the direction of DR. PEGGY CEBALLOS)

Children in the United States are experiencing a mental health crisis characterized by diagnoses of serious mental health disorders (CDC, 2013; SAMHSA, 2012; U.S. Public Health Service, 2000). One component of the array of treatment approaches for child mental health issues is residential treatment in which children receive therapeutic services in a residential setting. Children in residential treatment have experienced a variety of issues by the time they come into treatment, including: one or more mental health diagnoses (Connor, Doerfler, Toscano, Volungis, & Steingard, 2004; Handwerk et al., 2006; Sternberg et al., 2013), a history of abuse (Bettman, Lundahl, Wright, Jasperson, & McRoberts, 2011; Connor et al., 2004), and high rates of externalizing behaviors (Bettman et al., 2011; Connor et al., 2004; Handwerk et al., 2006; Sternberg et al., 2013; Trout et al., 2008). In a residential care setting, the primary source of direct resident care is residential care workers (RCW), who are prone to burnout (Seti, 2008) and must find ways to build relationships with the children in their care, as those relationships are important to the success of treatment (Moses, 2000). One promising approach to address this relational need is Child Teacher Relationship Training (CTRT; Morrison, 2006), which shows promise in addressing both teacher perceptions of children's behavior (e.g., Morrison, 2006) and teachers' relationships with children (e.g., Sepulveda, Garza, & Morrison, 2011). This study used a mixed methods approach consisting of a primary single-case experimental design with a qualitative case study to investigate the effects of

CTRT in the residential treatment environment with RCWs. More specifically, the study investigated effects of CTRT on RCWs': (a) perceptions of children's behaviors, (b) relationship with the child of focus, (c) ability to demonstrate empathy in individual play sessions, (d) ability to generalize child-centered play therapy skills to a classroom/group environment, and (e) symptoms of burnout. Additionally, the study qualitatively explored the RCWs' challenges, experiences, and perceptions related to the CTRT. Qualitative data suggested that the participants experienced the training positively and found it useful, experienced some challenges with the training, and planned to keep using the skills. The percentage of data points exceeding the median (PEM; Ma, 2006) was calculated and indicated that participants were able to generalize child-centered play therapy skills to their classroom. The treatment effects ranged from mildly effective to very effective (Scruggs & Mastropieri, 1998). The percentage of non-overlapping data (PND; Scruggs, Mastropieri, & Casto, 1987) was calculated and indicated that the treatment was very effective in helping participants increase the demonstration of empathy in play sessions. Qualitative descriptions of the relationship between the RCWs and their COFs were positive, but the quantitative data did not consistently align with the qualitative data across all participants. Two participants described ongoing experiences of behavioral challenges with their COF and one did not, which was supported by the quantitative data related to COFs' behavioral problems. Symptoms of burnout did not improve, but participants described job-related improvements related to the training.

DEDICATION

I dedicate this achievement to my whole family, be they biologically mine or somehow drawn into my world. To my husband, Peter, who never gave up on me and made sure I always had what I needed to keep at this, without you this would have never even gotten started, much less finished. You are a true partner in all aspects of life. There are no words to thank you enough for all you do. To my parents, Linda and Jack, you have always supported my educational dreams and challenged me to do my best. Mom, you helped me build a love of learning that has been invaluable, and Dad, you always make me laugh, even when things are tough. Thank you for being there for me and for my family. To my brother, Brandon, you are one of the smartest people I know. Your accomplishments never cease to amaze me and inspire me to aim high. To my grandparents, Gene and Jo, who have kept up with my accomplishments and always celebrated with me, I am grateful for your unwavering support. To Elizabeth, you believe in me, and I am grateful you accept me sans filters, no matter what. To Amanda, you have encouraged me in some of the toughest moments of this process and loved my kids as your own so I could, without worry, do what I needed to do, and Peyton, your smile brought me joy on some of the hardest days. I am so grateful for you both. And finally, to my children, Everett and Quinn, you taught me that some days are not for dissertations. You are the most amazing kids, and I am grateful for all you teach me and feel privileged to be your mom.

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CHAPTER 1: INTRODUCTION

There is a mental health crisis occurring in the United States, especially among children (U.S. Public Health Service, 2000). Though there is statistical evidence of this crisis (e.g., 13-20% of children experience a mental health disorder each year; Centers for Disease Control and Prevention [CDC], 2013), one need only turn on the news to see that people who are dealing with devastating mental health issues take action in ways that can have tragic consequences for large numbers of people. It is easy to recall such tragedies including school shootings that occurred at Sandy Hook Elementary in 2012 and Virginia Tech in 2007. In the wake of these tragedies, there are often questions related to the mental health issues of the person involved. Some have led to conversations about the need for change in the mental health systems in place in the United States and the need to provide early and effective intervention for all children with mental health concerns (U.S. Public Health Service, 2000). Thus, addressing the mental health needs of children who show socio-emotional problems seems to be a strategy that could help alleviate the onset of more severe consequences in the future.

According to the report from the Surgeon General's Conference on Children's Mental Health

> the nation is facing a public crisis in mental health for infants, children and
> adolescents. Many children have mental health problems that interfere with

normal development and functioning. In the United States, one in ten children and adolescents suffer from mental illness severe enough to cause some level of impairment…Recent evidence compiled by the World Health Organization indicates that by the year 2020, childhood neuropsychiatric disorders will rise proportionately by over 50 percent, internationally, to become one of the five most common causes of morbidity, mortality, and disability among children (U.S. Public Health Service, 2000, p. 11).

The Substance Abuse and Mental Health Services Administration (SAMHSA; 2012) reported that between the years of 2001 and 2004, 13.1% of children ages 8-15 had a mental health disorder and 11.3% had severe impairment from a mental health disorder within the last year. In a comprehensive compilation of many sources, the CDC (2013), report on children's mental health in the United States combined information from the CDC, the Health Resources and Services Administration (HRSA), and SAMHSA, suggesting that "mental disorders among children are an important public health issue because of their prevalence, early onset, and impact on the child, family, and community" (p. 2). These data were compiled from a variety of surveillance systems, surveys, and information systems associated with the aforementioned agencies including: the National Comorbidity Survey Replication Adolescent Supplement (NCS-A), the Autism and Developmental Disabilities Monitoring (ADDM) network, the National Health and Nutrition Examination Survey (NHANES), the National Health Interview Survey (NHIS), the National Survey of Children's Health (NSCH), the National Survey on Drug Use and Health (NSDUH), the National Violent Death Reporting System (NVDRS), the National Vital Statistics System (NVSS), the School-Associated Violent Death Surveillance Study (SAVD) and the National Youth Risk Behavior Survey (YRBS). Significant statistics presented in this report include: 13-20% of children in the United States experience a mental disorder each year; in 2010 suicide was the second leading

cause of death in children 12-17; a 24% increase in inpatient and substance abuse admission for children between 2007 and 2010; and the cost of mental disorders in people under 24 years of age is approximately $247 billion per year.

Though the reports compiled and presented by the CDC (2013) used slightly different age ranges to represent children and adolescents and varying ways to classify child mental health disorders, the statistics provide a general look at the status of child mental health in the United States. Related to specific disorders the estimates of prevalence of specific disorders were as follows: attention deficit and hyperactivity disorder, 6.8%-8.9%; oppositional defiant disorder and conduct disorder, 4.6%; depression, 2.1%-3.9%; anxiety disorders (surveys included parent report of anxiety problems), 3.0%-4.7%. It is important to note that questions varied by survey and some percentages are indicative of a history of diagnosis versus a current diagnosis. Further, the YRBS report in 2011 included the following information related to suicide: 15.8% of youth had seriously considered suicide, 13% had a plan, and 7.8% had attempted suicide. SAVD data showed 28 school-associated suicides in children aged 5-18 from July 2005 through June 2011. The prevalence of serious mental health disorders combined with the urging of the U.S. Public Health Service (2000) and the CDC suggest the need for effective mental health services for children at every level of care, from outpatient services to more intense inpatient and residential care.

<center>Background of Residential Treatment in the United States</center>

Residential treatment is one treatment option in the array of children's mental health services in the United States. As such, it seems that in the effort to improve mental health services in general and more specifically, mental health services for children,

residential treatment should be one focus of efforts to improve the efficacy and effectiveness of treatment. This treatment approach is plagued by a variety of challenges, not the least of which is lack of a clear and consistent definition (Leichtman, 2006) and questions about the effectiveness of the treatment provided in residential care for children (Walter, 2007; Office of Juvenile Justice and Delinquency Prevention [OJJDP], n.d.). In spite of these questions, the number of residential treatment centers has increased and so too have admissions (SAMHSA, 2012). In fact, admissions of children to 24-hour hospitals and residential treatment increased from 24,511 admissions (10.2 admissions per 100,000 general population) in 1986 to 60,620 (20.3 admissions per 100,000) in 2004. Further, the number of residential treatment centers increased from 261 in 1970 to 474 in 2000 (Ireys, Achman, & Takyi, 2006). According to SAMHSA (2012), in 1986 there were 437 residential treatment centers in the United States. This increased to 538 in 2008. This increase is potentially attributable to the closure of other types of mental health facilities for children (Ireys et al., 2006).

More recent statistics show that 211,000 children received mental health treatment at residential treatment centers in the United States in 2009 (SAMHSA, 2012). According to a survey of residential treatment programs, at the time of entry into residential treatment, children have top diagnoses of mood disorders, attention problems, oppositional disorders, posttraumatic stress disorder, anxiety disorders, and conduct disorders (Abt Associates Inc., 2008). Triggers for admission among those children included: community disruption, self-injury, inability to function in daily activity, and danger to others.

In spite of associated challenges, it is expected that the residential treatment environment will continue to be one part of the array of mental health treatment approaches available for children in the United States (Ireys et al., 2006). There is a need for effective services and research related to this approach to treatment (Ireys et al., 2006; OJJDP, n.d.; Walter, 2007). Considered together, the sobering statistics related to children's mental health, the call for action by several agencies, and the lack of evidence for care provided in residential treatment to some of the most vulnerable children, suggest the need for more research in this area.

<div align="center">Background of the Study</div>

According to Walter (2007), some of the issues in residential treatment are attachment disruptions, understanding what works, and high staff turnover rates. Though there is a documented need for more research, what seems to have an effect in residential treatment, according to Walter's review of the literature, are relationship factors. However, the people responsible for much of the care (who by default are the primary source of relationship opportunities for kids in treatment) face high turnover rates and increasing job demands (from severity of symptoms in children to decreasing resources). In fact, residential care workers (RCWs) are responsible for what can be called *The Other 23 Hours* (Treischman, Whittaker, & Brendtro, 1969). This book title refers to the hours not spent in therapy, those spent in the therapeutic milieu where day-to-day interactions are part of the treatment process. RCWs responsible for that time are prone to burnout from the stress of the job, which can result in consequences for their relationships with children in their care (Seti, 2008). The need for training that helps RCWs build skills that support their ability to create and sustain healthy and beneficial relationships, as well as

increase their belief in their own ability to be effective with children in their care, seems clear.

One approach that holds promise for addressing the mental health needs of children in residential care and RCWs' burnout is child teacher relationship training (CTRT; Morrison, 2006), an adaptation of child parent relationship therapy (CPRT; Landreth & Bratton, 2006). CPRT, a filial therapy approach with theoretical roots in child-centered play therapy (CCPT; Landreth, 2012), centers on the relationship between the parent and child as the most appropriate and effective vehicle for change in the child while positively affecting parental stress. CTRT is an adaptation of the CPRT model for use with teachers in a classroom environment. CTRT includes extra training and supervision sessions, beyond individual training with a specific child of focus. These sessions are used to address the participant's ability to generalize the CCPT skills learned to a group environment (i.e., the classroom). As RCWs are responsible for groups of children, the CTRT model presents a good fit to help them gain relationship-building skills to use with the children in their care. However, to date, no research has examined its effectiveness with RCWs.

As noted earlier, children in residential care present with complex and challenging problems including a history of abuse (e.g., Bettman, Lundahl, Wright, Jasperson, & McRoberts, 2011), trauma (e.g., Bettman et al., 2011), and mental health diagnoses (e.g., Sternberg et al., 2013). They also have high rates of externalizing behaviors, or behaviors that are directed outward (e.g., aggression), that can be challenging to manage in a group environment (e.g., Sternberg et al., 2013). CPRT has demonstrated effectiveness with similar issues (Ceballos & Bratton, 2010; Jang, 2000; Sheely, 2008; Smith & Landreth,

2003; Tew, Landreth, Joiner, & Solt, 2002; Yuen, Landreth, & Baggerly, 2002). Further, it has been shown to have a variety of effects on factors related to relationships between parents and children (Bratton & Landreth, 1995; Ceballos & Bratton, 2010; Chau & Landreth, 1997; Costas & Landreth, 1999; Harris & Landreth, 1997; Kale & Landreth, 1999; Landreth & Lobaugh, 1998; Lee & Landreth, 2003; Smith & Landreth, 2003; Tew et al., 2002; Yuen et al., 2002). CTRT, though not as well researched, has shown similar results with positive effects on children's behavior (Post, McAllister, Sheely, Hess, & Flowers, 2004; Morrison Bennett & Bratton, 2011; Smith & Landreth, 2004) including: reductions in externalizing behaviors (Helker & Ray, 2009; Morrison & Bratton, 2010; Morrison Bennet & Bratton, 2011), reductions in internalizing behaviors (Post et al., 2004; Smith & Landreth, 2004), increases in adaptive skills (Post et al., 2004), and reductions in withdrawn behaviors (Smith & Landreth, 2004). Teachers have also experienced the CTRT positively, changing their perspectives on children (Helker & Ray, 2009; Post et al., 2004; Sepulveda, Garza, & Morrison, 2011) and reporting more confidence in their ability to manage their classroom (Hess, Post, & Flowers, 2005; Sepulveda et al., 2011).

The combination of these findings suggest that CTRT, an intervention based on building and improving relationships between teachers and children, is a potentially effective way to address some of the needs identified in residential care. Research suggests that CTRT, and its predecessor CPRT, have shown effectiveness with challenging behaviors similar to those of children who enter residential treatment (e.g., Morrison & Bratton, 2010), as well as with improving relationships between children and parents (e.g., Bratton & Landreth, 1995) or children and teachers (e.g., Helker & Ray,

2009). Additionally, teachers have experienced positive effects that may be applicable in the reduction of burnout and stress associated with the job of RCWs (e.g., feeling more confident in classroom management skills as in Hess et al., 2005). On the whole, this suggests that CTRT is an intervention worth investigating in the context of a residential treatment environment and there is no study of this type in existence in the literature.

Significance of the Study

There is a clear indication of the need for mental health intervention with children (CDC, 2013; SAMHSA, 2012; U.S. Public Health Service, 2000). Residential treatment is one component of the array of services available to children with mental health problems, but it suffers from several problems including a lack of evidence and research related to effective treatments (OJJDP, n.d.; Walter, 2007). Staff members who are responsible for the care of children face issues of burnout (Seti, 2008) and the need to create relationships with children who face significant mental health challenges (Connor, Doerfler, Toscano, Volungis, & Steingard, 2004; Handwerk et al., 2006; Sternberg et al., 2013), because it is these relationships that are shown to have a treatment effect (Walter, 2007). CTRT is a treatment approach that has the potential to address these complex issues. To date, there is little empirical research related to CTRT, though CPRT has a relatively strong research base, and no study that addresses the use of CTRT in a residential treatment environment. This study could:

- provide information about a potentially effective treatment approach that could be integrated into existing residential care treatment models
- provide information about the specific effects of CTRT in the residential treatment environment, including relationship effects

- provide information about how RCWs who complete the CTRT perceive CTRT and its effectiveness

Understanding these things could contribute an initial piece toward addressing the general need in the United States for mental health services for children and the specific need for effective interventions in residential treatment.

Additionally, this model of treatment (CTRT) uses professional counselors to train paraprofessionals in relationship building skills. Training paraprofessionals as agents of change is important given the shortage of mental health providers in general (Thomas, Ellis, Konrad, Holzer, & Morrissey, 2009) and for children and adolescents specifically ("Children's mental health," 2006), because these trainings allow a single mental health provider to reach more children (Andronico & Guerney, 1967). Therefore, trainings such as CTRT can potentially serve as examples for counselor education programs on training future counselors to use consultation/paraprofessional models as a way to reach more clients, more efficiently. In addition, this study enhances the play therapy field and informs the teaching of play therapy by providing information about the usefulness of CCPT skills across settings.

Finally, within the field of counselor education, this study answers the call for more use of single-case design as a methodology to study counseling interventions. Ray, Barrio Minton, Schottelkorb, and Garofano Brown (2010) suggested counselor educators become knowledgeable about single-case design and teach it in their respective programs. Further, Lundervold and Belwood (2000) called single-case designs "the best kept secret in counseling" (p. 92). This study provides information about the use in counseling of a mixed methodology with a primary single-case design and provides support for the need

for its inclusion in research methodology taught in counselor education programs.

Purpose

The purpose of this study was to investigate the effects of CTRT in a residential treatment environment. More specifically, the purpose of this research was to investigate three main components of the effects of CTRT in residential care for children and adolescents: (a) effects on the relationship between the child of focus and the RCW participants, (b) ability of RCWs to use relationship skills learned in the training when interacting with groups of children, and (c) the effects of CTRT as perceived by RCWs.

Research Questions

The following research questions, organized according to the type of data that were used to answer them were addressed by this study:

Quantitative Research Questions:

1. What are the effects of the CTRT intervention on the residential care workers' ability to generalize child-centered play therapy skills to the classroom/group?

2. What are the effects of the CTRT intervention on the residential care workers' demonstration of empathy in play sessions with their child of focus?

Qualitative Research Questions:

3. How do residential care workers who complete CTRT perceive the training?

4. How do residential care workers who complete CTRT perceive the impact of the training?

5. How do residential care workers who complete CTRT describe the usefulness of the training?

6. What challenges, if any, related to CTRT do residential care workers experience?

Mixed Methods Research Questions:

7. What are the effects of the CTRT intervention on the relationship between residential care workers and children of focus?

8. What are the effects of the CTRT intervention on residential care workers' perception of the children of focus's internalizing, externalizing, and total behavior problems?

9. What are the effects of the CTRT intervention on the residential care workers' symptoms of professional burnout?

<div align="center">Delimitations</div>

The delimitations of this study are:

1. Study participants were volunteers from the residential care workers on staff at a single residential treatment facility for children and adolescents in the Southeastern United States.

2. The researcher investigated the effects of CTRT using a mixed methods approach including single-case experimental design, which is limited to a focus on individual patterns of response and does not permit group generalizations.

3. In the single-case design used in this study it was not possible to allow enough time for stability of behavior once the intervention was started for each participant and participants were started when paired with an available appropriate child of focus (COF) following the initial establishment of baseline stability.

4. The variable guiding the design of the study (generalization of skills to the group) was not expected to change until later in the treatment, which did not allow the demonstration of immediate treatment effects as typical in single-case design.

5. This research investigated the effects of CTRT, which is a modification of CPRT to be applied in the school environment, in an environment that is in some ways similar to but is not a school.

6. This research investigated the effects of CTRT only and not other models of relationship building trainings that are used in schools.

Limitations

The results of this study may be affected by the following factors that are beyond the control of the researcher:

1. The self-report assessments used in this investigation may have been affected by the subjective judgment of the participants.

2. Though efforts to train observers and raters of behavioral measures were made, there may have been differences in the way different observers scored participants on observational measures.

3. Children and workers in the residential treatment environment are affected by a variety of factors; there are multiple aspects of treatment occurring simultaneously.

4. Residential care worker participants were all employed at the same treatment facility and may have communicated with each other about aspects of the CTRT.

5. Participants were volunteers and may somehow differ from those who did not volunteer to participate in the study.

6. Children who were selected to participate in the study by their teacher and whose parent/guardian agreed to allow participation may differ from those who were not selected.

7. Single-case analysis (both visual and statistical) may be affected by autocorrelation, which may be present in this study.

Assumptions

The assumptions made include:

1. Participants answered honestly on self-report assessments and in interviews.

2. The training, a modified version of the manualized CPRT training (Bratton, Landreth, Kellam, & Blackard, 2006), is equivalent to the original training and will be provided consistently across participants.

3. Participants attempted to use and master the skills presented in the CTRT.

Threats to Validity

There are threats to internal and external validity in this study. Related to internal validity, instruments being used in this study, though reliable and valid, were used with a population for whom they are not designed. Several of the measures selected were designed for use with teachers, not with residential care workers, for whom there are no specific assessments. Efforts made to ensure their applicability to residential care workers include item review and the selection of measures that could be used with residential care workers without item modification, as well as consultation with dissertation committee members experienced in research. Additionally, single-case design requires ongoing assessment. Some of the measures selected in this study have not been assessed for their appropriateness to be used in weekly assessment, though efforts were made to ensure that their use in this way does not violate existing recommendations. In a treatment environment that is small, it is possible that participants communicated with one another about the training. Attempts to minimize this were made, including offering participants

the opportunity to participate in a post-study processing group in which they could talk about their training experiences. Participants were asked to save their communication with each other for this occasion. Finally, the variable guiding the single-case design was skill generalization in the classroom/group, which was not expected to take place until later in the training. Therefore, the treatment effects were not immediately evident, which would provide stronger evidence for a causal relationship between the treatment and the effect in this single-case design. However, changes were predicted to take place at specific times based on the treatment outline, so patterns were evaluated based on expectations.

External validity is limited primarily by the selection of study methods. This study used a mixed methods approach made up of a single-case design and a qualitative case study. Both of these methods focus on individual effects, thus limiting the generalizability of the findings. Further, the study took place in only one residential treatment center, with a limited number of staff members.

<div align="center">Operational Definitions</div>

For the purposes of this study the following operational definitions will apply:

Child-centered play therapy (CCPT): is, according to Landreth (2002):

> 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. 16).

This is an approach in which

> the play therapist's objective is to relate to the child in ways that will release the child's inner-directional, constructive, forward-moving, creative, and self-healing power…[such that] they are empowered and their developmental capabilities are

released for self-exploration and self-discovery, resulting in constructive change (Landreth, 2012, pp. 53-53)

Child parent relationship therapy (CPRT): is, according to Landreth and Bratton (2006) a

10-session format filial therapy model which is

> used by professionals trained in play therapy to train parents to be therapeutic agents with their own children through a format of didactic instruction, demonstration play sessions, required at-home laboratory play sessions, and supervision in a supportive atmosphere. Parents are taught basic child-centered play therapy principles and skills including reflective listening, recognizing and responding to children's feelings, therapeutic limit setting, building children's self-esteem, and structuring required weekly play sessions with their children using a special kit of selected toys. Parents learn how to create a nonjudgmental, understanding, and accepting environment that enhances the parent-child relationship, thus facilitating personal growth and change for child and parent (p. 11).

This treatment is available in a manualized format, designed to be adapted to specific

populations (Bratton et al., 2006).

Child teacher relationship training (CTRT): a modification of the CPRT model to include

additional sessions devoted to skill generalization in a classroom or classroom-like

environment, which is conducted in two phases. In CTRT Phase I, RCWs will

individually complete the equivalent of the CPRT manualized treatment (Bratton et al.,

2006), with minor modifications for scheduling and applicability to the residential

setting. In Phase II, RCWs will receive 30 minutes of coaching in skill generalization in

the classroom/group setting each week during unstructured group time. This will continue

for 3 weeks during which the RCWs will continue to receive weekly supervision.

CTRT Phase I: During this phase of training RCWs will complete the equivalent of the

10-session model in CPRT (Bratton, Landreth, Kellam, & Blackard, 2006). Session 1 and

session 2 will be combined. Following session 3, RCWs will begin weekly 30-minute

play sessions with their selected child of focus and will receive weekly supervision for

30-45 minutes from their CTRT therapist. During this phase, RCWs will be instructed to use the skills they are learning only in individual play sessions until they complete the 8th session, when generalization of the skills to the classroom/group will begin to be discussed.

CTRT Phase II: During this phase of training, RCWs will receive coaching while they are working with a group of children as part of their regular daily activities in the therapeutic milieu. This coaching will occur one time per week during unstructured time, which will typically be in a classroom-like space. The CTRT therapist who provided their Phase I training will provide the in-group coaching. This will continue for 3 weeks during which time the RCWs will continue to receive individual supervision for 30-45 minutes per week from their CTRT therapist.

CTRT therapist: Either a masters or doctoral level student with training in CPRT or a masters or doctoral level student enrolled in training for CPRT who is receiving ongoing group supervision in a course, as well as individual supervision from the primary investigator who has advanced training in CCPT and CPRT.

Residential treatment for children and adolescents: A treatment program that consists of "components of *a therapeutic milieu*, a *multidisciplinary care team, deliberate client supervision, intense staff supervision and training,* and *consistent clinical/administrative oversight"* (Butler & McPherson, 2007, p. 469) in an accredited facility where children and adolescents do not to exceed the age of 17.

Residential care worker (RCW): front-line staff members in a residential treatment program. They are the employees of the residential treatment facility who are responsible for all milieu activities. They may have a variety of training backgrounds.

Therapeutic milieu: time spent in the general population groups of residential treatment which consists of the environment in residential care in which life experience can be used in a therapeutic fashion (Leichtman, 2008). This is also referred to as *The Other 23 Hours*, the title of a book by Trieschman et al. (1969), to capture all of the daily life tasks that occur outside of the time devoted to therapy.

Child of focus(COF): the child selected to participate in weekly one-on-one play sessions with the participating RCW.

CCPT skills: skills taught in the CTRT intervention that the RCWs will first receive training to use in individual play sessions with a COF and then receive training to generalize to be used when interacting with groups of children. Operationalized according to the Child-Teacher Relationship Building Skills-Center Time Observation Form (CTRT-SC; Morrison, 2006). This form includes the following CCPT skills: tracking/reflect non-verbal play; reflect content; reflect feelings, wants, desires; esteem building/encouragement; returning responsibility; relational responses; choice giving; and A-C-T limit setting, including acknowledge the feeling, communicate the limit, and target the alternative, as well as a rating of whether or not the observer notice that the participant showed the ability to be with the child by being on the child's level, communicating attention and interest, and matching tone with the child.

Empathy: operationalized according to the Measurement of Empathy In Adult-Child Interactions (MEACI; Bratton, 1993; Stover, Guerney, & O'Connell, 1971). Empathy consists of communication of acceptance, willingness to follow the child's lead rather than control the child, and attention to and participation in the child's activity.

RCW-child relationship: the RCW-rated perception of his or her relationship with the COF according to the self-report Student Teacher Relationship Scale (STRS; Pianta, 2001). This consists of the RCW's perception of the conflict in the relationship, the dependency in the relationship, and the closeness in the relationship.

Internalizing behavior problems: problems characterized as within the self, as operationalized by the Teacher Report Form of the ASEBA School-Age Forms (TRF; Achenbach & Rescorla, 2001). This includes the subscales: Anxious/Depressed, Withdrawn/Depressed, and Somatic Complaints.

Externalizing behavior problems: problems characterized as primarily including conflicts with others, as operationalized by the TRF (Achenbach & Rescorla, 2001). This includes the subscales: Rule-Breaking Behavior and Aggressive Behavior.

Total behavior problems: operationalized as the sum of Internalizing Problems, Externalizing Problems, and the Social Problems, Thought Problems, and Attention Problems (consisting of Inattention and Hyperactivity-Impulsivity subscales) subscales of the TRF (Achenbach & Rescorla, 2001).

Professional burnout: "a syndrome composed of emotional exhaustion, depersonalization of clients, and loss of feelings of personal accomplishment" (Seti, 2008, p. 198). Operationalized as scores on the Maslach Burnout Inventory-Educators Survey (MBI-ES; Maslach, Jackson, & Leiter, 1996). This includes the three dimensions of burnout: emotional exhaustion, feelings of being emotionally and physical fatigued; depersonalization, negative and distant feelings related to teaching and students; and personal accomplishment, feelings of efficacy and meaning related to work.

Summary

This chapter provided the background from which this study emerged. It reviewed the status of children's mental health in the United States, as well as the need for services to address their mental health needs. It also provided background related to residential treatment, one component of the mental health treatment system for children and adolescents, and the need for effective treatments within residential treatment. Finally, CTRT was introduced as an intervention with the potential to address some of the mental health needs of children in residential treatment, by teaching RCWs relationship building skills to use in their work with children. There is currently no research that addresses this specific use of CTRT, and there is a dearth of research on CTRT in general. The following review of the literature related to these topics will cover in depth the associated research.

CHAPTER 2: REVIEW OF LITERATURE

The following review of the literature will provide the basis for the research

questions related to implementing child teacher relationship training (CTRT) in a

residential treatment facility for children and adolescents. This review will cover

residential treatment for children and adolescents, child parent relationship therapy

(CPRT), and CTRT. First, residential treatment will be summarized, including a brief

look at the history of this treatment approach. Research related to issues faced by children

and adolescents in residential care, such as behavior problems and relationship

disruptions, will be summarized. In addition, challenges faced by residential care

workers, including burnout and stress, will be identified as part of the basis for the need

for intervention within this system of child and adolescent treatment. Additionally, the

importance of the relationship between staff and residents will be reviewed and serve as

the basis for the need for interventions that improve this relationship. The exploration of

the history and literature related to CTRT will begin with a summary of the history and

effectiveness of child-centered play therapy (CCPT), as the theoretical base for CPRT

(which is the basis for CTRT). From there, the history of CTRT will be traced through

the development of filial therapy and CPRT. Following a brief summary of literature

related to CPRT, the literature related to CTRT will be examined closely. There is not yet

a large body of literature related to CTRT, so CPRT research will be used to further

support the establishment of variables of interest. The research related to the following variables will be examined closely: effectiveness of CTRT in addressing child behavior problems, effectiveness of CTRT in increasing the demonstration of empathy by trainees, effectiveness of CTRT in improving CCPT skill demonstration by trainees, and the experience of those who complete CTRT. Finally, this chapter will provide a summary and integration of these areas that informs the research questions.

<div align="center">Residential Treatment for Children and Adolescents</div>

Residential treatment is an approach to mental health treatment for children that professionals have struggled to define (Butler & McPherson, 2007; Lee, 2008; Leichtman, 2006). This has led to difficulty with conducting research that quantifies outcomes, as well as challenges to securing funding for this approach to treating children with mental health problems (Butler & McPherson, 2007; Lee, 2008; Leichtman, 2006). Yet in the midst of the confusion about defining residential treatment, there appears to be a clear call to understand what factors work in residential treatment to help children who end up in this level of care (Butler & McPherson, 2007; Lee, 2008). The following section will first briefly cover the history of residential treatment and proposed definitions from the literature before moving to address the characteristics of children and youths in residential care and their needs, staff issues and burnout, and the relationship between child and adolescent residents and staff.

History and Definition

Leichtman (2006) provided a comprehensive overview of the history of child and adolescent residential treatment. He suggested that the origin of residential treatment is associated with two factors: the establishment (by the medieval church and 18th and 19th

century reform movements) of facilities for those who could not support and care for themselves and the development of psychiatric treatment facilities in the early 20th century. In the 1940s, residential treatment began moving away from providing care for children based on economic reasons and moved toward providing care based on mental health needs of children. During the 1950s-1970s, the residential treatment approach was highly regarded, and the American Association of Children's Residential Centers (AACRC) was established. The great variability in the type of residential treatment facility became evident in the 1970s and 1980s when little to no distinction was made between hospital-like residential treatment facilities and other 24-hour facilities. Further, there was wide variability in who was being served and services provided. Currently, residential treatment faces four main challenges: (a) difficulty understanding what exactly residential treatment is; (b) pressure to shorten lengths of stay in residential treatment; (c) pressure to move children through to lower levels of care and develop all-inclusive plans for aftercare; and (d) providing the same level of service for children as funding continues to drop (Leichtman, 2006).

The early definition of residential treatment came from the AACRC, which delineated three components that make up residential treatment (Leichtman, 2006). These include: psychotherapy, milieu therapy (i.e., the use of day-to-day experiences in a therapeutic manner), and the ability of staff to conduct therapeutic interventions in context when events are occurring. These programs, though ranging from group homes to comprehensive interventions, are not to be confused with hospital settings organized around a medical model. According to Leichtman, the distinction between residential treatment and the inpatient medical model is that residential treatment is characterized by:

(a) organization around a parenting model as opposed to a medical staff model; (b) treatment by the community rather than doctors; (c) a less hierarchical staff model; (d) team treatment in which treatment aspects are more fluid and less specialized by provider; (e) a horizontal rather than vertical communication network in which there is ongoing communication among treatment team members; and (f) relationship based care in which conflicts are dealt with as part of the treatment process and relationships are fostered among staff.

As struggles have continued with defining and differentiating residential treatment, others have attempted to make the definition more clear. Butler and McPherson (2007) proposed that residential treatment be defined as requiring "components of *a therapeutic milieu*, a *multidisciplinary care team, deliberate client supervision, intense staff supervision and training,* and *consistent clinical/administrative oversight"* (p. 469). However, Lee (2008) found this definition to be lacking and too inclusive and suggested that residential treatment programs be more clearly classified based on three characteristics: (a) target population (i.e., who is being served at what level of care); (b) length of stay (i.e., specific treatment program lengths versus long-term residence); and (c) level of restrictiveness (i.e., locked units versus group care based on a family model). Further, Lee suggested that the term "therapeutic milieu" be more clearly defined, as it is used consistently and with much variation in the residential treatment model.

Clearly, one of the defining components of residential treatment is actually having the target population in residence. It is around these residents that treatments are designed and for whom they must be effective. In order to design, implement, and evaluate

effective treatment strategies in residential treatment, one must first understand more in-depth the following: (a) the children who are in residential treatment; (b) the characteristics of caregivers at residential treatment centers: and (c) the relationship between the two.

Children in Residential Treatment

Published research on the children and youths who are entering residential care suggests that they do so with significant academic, mental health, and behavioral problems (Trout et al., 2008). Many children have experienced multiple residential placements (Bettman et al., 2011; Connor et al., 2004), abuse (Bettman et al., 2011; Connor et al., 2004), separation from biological parents (Connor et al., 2004; Sternberg et al., 2013), some type of recent trauma (Bettman et al., 2011) and qualify for at least one, if not more than one, mental health diagnosis (Connor et al., 2004; Handwerk et al., 2006; Sternberg et al., 2013). Furthermore, they have high rates of externalizing behaviors (Bettman et al., 2011; Connor et al., 2004; Handwerk et al., 2006; Sternberg et al., 2013; Trout et al., 2008). Although some research has suggested that they have lower than average academic ability/intelligence (Connor et al., 2004; Trout et al., 2008), other research suggests that they actually have academic skill and intelligence above the normal range (Hagaman, Trout, Chmelka, Thompson, & Reid, 2009). In fact, Hagaman et al. (2009) were able to identify three clusters of types of children who enter residential treatment, only one of which is dealing with low academic skill. These included children with: (a) average academic skill, no behavior problems, and demographic risks; (b) low academic skill and evidence of rule breaking; and (c) average academic skill and rule

breaking and aggressive behavior. The most prevalent type of child who enters residential treatment is the third, designated "behavioral risks" (p. 525) by the researchers.

There are also some gender differences referenced in the literature. Connor et al. (2004), in their sample of admissions to a single residential treatment facility, found that girls were more likely to have been diagnosed with affective or anxiety disorders and boys more likely to have been diagnosed with a disruptive behavior disorders. In this same sample, girls demonstrated higher levels of psychopathology as evidenced by higher scores on internalizing, externalizing, and total score scales of the Devereux Scales of Mental Disorders. Further, Handwerk et al. (2006), in their study of 2,067 admissions to a residential treatment program, identified differences by gender in problems at admission and diagnosis at admission. Their findings align with Connor et al., as they found anxiety disorders and depressive disorders to be more common in girls. However, differently from Connor et al., Handwerk et al. noted that there were no gender differences in diagnosis of disruptive behavior disorders. Finally, girls were more likely to have more than one diagnosis (Handwerk et al., 2006).

Based on the issues identified in the research, this population is dealing with a host of challenges. Many of these challenges, such as externalizing behaviors, including aggressive behaviors, and one, if not multiple, mental health diagnosis are frequently identified. This suggests that these children and youths present with specific and significant challenges. Further, these challenges must be managed in treatment environments containing many other children who present with the same types of difficult to manage behaviors, yet who must also be considered as individuals with specific needs. This provides unique challenges in providing treatment that meets the

needs of the individual and the group when the population is in many ways heterogeneous. Finally, the types of behaviors identified as problematic for these children are likely to be disruptive and challenging for treatment providers to manage in a group environment.

Based on this information known about the children and adolescents in residential care, it seems clear that interventions designed to help alleviate some of the most challenging behaviors (e.g., externalizing behaviors) are needed. In particular, these interventions would be useful if they are able to affect multiple children at a time, as in changing the behavior of caregivers who care for multiple children in residential treatment. In addition, given this particular population's tendency to have experienced multiple disruptions in key caregiver relationships, it seems essential that treatment be delivered in a highly relational format. In fact, Perry (2001) suggests that maltreated children can be helped by parents and caregivers who: nurture, try to understand behaviors, have an understanding of emotional age versus chronological age, are consistent and predictable, model appropriate behaviors, listen to and talk with children, have realistic expectations, are patient with self and the child, take care of themselves, and use other available resources. It seems clear that caregivers in residential care are a key component in helping children and adolescents in residential treatment through treatment. However, these care workers themselves face significant challenges.

Residential Care Workers

The front line staff of residential treatment centers is made up of the residential care workers (RCWs). These are the staff members responsible for what Treischman et al. (1969) referred to in the title of their book as *The Other 23 Hours.* They must respond

to the children and youth in the therapeutic milieu and remain constantly alert to the

ongoing treatment that occurs therein. Although the number of responsibilities that make

up their job is great, and they spend the most significant amount of time in direct contact

with children, the pay is quite low, and they tend to have the least power within the

residential care system (Seti, 2008). In fact, 50% of residential care workers do not think

they are compensated appropriately for the work they do (Levin & Decker, 2008).

Further, residential care workers are responsible for dealing with the frequently

aggressive behaviors of children under their care, which contributes to the overall

stressors associated with this job (Pazaratz, 2003; Seti, 2008). They must also have good

communication skills, be able to express emotions appropriately, and understand the

context and needs of the children with whom they work, often while attending to the

children's basic daily needs and tasks (Pazaratz, 2003).

Given that residential care work is quite stressful, the small amount of empirical

research related to residential care workers is primarily related to understanding burnout

in this population. According to Seti's (2008) review of the literature on the causes and

treatment of burnout, burnout is defined as "a syndrome composed of emotional

exhaustion, depersonalization of clients, and loss of feelings of personal

accomplishment" (p. 198). This conceptualization of burnout is consistent in the literature

related to RCWs. Lakin, Leon, and Miller (2008) examined the concept of burnout

related to residential care by describing it in terms of these three dimensions found on the

Maslach Burnout Inventory (Maslach & Jackson, 1986): (a) emotional exhaustion,

meaning low emotional energy and the belief that one does not have the emotional

resources needed to deal with their circumstances; (b) depersonalization, when staff

members are detached and distant from clients and respond to them in ways that are not therapeutic; and (c) a negative perception of personal accomplishment, feeling a lack of ability to do the work.

Consequences of burnout can be both organizational and relational. Residential care workers experiencing burnout may leave the organization, resulting in loss of money for the organization. Turnover has been identified as significant with research over a 3.5 year period at one residential treatment center showing a staff turnover rate (all staff) of 46.1%, with RCWs being one of the three highest in turnover rate (Connor et al., 2003). In addition, children with whom the worker is involved may suffer from either the loss of the relationship (which takes time to build) or the worker's symptoms of burnout. This can be devastating to any progress made in relationships with children in the residential environment (Seti, 2008).

In her review of the literature related to burnout in residential care workers, Seti (2008) identified a variety of causes of burnout being explored in the literature. These include the following: (a) personal characteristics such as age, years of experience, and personality traits; (b) job/role characteristics such as time in direct contact with clients, boredom related to the job, and role stress (including role ambiguity and role conflict); and (c) organizational characteristics such as social support from co-workers and supervisors, organizational environment, lack of autonomy, lack of advancement opportunities, and lack of recognition. This same review of the literature suggested that findings related to personal characteristics are mixed, and the consensus in the literature appears to be that work settings are a more influential factor in burnout than personal characteristics. The most significant job/role variable identified in Seti's review was role

stress, as defined by Harrison (1980), in which workers experience role conflict, when incompatible demands are simultaneously placed on workers, and role ambiguity, when expectations related to job roles are unclear. The most significant organizational characteristic, per Seti's review, is social support from supervisors and co-workers.

Though Seti's review is extensive, there are some additional findings about burnout in the literature on residential care workers. Feeling as if one lacks adequate training leads to increased emotional exhaustion, a component of burnout, and demonstration of higher levels of empathic concern are associated with decreased depersonalization and increased personal accomplishment, two other components of burnout (Lakin et al., 2008). Other causes include the demand of working long hours in an emotionally difficult environment while managing large caseloads, large amounts of paperwork, with a lack of adequate supervision and training (Decker, Bailey, & Westergaard, 2002). Finally, Eastwood and Ecklund (2008) found that increased risk for burnout is associated with increased risk of compassion fatigue, a group of symptoms that resembles posttraumatic stress disorder and results from exposure to other's trauma.

In response to the issues with burnout, scholars in the field have suggested recommendations to decrease burnout for residential workers. These are summarized in Seti's (2008) review as follows: (a) allow workers to have more autonomy; (b) allow for career advancement; (c) allow for job responsibility rotation; and (d) create better connections between staff and supervisors. Additionally, based on their findings, Eastwood and Ecklund (2008) recommended residential treatment workers engage in self-care strategies such as, taking breaks, taking vacations, using strong support networks, exercise, sleep, and proper nutrition. Organizational recommendations

included: scheduling breaks for workers, encouraging and providing resources needed for workers to engage and maintain self-care, providing adequate vacation time and affordable benefits, and providing adequate training. Of note is the fact that though 78% of staff members in Lakin et al. (2008) thought they were trained adequately, 74% of them believed others were not. Further, they overwhelmingly (90%) reported that they could benefit from additional training. The link between emotional exhaustion and staff feeling inadequately trained identified by Lakin et al. suggests that additional training for residential care workers is appropriate. In fact, Lakin et al. recommend, "strong training is important in providing a solid foundation and skills base for residential staff…[and] more attention needs to be focused on adequate training of staff" (p. 263). This recommendation for training is supported by others (e.g., Decker et al., 2002; Eastwood & Ecklund, 2008).

Though there is a dearth of research within the literature regarding residential care workers, it is clear that there is significant concern for their ability to do the work required without suffering from burnout (e.g., Seti, 2008). The job of residential care workers is highly stressful and characterized by a role that has great diversity in responsibility. However, pay and other benefits can often be described as low (Levin & Decker, 2008). Additionally, lacking adequate training on how to best care for residents leads to increased emotional exhaustion (Lakin et al., 2008), making it imperative to find suitable training models for residential workers to reduce burnout and increase treatment success. Despite research showing that residential care workers' ability and availability to build relationships is crucial to the child's success in treatment (Gallagher & Green, 2012), there is a lack of training focusing on helping residential workers learn how to

form therapeutic relationships with the children and adolescents they serve (Gharabaghi & Phelan, 2011).

Relationship Between Residential Care Workers and Children and Adolescents

Though relational interactions that occur between treatment providers and children/adolescents within the milieu of residential treatment centers are commonly thought to be influential in treatment (Moses, 2000), there is a scarcity of research that investigates these interactions. In spite of the lack of research, it appears that the relationship between youth in residential treatment and their caregivers is highly important. Gallagher and Green (2012) interviewed 16 former residents of a residential treatment environment and found that the youths spoke emphatically and positively about their relationships with staff. They viewed the relationships as essential to their development and as having a major impact on them. One interviewee described staff being like a family. Specific benefits included: feeling safe, having someone to talk to, and having someone they could trust. Many interviewees also stated that relationships with staff helped them deal with challenges they were facing at the time. Finally, interviewees identified long-term impact resulting from the relationships formed with residential care workers, and many maintained the relationships over a long period of time.

Manso, Rauktis, and Boyd (2008) discovered similar positive feelings about relationships within a residential wilderness program. The 11 youths who participated in this qualitative study identified the following characteristics that contribute to a positive relationship: caring, helping, listening, and acting as a role model by managing emotions. Participants further described the ideal caregiver as a person with whom they feel

comfortable sharing thoughts and feelings and who does not give up on them even when they behave in ways that do not promote building relationships. Trust was described as essential. Youths in this study also acknowledged the changes in relationships over time and the need for time to build trust.

An emerging theme in the literature related to relationships in the residential treatment environment is looking at the relationships from an attachment perspective (e.g., Kendrick, 2013; Moses 2000). This conceptualization of relationships from an attachment perspective underscores the importance of the relationships that occur within the residential treatment environment. Further, it conceptualizes the relationship between caregiver and resident (not just therapist or counselor and resident) as significant and potentially healing.

Kendrick's (2013) article conceptualized relationships in the residential environment as family-like and suggested a framework for relationships in the residential treatment environment that can be related to attachment and resilience theory. Moses's (2000) qualitative research also examined relationships in residential treatment from an attachment perspective, finding that staff members use a variety of ways to connect with residents including: small talk, taking notice of them, asking for information, encouraging them to talk, and looking for something in common. Staff also attempted to understand behavior in context of the resident's history, but found difficult residents to be a strain on their own personal resources. Of concern, Moses noted that difficult-to-work-with residents received caregiving that was less in line with an approach that could break the cycle of negative attachment patterns. This caregiving was characterized by less emotional investment on the part of the caregiver and a belief that what was being done

was not and could not be effective. Thus, the residents who potentially need the most relationally responsive care might be the ones receiving the least.

In their research with 81 adolescents and 33 caregivers, Zegers, Schuengel, IJzendoorn, and Janssens (2006) found that mentors with autonomous attachment representations were perceived by adolescents as more psychologically available as a secure base (a component of attachment). Reliance on autonomous mentors increased between 3 and 10 months, while reliance on nonautonomous mentors decreased. This suggests that mentors or caregivers having autonomous attachment representations could be an influential treatment factor, where adolescents are more likely to use them as a secure base. However, the researchers also suggest that all caregivers, regardless of attachment representation, be trained to be more sensitive in order to attempt to break the cycle of negative attachment that many residents have experienced (Zegers et al., 2006). The conceptualization of the caregiver-resident relationship as an attachment relationship in this literature underscores the importance of the caregiver-resident relationship as potentially healing for the individual. This suggests that addressing this relationship is imperative and that training RCWs to be responsive and empathic regardless of attachment representation might promote their ability to behave in relationally healing ways with the children in their care.

Some concerns related to relationships in residential care were identified in Gharabaghi and Phelan's (2011) qualitative research related to the concept of accountability, defined as "the manner in which staff teams conceptualize the process of assisting children and youth to grow in terms of their personal development and prosocial decision-making skills" (p. 76). The researchers suggested that using external controls

has little long-term effectiveness when those controls are removed. They noted a need for control in the staff, in conjunction with little belief in relational approaches. This approach was informed by personal values and experiences of being parented, as the staff did not believe that conceptual literature had value and that clinical staff did not truly understand the context of the work being done. Though staff expressed a desire for training, they did not identify relationally based topics. Finally, the relationship was frequently conceptualized as a way to increase compliance with rules.

This body of research, in conjunction with the research related to children in residential care, continues to highlight the importance of the RCW-resident relationship. Challenges to the health of that relationship include issues of staff burnout and behaviors of children and adolescents in the residential treatment setting. The research in residential treatment suggests that the children and adolescents entering the treatment environment are dealing with a variety of significant difficulties (Bettman et al., 2011; Connor et al., 2004; Handwerk et al., 2006; Sternberg et al., 2013; Trout et al., 2008). These difficulties are often across domains, and many residents admitted to treatment receive serious mental health diagnoses (Connor et al., 2004; Handwerk et al., 2006; Sternberg et al., 2013). Staff members who are the most responsible for the residents, the residential care workers, are prone to burnout (Seti, 2008) and may not have training that addresses the important nature of the relationship (Gallagher & Green, 2012; Kendrick, 2013; Manso et al., 2008; Moses, 2000) necessary for treatment outcomes to be positive. This is most concerning, because the relationship between RCWs and residents can be significant (Gallagher & Green, 2012; Manso et al., 2008), have long-term positive impact

(Gallagher & Green, 2012), and serve as a vehicle to break the cycle of negative attachment that many residents have experienced (Zegers et al., 2006).

Further, though the literature suggests that the relationship between the residents and RCWs is important in the treatment (e.g., Moses, 2000; Walter, 2007), much of that research is qualitative and limited by the exploration of older children's experiences (e.g., as in Manso et al., 2008). Also, there has been little exploration of specific relationship building models and their effect. In other words, there is very little exploration related to how RCWs can effectively build the relationships that are deemed so crucial to the treatment of children in residential care. Additionally, the literature related to burnout suffers from the same gap related to implementation of interventions. There are suggestions about ideas to combat burnout provided in studies related to RCW burnout, but these are not investigated thoroughly.

Though some treatment models, such as the Neurosequential Model of Therapeutics (NMT; in use in some residential facilities; Perry, 2006), recognize the importance of the relationship in providing treatment interventions (e.g., using a filial therapy format to deliver interventions in a therapeutic preschool as in Barfield, Dobson, Gaskill, & Perry, 2011), RCWs seem to lack training related to the importance of the relationship between the resident and themselves (Gharabaghi & Phelan, 2011). Instead, they opt for more control-based approaches. This suggests that trainings in approaches that are relationally based and focused on improving caregivers' ability to respond to children and adolescents in empathic and understanding ways (as outlined by Perry, 2001) are needed in order to improve outcomes for children and adolescents in residential treatment, as well as help caregivers expand their repertoire of responses. CPRT

(Landreth & Bratton, 2006) and by extension CTRT (Morrison, 2006), seem well suited

to these purposes.

<div align="center">Child Parent Relationship Therapy</div>

CPRT (Landreth & Bratton, 2006) is a filial therapy approach that focuses on the

relationship between the parent and child as the ideal vehicle for creating change in both

the parent and child. In this model the definition of filial therapy is as follows:

> a unique approach used by professionals trained in play therapy to train
> parents to be therapeutic agents with their own children through a format of
> didactic instruction, demonstration play sessions, required at-home laboratory
> play sessions, and supervision in a supportive atmosphere. Parents are taught
> basic child-centered play therapy principles and skills including reflective
> listening, recognizing and responding to children's feelings, therapeutic limit
> setting, building children's self-esteem, and structuring required weekly play
> sessions with their children using a special kit of selected toys. Parents learn how
> to create a nonjudgmental, understanding, and accepting environment that
> enhances the parent-child relationship, thus facilitating personal growth and
> change for child and parent (Landreth & Bratton, 2006, p. 11).

History, Theoretical Foundations, and Development of CPRT

CPRT (Landreth & Bratton, 2006) has its roots in CCPT (Landreth, 2012), and

the therapeutic goals and skills for relationship building are similar between CCPT and

CPRT. Further, CPRT has been applied with modifications to relationships other than the

parent-child relationship, particularly in CTRT (Morrison, 2006). As CTRT is a

modification of CPRT that is suitable for use with teachers, the two are linked both

theoretically and in the research literature. It is important to understand CPRT as the

foundation of CTRT, and in the absence of extensive research on CTRT, the CPRT

literature is the foundation for understanding areas for further research. The following

section will trace the development of CPRT, from its theoretical roots in CCPT

(Landreth, 2012) and the original Guerney (1964) filial therapy model to its current

manualized status (Bratton et al., 2006). Following this section, CPRT modifications and empirical research will also be briefly summarized.

The Landreth Model of Child-Centered Play Therapy. Play therapy is an approach to working with children that acknowledges that children should not be treated in therapy as miniature adults, and that they communicate though play rather than words (Axline, 1969; Landreth, 2012). In fact, according to Piaget (1952), children lack the developmental ability to begin to think abstractly until they are 11 years old. Therefore, play, which functions in the world of the present and the concrete, is a far more natural way for children to communicate than verbalization.

In his summary of the history and development of play therapy, Landreth (2012) identifies the following major developments in the history of play therapy. Landreth noted that the first play therapy based approaches can be attributed to the work of several psychoanalytic therapists including: Sigmund Freud, Hermine Hug-Hellmuth, Anna Freud, and Melaine Klein. This form of play therapy was highly interpretive in nature, and the therapists believed that play was the connection to the inner experience or unconscious of the child. The second major development identified by Landreth is the development of release play therapy in the 1930s, which was not dependent on interpretation. Therapists like Daniel Levy (1938) believed that facilitating the re-experiencing of a traumatic experience through play was the curative factor in play therapy. Through a combination of free play and play situations created by the therapist, the child is able to exert his or her own control over the situation and experience emotional release. Landreth credits Jesse Taft (1933) and Frederick Allen (1934) with the third important play therapy development known as relationship play therapy. Unlike

psychoanalytic approaches, which were focused on interpretation, and release play

therapy, which was focused on re-experiencing a traumatic event, the focus in

relationship play therapy is the relationship and connection between the therapist and the

child as it is in the present. The fourth development in the history of play therapy is

identified as the development of the nondirective or child-centered approach (Landreth,

2012). This was influenced by the work of Carl Rogers's client-centered therapy (1951).

Virginia Axline (1969) is credited with taking the work of Carl Rogers and translating it

to work with children in her approach to play therapy. Axline's approach to non-

directive work with children is the historical foundation for the Landreth model of CCPT,

which is the historical and theoretical foundation for CPRT and, by extension, CTRT.

     The Landreth Model of CCPT has its roots in the work of Virginia Axline (1969).

This approach to working with children in therapy is non-directive and relies on the belief

that, given the right conditions, each child has within the innate tendency toward growth

and development. More specifically non-directive play therapy is "described as an

opportunity that is offered to the child to experience growth under the most favorable

conditions" (Axline, 1969, p. 16). This approach also relies heavily on the relationship

between the therapist and the child. This relationship is viewed as essential in creating the

environment needed by the child for healing and progress toward maturity. This is

reflected in Axline's eight principles and Landreth's (2012) "tenets for relating to

children" (p. 46). According to Axline, the non-directive therapist: (a) establishes with

the child a relationship that is warm; (b) is accepting of the child; (c) creates an

environment that is permissive to promote the child's free expression; (d) uses the

identification of the child's feelings to promote insight on the part of the child; (e)

respects the child's capability and self-responsibility for solving his or her own problems;

(f) allows the child to lead; (g) is patient with the process and does not try to rush

therapy; and (h) provides minimal limits only when needed.

Landreth's (2012) tenets, while more focused on a view of children instead of

what the therapist does, are also reflective of the type of relationship that is necessary for

CCPT. These tenets are statements about children and provide the child-centered play

therapist with the basic understanding of children that serves as part of the underpinnings

of CCPT. The tenets are as follows:

1. Children are not miniature adults…
2. Children are people…
3. Children are unique and worth of respect…
4. Children are resilient…
5. Children have an inherent tendency toward growth and maturity…
6. Children are capable of positive self-direction…
7. Children's natural language is play…
8. Children have a right to remain silent…
9. Children will take the therapeutic experience to wherever they need to be…
10. Children's growth cannot be speeded up. (p. 46)

It is through these tenets of beliefs about and understanding of children that the child-

centered play therapist begins to establish the relationship with the child. The play

therapist believes these tenets about children and therefore treats each child as an

individual person, deserving of respect and attention and entitled to emotions that should

be heard and acknowledged by others.

Though the beliefs about children are essential to the child-centered play

therapist's ability to create the relationship that promotes growth, there are other

fundamental components to this approach to working with children. The child-centered

play therapist attempts to communicate to children the following healing messages with

both words and actions "I am here…I hear you…I understand…I care" (Landreth, 2012,

pp. 209-210). Through his or her innate belief system about children and by using skills including tracking what the child is doing, reflecting content and feelings, returning responsibility to the child, responding to the child's efforts and esteem-building, and limit setting the therapist communicates the healing messages to the child and builds his or her relationship with the child.

Therapeutic limit setting is an essential part of CCPT. According to Landreth (2012), it is used only when necessary. Behavioral limits, in the Landreth model, are set in a specific process that communicates acceptance of the child and his or her feelings, while placing the limit on the behavior itself. Limits are externalized, and the goal is to help children find an alternative way to express their emotions. Setting limits in this manner promotes the child's ability to learn that (s)he can control his or her behavior and gives the child the opportunity to develop self-control and decision making capabilities.

With the appropriate growth environment provided (a safe relationship with a caring adult and a playroom equipped with toys for a range of expression) the child can begin to engage his or her innate tendency toward growth and maturity. According to Landreth (2012), children learn eight principles about themselves, which lead them to be able to change and grow. These are:

- Children learn to respect themselves…
- Children learn that their feelings are acceptable…
- Children learn to express their feelings responsibly…
- Children learn to assume responsibility for themselves…
- Children learn to be creative and resourceful in confronting problems…
- Children learn self-control and self-direction
- Children gradually learn, at a feeling level, to accept themselves…
- Children learn to make choices and to be responsible for choices. (pp. 87-89)

As children learn these principles in child-centered play therapy, they are able to resolve their problems for themselves.

Play therapy in general has been shown to be effective according to two meta-analyses. LeBlanc and Ritchie (2001) identified 42 studies that met their inclusion criteria. This included 23 journal articles, 16 dissertations, and three unpublished documents. The overall effectiveness of play therapy, based on these 42 studies, was calculated at .66 standard deviations, $p<.001$. According to Cohen (1988) this is a medium to large effect size.

Bratton, Ray, Rhine, and Jones (2005) also published a meta-analysis of play therapy treatment outcomes. A total of 94 studies that met inclusion criteria were examined, which consisted of 42 refereed journal articles, two ERIC documents, and 50 unpublished dissertations, with publication dates between 1942 and 2000. Bratton et al. found the average treatment effect to be .80, $p<.001$. According to Cohen (1988) this is a large effect size. Bratton et al. also examined effect size related to directive and non-directive approaches to play therapy. Of note is that CCPT is a non-directive approach, and studies using this approach would likely have been categorized as such. Bratton et al. found the treatment effect of non-directive play therapy approaches to be .92, $p<.05$. Further, this result was significantly different ($p<.03$) from the lower effect size (.71) found for directive play therapy. However, the researchers suggest this be interpreted with caution due to a disparity in the number of studies in each category (i.e., there were more in the non-directive category) and concerns about the lack of specificity about interventions and treatment protocols in the analyzed studies. Finally, Bratton et al. investigated the treatment effect based on problem behaviors and found that play therapy was effective for internalizing (*ES*=.81), externalizing (*ES*=.78), and a combination of internalizing and externalizing behaviors (*ES*=.93).

In the only meta-analytic study to date that has addressed the treatment effects of CCPT specifically, Yin's (2011) doctoral dissertation included 52 controlled-outcome studies from the years 1995 to 2010 that used a CCPT methodology. Yin found an overall effect size of .47, $p<.001$. Though this is not as strong of an effect size as some other play therapy meta-analyses, the researcher cautioned that this may be due to more rigorous statistical methods used for the analysis.

Yin's (2011) dissertation also included additional examination of the data to determine effect sizes for specific categories. This portion of Yin's research suggested that CCPT is at least somewhat effective for a variety of presenting issues including: total behavior problem (ES=0.53), internalizing behavior problem (ES=0.37), externalizing behavior problem (ES=0.34), caregiver/child relationship stress (ES=0.60), and self-efficacy (ES=0.53). Additionally, the effect size of .76 for non-Caucasian ethnic groups suggests that CCPT is a culturally appropriate treatment modality.

Taken collectively, these three meta-analytic studies suggest that play therapy itself, as well as non-directive play therapy/CCPT in particular, are effective treatments for children experiencing difficulty. It is important to consider that a strength of these meta-analyses is that the researchers made efforts to include unpublished studies in order to combat publication bias, in which journals tend to publish studies with statistically significant findings. This suggests that the positive treatment effects are not attributable to the publication and thereby inclusion of only studies that have statistically significant results. Though there is much to be further understood about the factors that contribute to the effectiveness of play therapy, these studies provide the necessary evidence to justify CCPT as an appropriate treatment approach. In light of the benefits of CCPT, play

therapists started developing models to teach parents how to use these principles as a way to help their own children, the first of which was filial therapy (Guerney, 1964).

Filial Therapy. The roots of filial therapy can be traced back to the end of the 19th century. Landreth and Bratton (2006) and Guerney (1964) both identify Sigmund Freud's (1959) work with father-child play sessions in 1900 as the earliest precursor to current filial therapy approaches. Additional early pioneers in supporting the use of parents as therapeutic agents in their children's lives also included: Dorothy Baruch (1949), who suggested that home play sessions be used to support positive parent-child relationships; Clark Moustakas (1959), who advocated play sessions between parents and children with no clinical problems; and Natalie Fuchs (1957), daughter of Carl Rogers, who used play sessions based on Axline's (1947) model with her own daughter.

Though they were early pioneers in using parents as therapeutic agents in the lives of their own children, the aforementioned people did not create a structured approach based on this innovative method. The first to coin the term *filial therapy* and outline an approach to therapy that was structured around using the parent as a therapeutic agent was Bernard Guerney, Jr. (1964). Filial therapy was developed and initially researched by both Bernard and Louise Guerney in the 1960s. According to Landreth and Bratton (2006), in the Guerney model, the principles and techniques of CCPT are taught to parents in a group format over the course of one year consisting of 2-hour meetings each week. However, as filial therapy developed into the 1970s and 1980s the Guerneys shortened the length of the process to approximately 5 or 6 months (Guerney, 2000).

Guerney (1964) presented a rationale for filial therapy that was counter to the belief prevalent at the time in which parents and their pathology were viewed as the

source of their children's problems and therefore parents could not be part of the healing process for the children (Guerney, 2000). In fact, Guerney's rationale for filial therapy was just the opposite, suggesting instead that most parents have the ability to contribute to healing in their children (Guerney, 2000) and that parents should be given the opportunity to experience learning that would lead to a decrease in the parental behaviors that are potentially contributing to child maladjustment (Guerney, 1964). According to Guerney, parents are in the unique position, based on their inherent daily interaction and preexisting bond with their children, to help them deal with and overcome problematic behaviors that are rooted in the relationship.

Further, Guerney (1964) suggested that, by the very nature of involving the parent in the treatment process, the therapist encounters less resistance from the parent. This is because the parent is less likely to feel identified as the source of the problem and more likely to feel a part of the solution, someone willing to accept help in order to become more helpful. Guerney took a more positive view of parents than was typical at the time, viewing them as capable and motivated to become therapeutic agents of change in their children's lives. Guerney acknowledged that just as play therapists use play therapy techniques to help the child revise self-concept, work though conflict and feelings, and correct distorted beliefs about others, so too could parents. Further, anything the parent did in the same vein would be exponentially more powerful.

Early research in filial therapy suggested that parents could, as Guerney hypothesized, successfully learn the skills of CCPT and use them in sessions with their children (Stover & Guerney, 1967). Mothers who had participated in a portion of filial training both increased reflective statements in play sessions and decreased directive

statements. Further, it appeared that this change in the mother had also affected the child's behavior. In 1971, Guerney and Stover's study with 51 mother/child dyads showed that mother's empathic interactions increased and children's behavior improved. Guerney's (1975) follow-up with the mothers from the 1971 study found that 76% of participants reported continued improvement by the children and 86% reported maintenance of improvements. Finally, in one other study/follow-up pair, Sywulak (1978) trained 32 parents in filial therapy, finding that parental acceptance increased and children's adjustment was improved, and Sensue (1981) compared the parents in Sywulak's study with parents who had not participated in filial therapy at 6 months and 3 years. The difference in parental acceptance and child adjustment between the original filial trained group and the untrained parents was statistically significant.

This early success in teaching parents to use the skills of CCPT in session with their children suggested that Gurney (1964) was correct in hypothesizing that parents, based on their pre-existing child-parent attachment and daily interactions, are in a unique and powerful position to use specific skills in non-directive play sessions in order to promote positive change in their children. However, because the filial model required parents to be in training for 6 to 9 months, it limited treatment accessibility to only parents who could commit and afford economically and otherwise to be in treatment for that long period of time. In response, the 10-session CPRT model (Landreth & Bratton, 2006) was developed from historical and theoretical roots in CCPT and filial therapy.

The 10-Session Child Parent Relationship Therapy Model. In his book, co-authored with Sue Bratton, Gary Landreth (2006) described the process of developing the CPRT approach. Like the Guerney (1964) model, the Landreth 10-Session Filial Therapy

Model is based on the premise that in most cases, parents are the most effective and appropriate choice to act as therapeutic agents for children. With a strong theoretical foundation in the principles of CCPT (Landreth, 2012), CPRT provides parents with the skills needed to help them better understand their child. As they begin to realize the inner world of their child, parents are able to help their child develop confidence and coping skills, as well as reduce behavioral symptoms. The authors defined the process of CPRT as:

> Through didactic instruction, demonstration play sessions with children, viewing of videotapes, role-playing, and supervision of parents' play sessions, parents' sensitivity to their children is enhanced, and parents learn how to create an nonjudgmental, understanding, and accepting environment in which children feel safe enough to explore other parts of themselves as persons and other ways of relating to their parents (Landreth & Bratton, 2006, p. 12).

Landreth reported that, though the Guerney (1964) model seemed to him a natural fit, he struggled with the long-term nature of the approach (Landreth & Bratton, 2006). Therefore, in his first attempts to modify the filial therapy approach to a shorter timeframe, Landreth used a 15-week model to coincide with a school semester and later a 12-week model. Though this was much shorter in duration than the Guerney model, there were still difficulties in keeping parents engaged toward the end of the treatment period. He realized that 10-weeks seemed to be the right amount of time to conduct the training while reducing attrition rates significantly. Originally, the 10-week model was entitled Child-Parent-Relationship (C-P-R) Training and was published in the first edition of *Play Therapy: The Art of the Relationship* (Landreth, 1991). However, through a process of ongoing adjustment while teaching and facilitating filial therapy groups, Landreth arrived at the current CPRT model, which was originally presented in the second edition of *Play Therapy: The Art of the Relationship* (Landreth, 2002) and covered in *Child Parent*

Relationship Therapy (CPRT): A 10-Session Filial Model, as well as manualized in the

Child Parent Relationship Therapy (CPRT) Treatment Manual: A 10-Session Filial

Therapy Model for Training Parents (Bratton et al., 2006).

       In CPRT, parents are trained in small groups in basic child-centered play therapy

skills including: returning responsibility and facilitating decision making, tracking,

reflecting content, reflecting feelings, esteem-building and encouragement, and

therapeutic limit setting (Landreth & Bratton, 2006). In the unmodified 10-week model,

parents participate in a didactic and process oriented group meeting for around 2 hours

one time per week. They select a child of focus with whom they will conduct 30-minute

play sessions beginning after week 3 of the training. Over the course of the group, parents

learn the play therapy skills, as well as receive support and supervision within the group.

Parents present tapes of their sessions, and supervision is designed to be strengths based.

The CPRT treatment manual (Bratton et al., 2006) has a therapist's handbook outlining

how each session must be conducted and a parents' handbook to be distributed to

participants as a resource for the training.

Research on the Child Parent Relationship Therapy Model

       Research on CPRT has been extensive with over 34 studies showing effectiveness

of CPRT as a treatment modality that promotes positive growth for parents and children

(Landreth & Bratton, 2006). A meta-analysis conducted by Bratton et al. (2005) showed

that filial therapy approaches in general have shown impressive results for both children

and parents who participate. Bratton and Landreth (2006) further analyzed the

effectiveness of only CPRT studies and found an effect size of 1.25, an effect size larger

than the one found for filial studies as a group. The existing CPRT research highlights

three main areas: (a) effectiveness of CPRT with parents and their children, (b) effectiveness of CPRT across diverse cultural groups, and (c) effectiveness of CPRT when adapted to be used with paraprofessionals (e.g., teachers).

CPRT With Parents. Research has been done on the CPRT model with a variety of parent populations and across a variety of child issues. Parent populations have included non-offending caregivers (Costas & Landreth, 1999), incarcerated parents (Harris & Landreth, 1997; Landreth & Lobaugh, 1998), single parents (Bratton & Landreth, 1995) and mothers living in a domestic violence shelter with their children (Smith & Landreth, 2003). Child issues have included sexual abuse (Costas & Landreth, 1999), child witnesses of domestic violence (Smith & Landreth, 2003), children with learning difficulties (Kale & Landreth, 1999), and chronically ill children (Glazer-Waldman, Zimmerman, Landreth, & Norton, 1992; Tew et al., 2002). Positive outcomes have included increases in parental acceptance (Bratton & Landreth, 1995; Costas & Landreth, 1999; Harris & Landreth, 1997; Kale & Landreth, 1999; Landreth & Lobaugh, 1998; Tew et al., 2002) increases in parental expression of empathy (Bratton & Landreth, 1995; Costas & Landreth, 1999; Harris & Landreth, 1997; Smith & Landreth, 2003) decreases in problematic behaviors in children (Smith & Landreth, 2003; Tew et al., 2002), and decreases in parental stress (Bratton & Landreth, 1995; Costas & Landreth, 1999; Kale & Landreth, 1999; Landreth & Lobaugh, 1998; Tew et al., 2002). Additionally, there have been some positive findings related to improvement of child self-concept (e.g., Landreth & Lobaugh, 1998).

CPRT Across Cultures. Several studies have addressed the cross-cultural applicability of CPRT. The effectiveness with Chinese parents, Korean parents, Latino

parents, African American, and Native American parents has been investigated.

Statistically significant results have been found that are similar to other parent studies

including: decrease in parental stress (Ceballos & Bratton, 2010; Chau & Landreth, 1997;

Lee & Landreth, 2003; Yuen, Landreth, & Baggerly, 2002), increase in demonstration of

empathy (Chau & Landreth, 1997; Glover & Landreth, 2000; Jang, 2000; Lee &

Landreth, 2003; Sheely, 2008; Yuen et al., 2002), increase in parental acceptance (Chau

& Landreth, 1997; Lee & Landreth, 2003; Yuen et al., 2002), and decrease in problematic

behaviors in children (Ceballos & Bratton, 2010; Jang, 2000; Sheely, 2008; Yuen et al.,

2002). Overall, these studies indicate that CPRT demonstrates effectiveness cross-

culturally. Researchers have noted the appeal of the didactic components of the training.

Further, they have noted the importance of adaptations undertaken (e.g., the addition of

an extra session to incorporate cultural value of socialization in Ceballos & Bratton,

2010) or recommended adaptations to be considered (e.g., as in Glover & Landreth,

2000) or reasons for non-compliance with homework (e.g., as in Solis, Meyers, & Varjas,

2004). These results highlight that CPRT is a treatment that can be adapted to make it

culturally responsive and effective across different cultures.

CPRT With Paraprofessionals. CPRT has also been used with success outside of

traditional caregiver roles. There are currently three published studies and one

dissertation that have examined the use of the CPRT model with non-parent, non-teacher

relationships. These include studies that paired older students with younger students

(Baggerly & Landreth, 2001; Jones, Rhine, & Bratton, 2002; Robinson, 2001) and one

that paired senior citizens with children (Yoder et al., 2013). Older students were able to

demonstrate CPRT skills in their work with younger children (Jones et al., 2002;

Robinson, 2001), and children who were the focus of the CPRT intervention demonstrated improved behaviors (Baggerly & Landreth, 2001; Jones et al., 2002). Senior citizens who participated in Yoder et al.'s (2013) pilot study in which they were trained in an adapted CPRT model responded positively to the training and reported feeling good about helping someone else. Similarly, studies have been conducted to study the modified CPRT with teachers, now called CTRT (Morrison, 2006). Given the focus of this dissertation on CTRT, these studies will be discussed in more detail later.

Summary. Though extensive, the current research on CPRT is limited in a number of ways. Sample sizes are often small. There is a lack of research related to long-term effects, and the measures used to study the effects of CPRT are often the same, leading to what may be a somewhat one-dimensional view of the outcomes. Further, the age of the children in the studies tends to be on the younger end of the appropriate age range for play therapy. There has been no research with slightly older children or children who are chronologically older, but have experienced trauma that may have delayed emotional development, thereby extending the appropriate upper age limit for play and CPRT. In spite of these limitations, the current findings suggest CPRT is effective in helping parents, paraprofessionals, and children achieve positive outcomes after participating in the training. In response to the promising results of filial and CPRT studies, scholars in the field have turned their attention to training teachers on the use of CCPT skills to become therapeutic agents of change in their students' lives (e.g., Helker, 2006; Morrison, 2006). The modified CPRT training is now recognized in the field as Child Teacher Relationship Training.

Child Teacher Relationship Training

Some of the first researchers and professionals to suggest that using teachers as therapeutic agents in children's lives could be beneficial were Virginia Axline (1947/1969), Andronico and Guerney (1967), and Guerney and Flumen (1970). This concept of using teachers as therapeutic agents in the lives of children is based in the belief that the relationship between the student and teacher is significant for both parties. Virginia Axline (1947/1969) suggested that using non-directive skills with children in the classroom would help teachers address the socio-emotional needs of children and would create an environment that promotes mental health for both teachers and children. In fact, Axline identified "the most important single factor in establishing sound mental health [for pupils in schools] is the relationship that is built up between the teacher and his or her pupils" (p. 140). Greeting each child with warmth and acceptance, while acknowledging and identifying his or her feelings helps the teacher create an environment in which all children can learn.

From the early suggestions of using therapeutic skills in the classroom, many scholars have developed specific trainings models to train teachers. In her review of counseling-based teacher interventions (CBTI) in the existing literature, Stulmaker (2012) noted that strong relationships are of benefit to both teachers and students. There are several examples of CBTI approaches that can be identified in the counseling literature including: Kinder Therapy (White, Flynt, & Draper, 1997; White, Flynt, & Jones, 1999), Teacher-Child Interaction Therapy (McIntosh, Rizza, & Bliss, 2000; Tiano, 2010), those from a particular theory base (e.g., rational emotive behavior therapy; Nucci, 2002), CTRT (Helker & Ray, 2009; Morrison, 2006) and other filial therapy based

approaches to improving the teacher-child relationship (e.g., Carlson, 2011; Helker,

Schottelkorb, & Ray, 2007; Ray, Muro, & Schumann, 2004).

CBTI is a new term in the counseling-related literature, used to refer to those

interventions that are aimed at providing teachers with a specific set of relational skills

that they can use in one-on-one sessions with a student, in the classroom, or both.

Stulmaker (2012) defined CBTI as:

> all trainings and interventions that encompass educating teachers and encouraging
> them to use adapted counseling and play therapy techniques in the classroom with
> students…[in order to] strengthen the teacher-child relationship to facilitate
> clearer communication, allowing teachers to meet students' needs and optimize
> learning. (p. 2)

These types of interventions are rooted in the belief that children benefit from

experiencing qualities found in the therapeutic relationship with people who are already

significant in their lives (Andronico & Guerney, 1967). Because teachers also benefit, the

reciprocal nature of the child-teacher relationship is such that they are involved in a

constant dance of influencing each other (Guerney & Flumen, 1970). The teacher's

actions influence the child's perceptions around authority figures and adults, as well as

the child's own self-image. In turn, the child's actions influence the teacher's self-

efficacy beliefs around his or her competence as a teacher.

Further, Andronico and Guerney (1967) believed that using filial therapy in the

schools, both as an intervention with parents and as an intervention with teachers would

allow school psychologists to reach more children and have a greater effect than if they

were working alone. By reaching out to teachers and training them in the skills necessary

to help children, school psychologists essentially multiply their power to help children

and build on relationships that are already important in the individual child's life.

According to Andronico and Guerney (1967), the benefits of training teachers in nondirective play techniques are both individual and systemic. Children chosen to receive individual play sessions benefit from improved self-concept, and teachers are better able to understand the child. Teachers' potential generalization of the skills to the whole classroom and beyond leads to improvement of the entire system of the school and increased communication and collaboration between teachers and school mental health personnel (Andronico & Guerney, 1967; White et al., 1997). Thus, this multiplies the effect of an individual school mental health provider throughout the entire school system.

The two CBTIs most present in the counseling literature are Kinder Therapy (White et al., 1997; White et al., 1999) and CTRT (Morrison, 2006). The work of Axline (1947/1969), Andronico and Guerney (1967), and Guerney and Flumen (1970) have influenced the development of CBTIs including Kinder Therapy (White et al., 1997; White et al., 1999). Kinder therapy is similar to CTRT, as it uses a specific approach to help teachers develop skills in non-directive play and includes a component in which the teacher works with a supervisor to develop those skills. However, Kinder Therapy, as described in the current literature, does not include a specific portion of the training devoted to practicing generalizing skills to the classroom. Instead, Kinder Therapy combines Guerney's (1964) filial therapy skills with Alfred Adler's (1983) Individual Psychology concepts in an effort to improve teacher-child relationships, thereby affecting both the teacher and child's behaviors in the classroom. The goal is not to "involve teachers [in] becoming counselors or therapists," (p. 38) but to help them gain the skills necessary to create relationships with their students. The primary trainer in this model is the school counselor. The core steps in providing Kinder Therapy are: (a) training in non-

directive play therapy techniques and Adlerian concepts; (b) teacher's observation of a play session; (c) teacher using play skills in session with counselor present; (d) ongoing feedback provided by the counselor; (e) relation of Adlerian concepts to classroom situation; and (f) ongoing follow-up sessions with the school counselor as needed.

CTRT is an adaptation of the CPRT model (Landreth & Bratton, 2006). Adaptations are made to the CPRT model to make it more applicable to teachers. In general, CTRT is broken up into three phases (Helker & Ray, 2009). During the first phase (CTRT Phase I), teachers participate in training to cover the first four sessions of the CPRT model. Then, the teachers conduct weekly 30-minute sessions with a child of focus each week for 7 weeks. During this 7-week period, teachers meet as a group for supervision of their play sessions and ongoing introduction and discussion of the remaining CPRT material (sessions 5-10).

During CTRT Phase II, the focus shifts to the generalization of the play session skills to the classroom environment. Teachers conduct Child Teacher Relationship (CTR) time in the classroom several times per week. During this unstructured playtime, the CTRT therapist coaches and models in the classroom the use of the previously learned skills. The therapist gradually reduces his or her involvement allowing the teacher to take more responsibility for the time. During Phase II, teachers continue to meet weekly in groups with the CTRT therapist. The focus of these groups shifts from learning the skills in individual sessions to the process of implementing the CTRT skills in the classroom environment.

Phases I and II make up the training portion of the CTRT model. Following the 10 weeks of Phase II, if desired by the CTRT therapist, the teachers enter a period of 10

weeks of no training, supervision, or contact with CTRT therapists. This is designated Phase III, at the end of which data can be collected related to skill retention or other longer-term effects of the CTRT intervention.

CTRT Research

Though it is not a study based on the CTRT approach, Guerney and Flumen's (1970) study represents the first study of using a structured approach to filial therapy with teachers. Guerney and Flumen (1970) trained 11 teachers in filial therapy techniques. The teachers participated in 20 weeks of group meetings in which they learned theory, watched skill demonstrations, and practiced skills themselves. Additionally, teachers conducted one 40-minute play session per week and received supervision during the group meetings. After the training was complete, teachers conducted 14 weekly 45-minute play sessions with a child whom they identified as withdrawn. During the weekly sessions with the experimental group children (n=9), teachers continued to participate in weekly group sessions for supervision and discussion. All children in the experimental group showed increasing assertiveness in the classroom, and none of the control group children exhibited the same pattern. Finally, teachers reported satisfaction with the training and the resulting behavior changes in the children.

Due to its relatively recent development, research on the CTRT model is just beginning to appear in the literature. Current studies have shown positive outcomes related to both children and teachers. Though there is minimal research, outcomes suggest that the CTRT model promoted positive behavioral changes in children of focus (Post et al., 2004; Morrison Bennett & Bratton, 2011; Smith & Landreth, 2004), as well as all children in the classroom of the trained teacher (Helker & Ray, 2009; Morrison &

Bratton, 2010). More specifically, children experienced a decrease in externalizing

behaviors (Helker & Ray, 2009; Morrison & Bratton, 2010; Morrison Bennet & Bratton,

2011), a decrease in internalizing behaviors (Post et al., 2004; Smith & Landreth, 2004),

an increase in adaptive skills (Post et al., 2004), and a decrease in withdrawn behaviors

(Smith & Landreth, 2004).

There were also positive outcomes for teachers. They perceived children more

positively, viewed their relationship with children more positively, and changed their

perspective on children (Helker & Ray, 2009; Post et al., 2004; Sepulveda et al., 2011).

Additionally, teachers felt more confident in classroom management (Hess et al., 2005;

Sepulveda et al., 2011). Though the time commitment was significant, teachers found the

training worth it (Morrison & Bratton, 2010), and they successfully mastered play

therapy skills both in and out of the playroom (Post et al., 2004), which were maintained

over time when revisited in individual sessions with a child (Hess et al., 2005) and

through the Phase III of the CTRT model (Helker & Ray, 2009). Teachers were also able

to increase their demonstration of empathy in play sessions (Post et al., 2004; Smith &

Landreth, 2005), which was maintained over time (Hess et al., 2005). Finally, some

improvements in children's behavior were related to the teachers' demonstration of skills

learned in CTRT (e.g., externalizing problems; Helker & Ray, 2009).

As CTRT has developed, there have been studies that have used only the original

Landreth (2002) 10-week training model as a treatment intervention (e.g., Smith &

Landreth, 2004), studies that used the 10-week model plus some training specific to

classroom generalization (e.g., Post et al., 2004), and studies that used a full CTRT model

(e.g., Morrison, 2006). Some studies have investigated only the effects of training on

children in the classrooms of teachers who complete CTRT (e.g., Morrison & Bratton, 2010), others have looked primarily at changes in the child of focus who received the individual play sessions with the teacher in training (e.g., Morrison Bennett and Bratton, 2011), and others have investigated the effects on both teachers and children (e.g., Helker & Ray, 2009). Also, one study looked specifically at the teachers' experience of completing the CTRT (Sepulveda et al., 2011), though others have reported teachers' experiences somewhat anecdotally. The following is a summary of studies completed on the CTRT intervention as they are related to the variables of interest in this study. Though the focus is on CTRT, CPRT literature will be used to supplement the CTRT literature, as there is a strong conceptual relationship between the two literature bases.

Finally, in reviewing the CTRT literature, it is important to note that several of the studies drew from the same sample, and though they report different information, they are based on one intervention conducted with one group of participants at the same time. These studies include: Helker (2006); Helker and Ray (2009); Morrison (2006); Morrison and Bratton (2010); Morrison Bennet and Bratton (2011); and Sepulveda et al. (2011). In these studies, the researchers looked at data comparing different aspects the CTRT treatment when compared to the Conscious Discipline training (Bailey, 2000). As mentioned above, these studies drew on data collected from one intervention conducted as part of dissertation research by Helker (2006) and Morrison (2006). In examining the data from these studies, it is useful to consider them both as individual studies and as part of the same intervention.

Effect of CTRT on Teachers' Ability to Demonstrate Empathy and CCPT Skills. CTRT has been shown to affect teachers' ability to demonstrate empathy in both

individual play sessions and the classroom. Brown (2000) conducted dissertation research in which undergraduate teacher trainees received training in the modified Landreth model. This particular study did not include any efforts to get the trainees to generalize their skills into a classroom environment, focusing on the trainees' interactions with the selected children of focus, their attitudes about parenting, and their knowledge, skills, and attitudes related to child-centered play therapy. Participants included 38 students enrolled in a specific university course, of whom 18 students volunteered to be in the experimental group. The students in the experimental group participated in 10 weeks of training for 90 minutes per week and conducted play sessions with a child of focus starting after the third week of training. When compared to control group participants, teacher trainees in the experimental group demonstrated higher levels of empathy (p=.000), communication of acceptance (p=.000), allowing the child self-direction (p=.000), and involvement in the child's play (p=.000) as measured by the Measurement in Adult-Child Interaction (MEACI; Stover et al., 1971). Teacher trainees in this study also demonstrated increased play therapy knowledge (p=.000) and skills (p=.000) as measured by the Play Therapy Attitude-Knowledge-Skills Survey (Kao & Landreth, 1997).

Smith and Landreth (2004) also found similar results in their pretest, posttest non-equivalent control group design study, in which they trained teachers of deaf and hard of hearing children in the modified Landreth model. This training also did not include a portion devoted to classroom generalization and was focused only on the teachers' use of skills in play sessions, as well as the outcomes related to the child of focus. Additionally, the Landreth 10-week model was modified slightly such that teachers in the experimental group (n=12) attended five 3-hour training sessions in one of two smaller groups and five

2-hour training sessions as a whole group and began their 30-minute play sessions after Week 1. Teachers who received CPRT training in Smith and Landreth's research increased their ability to demonstrate empathy (p=.001, η^2=.638), communicate acceptance (p=.001, η^2=.607), allow the child self-direction (p=.001, η^2=.506), and be involved in the child's play (p=.001, η^2=.662) as compared to the control group teachers (measured using the MEACI; Stover et al., 1971). According to Cohen's (1988) recommendations, the effect sizes were large for the total score, as well as all the subscales related to empathy.

Unlike Smith and Landreth (2004), Post et al. (2004) included with the 10-week model 13 additional group sessions to help teachers generalize skills to the classroom. With this research, they hoped to look at the impact of the training on both children and teachers. Though this research is referenced as Kinder Training in the published article, it is included in this review based on the use of the Landreth model. Participants in this quasi-experimental nonequivalent group design were nine teachers in the experimental group, eight teachers in the control group, nine children in the experimental group, and nine in the control group. There were statistically significant differences from pretest to posttest in demonstration of empathy (as measured by the MEACI; Stover et al. 1971) in individual sessions with teachers' child of focus (p<.01, d=1.95), as well as demonstration of play therapy skills in individual sessions with the child of focus (p<.01, d=4.10). Finally, there was a significant difference between the treatment and control group of teachers in their demonstration of play therapy skills in the classroom environment, with teachers in the experimental group demonstrating more use of the play therapy skills in the classroom (p<.01, d=1.76).

In an effort to determine if skills learned in teacher trainings are maintained over time, Hess et al. (2005) conducted a follow-up study with the same teachers from Post et al.'s (2004) research. Teachers from the experimental group continued to demonstrate greater use of play therapy skills and empathy in individual play therapy sessions, as compared to control group teachers one year following the initial training. Although the difference between the groups in demonstration of empathy and play therapy skills in the classroom environment was not significant, in focus groups teachers who received the training reported a positive response to the training. They reported better relationships with children, a new understanding of children, making use of the skills in the classroom, belief in play therapy skills, increased confidence in classroom management skills, and challenges using skills in the classroom due to the number of children. In spite of the lack of statistically significant findings in classroom sessions, the skill retention in individual sessions and reflections from focus groups suggest that this training was useful and transformative for the teachers who were trained. Also, the ability to detect differences in the classroom may have been limited by the fact that the classroom observations were conducted only one time.

In the first published study using a structured 3-phase model for training teachers, which was based on the manualized CPRT model (Bratton et al., 2006), Helker and Ray (2009) trained teachers in a Head Start program in CTRT to determine if teachers could use acquired skills over time, how their students' behaviors were affected, and what the relationship between behavioral effects and teachers' skill demonstration was. In this repeated measures quasi-experimental design, participating children (*n*=32) had scores in the borderline or clinical range on one syndrome scale of the Child Behavior Checklist

Caregiver-Teacher Report Form (C-TRF; Achenbach & Rescorla, 2000) and were not participating in the school's play therapy program. Child participants included children in the classroom, rather than just children of focus. Participating teachers were 12 teacher/classroom aide pairs, six in the experimental group and six in the active control group. The C-TRF served both as a screening tool and a measure to assess change in the participating children. Additionally, in order to assess teacher skill acquisition and retention, Helker and Ray created the Child Teacher Relationship Training Skills Checklist (CTRT-SC), based on the Play Therapy Skills Checklist (Ray, 2004). Teachers were able to learn and maintain CTRT skills. Teachers in the experimental group demonstrated use of relationship skills according to the CTRT-SC more frequently than the control group, both at the end of Phase II and Phase III, and there was a statistically significant effect of time related to the experimental group's scores on the CTRT-SC ($p<.01$, partial $\eta^2=.87$). However, of note is the fact that the assumption of homogeneity of variance was violated in the comparison of skill use between the experimental and control groups.

Similar results related to empathy and skill demonstration can be found in the CPRT literature, providing additional evidence for the effectiveness of this intervention in increasing caregivers' ability to demonstrate empathy and CCPT skills. Increases in empathy have been demonstrated with incarcerated fathers (Landreth & Lobaugh, 1998), incarcerated mothers (Harris & Landreth, 1997), single parents (Bratton & Landreth, 1995), non-offending caregivers of children who have experienced sexual abuse (Costas & Landreth, 1999), mothers of child witnesses of domestic violence (Smith & Landreth, 2003), and adoptive families (Carnes-Holt, 2010). This increase in demonstration of

empathy was found to be consistent across culture in Chinese parents (Chau & Landreth,

1997; Yuen et al., 2002), Korean parents (Jang, 2000; Lee & Landreth, 2003), and Native

American parents (Glover & Landreth, 2000).

Effect of CTRT on the Child-Teacher Relationship. There is a scarcity of

literature related specifically to measuring relationship variables related to CTRT. Thus,

it is necessary to move beyond the literature specific to CTRT to consider this variable.

Though not a study based on the CTRT method alone, Carlson's (2011) dissertation

investigated the effects of a play-based teacher consultation with kindergarten, first, and

second grade teachers. This intervention incorporated elements of the RELATe model

(Ray et al., 2004), Kinder Training, and CTRT, and results were positive. Using single-

case design, Carlson worked with eight teachers, hoping to increase teacher

responsiveness, decrease criticism and justification, and improve teacher perceptions of

the teacher-child relationship. Results from 5 of 8 teachers suggested that the intervention

was mildly to very effective at increasing teachers' responsiveness and effective to very

effective at decreasing criticism and justification (both observed in the classroom).

Finally, there were some small but positive relationship changes related to the

relationship between the child of focus and the teacher.

Measures of the relationship in the CPRT literature frequently rely on the Parent

Stress Index (Abidin, 1995), a measure of relationship stress. Decreases in relationship

stress were found in CPRT studies in parent-child relationships containing incarcerated

fathers (Landreth & Lobaugh, 1998), single parents (Bratton & Landreth, 1995), children

who have experienced sexual abuse and their non-offending parent (Costas & Landreth,

1999), children who are chronically ill (Tew et al., 2002), children who are experiencing

learning difficulties (Kale & Landreth, 1999), and adoptive families (Carnes-Holt, 2010).

This has been noted cross-culturally with Chinese parents (Chau & Landreth, 1997; Yuen

et al., 2002), Korean parents (Lee & Landreth, 2003), and Latino parents (Ceballos &

Bratton, 2010). Though not statistically significant, positive trends in decreases in

relationship stress were noted in Glover and Landreth's (2000) study with Native

Americans.

Effect of CTRT on Teacher Perceptions of Child Behavior. As children's

behavior has not yet been measured objectively in the literature on CTRT, the measures

of children's behavior are often interpreted as teachers' perceptions of children's

behavior. Smith and Landreth (2004) found changes in teachers' perceptions of deaf and

hard of hearing children. The students of teachers in the experimental group scored lower

on the total behavior problems ($p=.007$, $\eta^2=.601$), internalizing behaviors ($p=.002$,

$\eta^2=.167$), and withdrawn behavior ($p=.001$, $\eta^2=.222$) subscales of the C-TRF (Achenbach

& Rescorla, 2000) when compared to the students of teachers in the control group. There

were no statistically significant differences between treatment and control group children

on the externalizing behavior, anxious/depressed behavior, and aggressive behavior

subscales.

Changes in behavior have also been noted with at-risk populations in early

childhood preschool programs. Post et al.'s (2004) research found changes in perceptions

of children's behavior. Outcomes for children of focus in the experimental group

revealed a decrease in internalizing problems ($p=.03$, $\eta^2=.20$), behavioral symptoms

($p=.04$, $\eta^2=.18$), and an increase in adaptive skills ($p=.04$, $\eta^2=.18$) according to teacher

report on the Behavior Assessment Scale for Children (Reynolds & Kamphaus, 1998).

Helker and Ray (2009) also found that children in the experimental group (all classroom children, not just children of focus) showed a statistically significant difference (p=.037, partial η^2=.14) from the control group in externalizing problems at the end of Phase II of the CTRT. There were no other statistically significant differences in Internalizing Problems or Total Problems at the end Phase II or in Externalizing Problems, Internalizing Problems, or Total Problems at the end of Phase III. Finally, there was a correlation found between the teachers' use of relationship building skills and a decrease in Externalizing Problems.

Morrison and Bratton (2010) also looked at the effects of CTRT on children (n=52) in a Head Start program who scored in the borderline or clinical range on one syndrome scale of the C-TRF (Achenbach & Rescorla, 2000). Like Helker and Ray (2009), Morrison and Bratton focused on the children in the classroom as a group, rather than only the child of focus. Unlike Helker and Ray, Morrison and Bratton's research focused only on Phases I and II of the CTRT model. Results showed that the experimental group children (n=26) demonstrated a reduction in externalizing behaviors (p=.002, partial η^2=.22) when compared to the control group children (n=26), that this change was consistent across the phases of the CTRT intervention, and that the treatment effect was larger at the end of Phase II than Phase I. An investigation of the clinical significance of the intervention showed that 9 of 15 children in the experimental group moved from a C-TRF score in the borderline or clinical range for Externalizing Problems to a normal score. Six of those 9 children had scores that dropped 15 points or more. Eight of 12 children in the experimental group who scored in the clinical or borderline range in Internalizing Problems moved to a normal range.

In Morrison Bennett and Bratton's (2011) research, the researchers chose to investigate the treatment effects on the children of focus, instead of groups of children in the classrooms. As in Helker and Ray (2009) and Morrison and Bratton (2010), children (n=22) were selected based on a C-TRF score in the borderline or clinical range on at least one syndrome scale. The children of focus in this study showed statistically significant decreases in Total Problems (p=.017, partial η^2=.349) and Externalizing Problems (p=.004, partial η^2=.437) when compared to the active control group. There was not a statistically significant difference between the groups in Internalizing Problems. These treatment effects were shown to be greater at the end of Phase I, which is the time the children were receiving individual play sessions.

In the only research available to focus specifically on cross-cultural applicability of the CTRT intervention, Kinsworthy (2010) worked with teachers and aides in two schools with Head Start Programs to determine the effects of CTRT with Hispanic students. Teachers and aides in the experimental group completed the CTRT intervention in two phases. In Phase I, teachers and aides attended a 14-hour training over two days. This training consisted of the first four training days of the CPRT manual. Over the remaining six weeks of training, those in the experimental group conducted play sessions and met weekly. In Phase II, teachers and aides learned to generalize their skills in the classroom for 10 weeks during center time. Data were gathered on all children in the classroom who qualified for the study. There were no statistically significant results for externalizing, internalizing, or total behavior on the C-TRF for Hispanic students whose teachers and aides were trained using CTRT. However, this research took place during Hurricane Ike, and thus could have been affected significantly by this event.

These findings, like those related to caregiver skill demonstration, are bolstered by the literature in CPRT. Parents' perceptions of children's problems changed in a positive direction for incarcerated fathers (Landreth & Lobaugh, 1998), incarcerated mothers (Harris & Landreth, 1997), single parents (Bratton & Landreth, 1995), parents of children who have witnessed domestic violence (Smith & Landreth, 2003), parents of children experiencing chronic illness (Tew et al., 2002), and parents of adopted children (Carnes-Holt, 2010). Though not statistically significant, there were positive trends noted in decrease in problematic behaviors by non-offending caregivers of children who had experienced sexual abuse (Costas & Landreth, 1999). These changes were also found in the investigation of cross-cultural applicability of CPRT with Chinese parents (Yuen et al., 2002), with Latino parents (Ceballos & Bratton, 2010), and with African American parents (Sheely, 2008).

Teachers' Experiences of CTRT. Finally, in the only study that specifically investigated the experience of teachers learning CTRT, Sepulveda et al. (2011) conducted a phenomenological study of 10 Head Start teachers. This study was completed at the end of Phase I of the training, which is at the completion of the individual play sessions and CTRT training, but prior to Phase II where teachers learn to integrate the skills into their classroom interactions. Teachers in this study reported many positive effects of the training including: (a) that the training improved the teacher-child relationship, (b) positive behavior changes in the child of focus, (c) value of their trainers and feeling supported, and (d) feeling more confident in classroom management skills. Though anecdotally, teachers in Post et al. (2004) reported that they believed the training was meaningful.

In research that supports positive findings related to teacher experiences with CTRT, parents and caregivers who completed CPRT have also reported positive reactions. Parents in Bavin-Hoffman, Jennings, and Landreth's (1996) study reported improved family function including better parent-child communication, improved family communication, and improved partner communication. Further, parents reported improved child behavior. Overall, they valued the training they received. Similarly, Edwards, Sullivan, Meany-Warren, and Kantor (2010) found that parents who completed CPRT described feeling more knowledgeable and confident in their parenting. As in Bavin-Hoffman et al., the parents in Edwards et al., reported better parent-child communication and improved child behavior. The parents in this study all reported feeling positively about the CPRT intervention. Echoing the positive responses from parents in other studies, parents in Wickstrom's (2009) study reported an improved parent-child relationship including having learned new ways to relate to and better understand their child, as well as revised expectations of their child. Further, within the family they experienced new ways of seeing themselves as parents, improved marital relationships, improved relationships among siblings in the family, and improved family of origin relationships.

Summary. CTRT appears to be an intervention that leads to positive outcomes for teachers, children in classrooms, and children of focus. Though there is not a large body of research supporting this intervention, what has been done hints at the potential for this approach to be effective in helping teachers help troubled children, as well as increase their confidence in their ability to be helpful. Reported effect sizes related to significant effects for children were, in some cases, large as with Total Problems on the C-TRF (e.g.,

Morrison Bennett & Bratton, 2011; Smith & Landreth, 2004) and Externalizing Problems

(Morrison & Bratton, 2010; Morrison Bennett & Bratton, 2011). Effects for teachers also

were reported to be large, in some cases, as with increases in demonstration of empathy

(Smith & Landreth, 2004) and maintenance of CTRT skills over time (Helker & Ray,

2009). Additionally, some effect sizes were moderate or large even though results were

not statistically significant. This was most evident in the C-TRF measures related to

Internalizing Problems in Morrison and Bratton (2010), Helker and Ray (2009) after

Phase III, and Morrison Bennett and Bratton (2011). Finally, Helker and Ray discovered

a moderate, though not statistically significant, treatment effect for Total Problems at the

end of Phase II of the CTRT intervention. These positive effects are bolstered by results

from Carlson's (2011) single-case design study, which suggested that the play-based

teacher consultation containing elements of CTRT was mildly to very effective at

changing teachers' way of communicating with children in the classroom.

Though the statistically significant results and positive effect sizes suggest that

the CTRT intervention is potentially effective, there are issues with this body of research,

not the least of which is the small amount of research done so far. For the most part,

sample sizes tend to be small (e.g., Helker, 2006), and there is a pattern of lack of random

assignment to treatment versus control groups (e.g., Helker, 2006; Morrison, 2006). In

some cases there were pre-existing differences in the treatment and control groups that

may have affected the outcomes (e.g., Helker & Ray, 2009). The recent studies in CTRT

(i.e., Helker, 2006; Morrison, 2006) have many strengths, including that they compared

the CTRT model to another approach, were very structured in their application of the

manualized treatment model, and included a 10-week follow-up. However, the issue of

the fact that several of the published articles related to CTRT are the result of the same intervention cannot be ignored (e.g., Helker & Ray, 2009; Morrison & Bratton, 2010; Morrison Bennett & Bratton, 2001; Sepulveda et al., 2011). This indicates that there are, in fact, even fewer studies than one might assume.

There are also several issues related to the outcomes data. Much of the research uses the same tool to quantify child outcomes (the C-TRF). Further, this might limit the interpretation of child outcomes resulting from the CTRT intervention, because it is only one lens through which the child is viewed. Observations of teachers to understand their skill development in the classroom may have been short or were not well described and therefore might not have led to a clear picture of teacher skill acquisition related to classroom use.

Also, the population on which the research has been done is limited thus far. Though cross-cultural applicability of CPRT has been shown by several studies reviewed above, the cross-cultural applicability of CTRT as a primary variable of interest has yet to be fully investigated. In fact, although Morrison (2006) and Helker (2006) both had ethnically diverse samples of teachers and children, Kinsworthy (2010) is the only available CTRT study that specifically addressed the cross-cultural application of CTRT. Further, the existing studies are limited to the preschool age range, and no one has yet examined if this approach is effective for teachers working with older children. Finally, there are many more treatment environments that could be investigated including schools and treatment facilities, such as residential care.

Summary

This chapter has reviewed the literature in residential treatment for children and youth, child parent relationship therapy, and child teacher relationship training. Though there is a fairly strong empirical literature basis for CPRT and play therapy, CTRT is a relatively new intervention about which there is much yet to be known. Currently, the research in CPRT and CTRT is focused on the younger end of the age range for which these types of interventions are considered appropriate. Little is known about the effects of these interventions with slightly older children (as can potentially be found in residential treatment). Further, there is no research with children who are experiencing significant mental health difficulties, particularly those who have ended up that the highest levels of care and who demonstrate the most significant relational needs that largely result from traumatic experiences.

In addition to highlighting areas of needed research, this review demonstrates the potential for CTRT to be effective with residential care workers and children in residential treatment environments. CTRT is a relationship based treatment approach that makes use of pre-existing relationships between children and caregivers, such as the relationship between RCWs and children and adolescents in residential treatment. The CTRT and CPRT literature reflect effectiveness of this approach to increase demonstrations of empathy in relationships (e.g., as in Bratton & Landreth, 1995) and the use of CCPT skills by caregivers (e.g., as in Post et al., 2004). This has been shown to have effects on perceptions of children's behaviors (e.g., as in Post et al., 2004); behaviors that are similar to those experienced by children in residential treatment environments (e.g., reduction of externalizing behaviors as in Helker & Ray, 2009). Also,

parents and teachers have reported positive feelings related to training (e.g., as in Morrison & Bratton, 2010), which has the potential to address issues faced by RWCs including the need for more training related to the importance of the caregiver-resident relationship and improved self-efficacy related to working with this challenging population. With more training and a wider repertoire of relationship building skills, it is possible that RCWs could feel less relationship stress and experience fewer symptoms of burnout, which according to Seti (2008) is a significant issue in this population. Thus this review of the literature related to behavioral and mental health issues of children and adolescents in residential treatment, challenges faced by residential care workers, the effectiveness of CPRT and CTRT on the ability of caregivers to demonstrate empathy and CCPT skills, the effectiveness of CPRT and CTRT in reducing relationship stress, and participants' experiences in CTRT and CPRT strongly suggests that CTRT has the potential to effect change in the child/adolescent residential treatment environment.

CHAPTER 3: METHODOLOGY

The purpose of this study was to investigate the effects of child teacher

relationship training (CTRT) on children and residential care workers (RCWs) in a

residential treatment setting. The research design was fully mixed concurrent dominant

status mixed methods approach (Leech & Onwuegbuzie, 2009). This mixed methods

design included both a multiple baseline across participants single-case experimental

research design, which was the dominant methodology, and a holistic multiple-case study

(Yin, 2014). By mixing methods, this study was able to best examine the experiences of

the participating RCWs, the effects of the CTRT on the RCWs and the children in

residential treatment, and the relationship between the RCWs and children in residential

treatment. This chapter will cover the research design, research questions, participants,

instruments, CTRT treatment protocol, data collection procedures and data analysis

procedures.

Research Paradigm

Mixed methods research is characterized by the combination of methods aimed at

achieving a clearer understanding of a given phenomenon that would not be achieved

using either quantitative or qualitative approaches alone (Greene & Hall, 2010). Debate

exists among researchers in the field regarding the best way to articulate and understand

the philosophical underpinnings of mixed methods research. Research is inherently

informed by the researcher's philosophical paradigm, which

> includes the philosophical issues of ontology or what is the nature of the social world we study, epistemology, or what counts as warranted knowledge, methodology or how to generate and justify such knowledge, and axiology or what is the nature and role of values in social inquiry (Greene & Hall, 2010, p. 121).

According to Creswell and Plano Clark (2011) the paradigm or worldview issue in mixed methods research presents the researcher with four options: (a) adopt a single paradigm that is suited to mixed methods research alone; (b) use multiple paradigms based on how the researcher is attempting to understand the world; (c) use multiple paradigms as dictated by selected methodologies; and (d) turn to perspectives based in the research community from in which the researcher is based.

This study design embraces the belief that different research paradigms can be combined to more clearly illuminate a phenomenon of interest. This is representative of the dialectical perspective that "affords a meaningful engagement with difference, an engagement intended to be fundamentally generative of insight and understanding that are of conceptual and practical consequence" (Greene & Hall, 2010). This study adopted a postpositivist paradigm in the quantitative portion of the study and a constructivist paradigm for the qualitative portion of the study. The postpositivist paradigm suggests that there is a reality that can be studied and tested deductively and requires of the researcher attempted distance and impartiality (Creswell & Plano Clark, 2011). The constructivist paradigm suggests that there are multiple realities, and the researcher explores these through an inductive process (Creswell & Plano Clark, 2011). The ability to combine these two seemingly contrary research paradigms is made possible by the process of engaging in the exploration of different and congruent findings and the belief

that each paradigmatic tradition provides a unique perspective on a particular phenomenon (Greene & Hall, 2010).

<div align="center">Research Design</div>

In order to best understand the effects of a CTRT intervention in the residential treatment environment, the study used a fully mixed concurrent dominant status mixed methods approach, consisting of a multiple-baseline across participants single-case design (dominant) paired with a holistic multiple-case study design. Because this is the first study of the use of CTRT in a residential treatment environment, the goal was to begin to understand what happens during the course of the implementation of the CTRT and participants' experiences through more than one lens. Therefore, specific methodological approaches that best provide information contributing to that goal were selected.

Mixed Methods

Leech and Onwuegbuzie (2009) define mixed methods research as "research that involves collecting, analyzing, and interpreting quantitative and qualitative data in a single study or in a series of studies that investigate the same underlying phenomenon" (p. 267). A characteristic of mixed methods research, according to Creswell and Plano Clark (2011) is that mixed methods research is a combination of methods, philosophy, and research design. Inherent in these two definitions is the belief that exploring a phenomenon through multiple lenses leads to a better understanding of the identified phenomenon.

The history of mixed methods designs can be traced through the early 1900s, when qualitative research began to appear in reaction to the quantitative research

paradigm. Mixed methods approaches began to appear in the 1960s and have become more and more common across a variety of disciplines including education and psychology (Leech & Onwuegbuzie, 2009). Advantages of a mixed method design include the ability to address complex issues and gain deeper understanding of specific research problems (Creswell, 2009).

There are many approaches to classifying mixed methods designs in the literature (Creswell & Plano Clark, 2011). The mixed methods design in this study was fully mixed concurrent dominant status (Leech & Onwuegbuzie, 2009). The design was concurrent rather than sequential, because, though qualitative data were not collected the entire time quantitative data were collected, they were collected in close temporal proximity. Further, neither type of data were used to inform the procedures in the other portion of the study. The study is classified as fully mixed, because the data were mixed after both types of data were collected, in more than one phase (the results and interpretation phases) of the study. Finally, the qualitative data were integrated and used to support and expand the quantitative findings.

Using a mixed methods approach to understand the effects of CTRT in the residential treatment environment allows for the complexity of the potential outcomes of the intervention. According to Bryman (2006), there are 16 reasons for choosing a mixed methods design. In this study, the choice of mixed methods provides a more complete picture of the effects of CTRT, allows for different research questions to be answered, and improves the utility of the findings by understanding not only the effects of the treatment on children and RCWs in residential care, but the RCWs experiences and perceptions related to the training. Further, there is little research related to CTRT, and in

particular only one qualitative study (Sepulveda et al., 2011), that examined the experiences of teachers completing the CTRT. Overall, as there is no study in the literature related to CTRT with residential care workers, it was appropriate to choose a mixed methodology to gain deeper and broader understandings of the application of this intervention in residential treatments through multiple lenses.

Mixed methods studies need to contain procedures that address validity in qualitative, quantitative, and mixed methods terms (Creswell & Plano Clark, 2011). There are threats to validity that are specific to the process of merging data in a mixed methods design in data collection, data analysis, and interpretation. To address issues related to data collection identified by Creswell and Plano Clark (2011), the same participants made up the sample for both quantitative and qualitative data collection, providing equal sample sizes for each phase, as well as establishing the same sample for both quantitative and qualitative data collection. Data collection procedures were separate and data collected from both portions of the study clearly contribute to understanding the effects of CTRT in the residential treatment environment. To minimize threats to validity related to data analysis and interpretation, divergent findings were presented and explored thoroughly; and the quantitative and qualitative data were given equal consideration in interpretation of findings.

Quantitative

The quantitative portion of this study used a multiple-baseline across participants single-case experimental design consisting of two concurrent baselines and one baseline for which data was collected concurrently with other data collection, but was started after treatment had begun for the first two participants. This was necessary due to changes in

the staffing that required one original participant to be moved to a classroom where he would no longer work with children in the appropriate age range for this study. In general, single-case design is characterized by ongoing assessment, as well as a baseline assessment period during which stability for the dependent variable is established (Kazdin, 2011). Experimental control in single-case design is dependent on replication (Kratochwill et al., 2010) and demonstration that the baseline changes after the introduction of an intervention (Kazdin, 2011). "In most cases experimental control is demonstrated when the design documents three demonstrations of the experimental effect at three different points in time with a single participant (within-subjects replication), or across difference participants (inter-subject replication)" (Horner et al., 2005). Though there is no empirical evidence supporting it, the three point replication is represented in the literature related to single-case design as the standard necessary to demonstrate experimental control (Kratochwill & Levin, 2010). In addition, according to the What Works Clearinghouse, it serves as the guideline for studies to be assigned the category of *meets standards* in establishing evidence-based practice (Kratochwill et al., 2010). Finally, single-case design is characterized by in-depth exploration of participant characteristics in order to better understand the specifics of an intervention's applicability (Gast, 2010).

The multiple-baseline across participants design accomplishes replication in a between-subjects format, showing that changes in the dependent variable occurred for each participant after the intervention was introduced (Kazdin, 2011). This design attempted to demonstrate the three replications by showing that the intervention is linked to change for at least three participants. In a concurrent multiple baseline design, baseline

conditions occur at the same time for all participants and intervention is generally applied to one person after baseline has stabilized for all participants (Kazdin, 2011). The second person receives the intervention after the measured behavior is stabilized across participants again and so on until all participants have received the intervention. Nonconcurrent multiple baseline designs do not require that data be collected simultaneously and use unequal baselines with intervention timing controlled by the researcher to establish experimental control (Harvey, May, & Kennedy, 2004). In this study, the interval for introduction of the intervention following the start of the initial participant was planned to be at least 2 weeks or until an appropriate child was available in the classroom of a participating staff member. This decision was based on the need to establish differing baseline lengths as well as the availability of a child participant who was appropriate for the study. Due to the fact that change was not expected until later in the treatment phase and that the treatment was not a one-time intervention, but a multi-week treatment process, it was not appropriate to wait for change in order to begin the next participant's training.

This approach to the quantitative portion of this research was appropriate given the goal of understanding the effects of the training, the real-life setting in which the research took place, the nature of the CTRT intervention, and the lack of research on CTRT in the residential treatment environment. Single-case design allows for experimental control when large numbers are not available or practical (Kennedy, 2005). In this case, the residential treatment center environment is small, which did not allow for a randomized controlled study. Further, this methodology is appropriate for behavioral phenomena about which not much is known. It allows the researcher to monitor carefully

the effects of an intervention over time. Given the lack of existing research related to using CTRT with RCWs in residential treatment, close observation seemed advisable in order to begin to better understand treatment effects, as well as those for whom the CTRT intervention is appropriate.

The multiple baseline design was appropriate, because, in this case, it was neither ethical nor possible to conduct research using an ABA design, in which treatment is removed (Kazdin, 2011; Kennedy, 2005). As CTRT involves learning by participants, as well as cumulative effects on behavior, it was not expected that behavior would return to pre-treatment levels. A multiple baseline across participants design helps reduce threats to validity related to extraneous events that may happen during treatment phases by moving individual participants into the treatment phase at different times (following the establishment of baseline stability). The ability to demonstrate across participants that change occurred, as expected, after an intervention is introduced, and not at other times, provides evidence of a functional relationship between the independent and dependent variables (Kennedy, 2005).

Finally, single-case design has been suggested for use in the counseling profession as a potential source of research needed to establish evidence-based practices in play therapy (Ray & Schottelkorb, 2010), as well as in counseling practice in general (Ray et al., 2010). Advantages cited by Ray and Schottelkorb (2010) include: single-case design can be implemented without significant monetary or human resources, flexibility of the design to incorporate treatment changes based on client response, and a focus on clinical significance of treatment which makes the design relevant to practicing counseling professionals. Ray et al. stated that the strengths of single-case design for use

by practitioners and researchers suggest that counselor educators need to learn about and teach single-case design. These strengths are echoed in the psychology literature wherein Brockardt et al. (2008) suggested that single-case design is well suited to better understanding how treatment protocols translate to real-world practice and to encouraging dialogue between practitioners and researchers.

Qualitative

The use of case study in this study is best summarized by Yin's (2014) definition of the scope of a case study as "an empirical inquiry that investigates a contemporary phenomenon (the "case") in depth and within its real-world context, especially when the boundaries between phenomenon and context may not be clearly evident" (p. 16). The qualitative portion of this study consisted of a holistic multiple-case study (Yin, 2014). The holistic nature of the case study is demonstrated by the consideration of the individual participant as the case and the fact that the focus of the case study included no embedded units of analysis. The case study was longitudinal and looked at the same case at pre-determined points in time (Yin, 2014). This type of case study best reflects the changes that were expected as a result of the CTRT intervention. In this study, participants were interviewed both prior to and following the completion of the CTRT intervention to gather information related to the training effects, their experience in the training, and their perceptions of the training.

Several issues related to qualitative research validity apply to case study research. In this study, several procedures addressed trustworthiness of the findings. Member checking was conducted to allow for participants to check transcripts for accuracy. Coding and data analysis were conducted with regular discussion with an independent

auditor. Conflicting evidence was thoroughly explored and reported. Finally, triangulation of the data occurred inherently as it is the nature of the mixed methods research to combine more than one stream of data. Both quantitative and qualitative data were used to support research findings.

Researcher Subjectivity. I have a Master of Arts (M.A.) in counseling, which I received in 2005. During that time, I completed an introduction to play therapy course, as well as attended several workshops and conferences related to play therapy. During my 9 years of clinical work, I have primarily worked with children using play therapy. Further, my training in play therapy has continued through my doctoral training and now includes a filial therapy course and a play therapy supervision course. I have supervised novice play therapists throughout my doctoral training, co-taught an introductory play therapy course for my teaching internship, and taught a filial therapy course under supervision. As a result, my belief in play therapy skills, particularly CCPT skills, is strongly held, and I have continued to use these skills, as well as teach them to others.

Throughout my studies I have been exposed to multiple theoretical perspectives related to play therapy, but have ended up identifying as child-centered. I believe that the child-centered skills taught in CPRT and CTRT are very effective in helping children and adults improve relationships. Further, I believe that the relationship between children and adults has the potential to be the most therapeutic thing that children experience in a residential treatment setting. I chose this dissertation topic as a result of seeing RCWs who meant well make missteps when trying to connect with children. This was observed many times during my doctoral clinical internship in a psychiatric residential treatment

facility (PRTF) for children. I do not believe that authoritarian approaches to helping kids work and saw many children struggle when being approached from this perspective.

My personal experiences as a parent using CCPT skills have also influenced my beliefs about these skills. I use child-centered skills every day, both personally and professionally. I have seen my children respond well to these skills and believe that we have a stronger relationship because of my use of these skills.

Additionally, I have spent a significant amount of time in the PRTF facility where the research was conducted, prior even to starting the research. I completed a 9-month doctoral level clinical internship during which I was present on-site 10 hours per week. During this time I got to know and understand the culture of the facility, as well as became acquainted with many of the staff members. However, I did not work closely with any of the participants in this research prior to their involvement in the research. Their use of the neurosequential model of therapeutics (NMT; Perry, 2006) approach rather than a behavioral approach is well aligned with my beliefs about helping children. Another part of why I chose this dissertation topic was because I believe that CCPT skills can easily enhance the approach already in use there.

I believe that I have a strong bias toward a child-centered approach related to how to build relationships with children. This could be viewed as a potential problem in research involving teaching CCPT skills to adults. However, I think that this level of experience added to my ability to teach the skills in a useful way. Also, my counseling skills helped me explore non-judgmentally each participant's beliefs about the training and skills, as well as be flexible enough to work together with them to fit the skills into their work. I think that my relationship that was built with the participants as they went

through the training served as the basis for them to feel more comfortable in poststudy interviews with me. In order to protect the integrity of this research, I was attentive in interviews to my own feelings in order to maintain objectivity to the best of my ability. I also worked hard to encourage honest communication in my relationships with participants throughout the training process and continued this in the interviews. I believe that my true desire to understand how these skills did and did not help RCWs was a primary motivator for me, rather than the desire to see the skills be effective. I believe this helped me be more objective in interviews as well.

Research Questions

The following research questions were addressed by this study. As this was a mixed methods study, the research questions are organized according to the type of data that was used to answer them. The quantitative research questions were supported by some qualitative data if appropriate, but are different from the mixed questions in that they are almost fully dependent on a quantitative measure. See Table 1 for a summary of instruments and data type by research question.

Quantitative Research Questions:

1. What are the effects of the CTRT intervention on the residential care workers' ability to generalize child-centered play therapy skills to the classroom/group?

2. What are the effects of the CTRT intervention on the residential care workers' demonstration of empathy in play sessions with their child of focus?

Qualitative Research Questions:

3. How do residential care workers who complete CTRT perceive the training?

4. How do residential care workers who complete CTRT perceive the impact of the training?

5. How do residential care workers who complete CTRT describe the usefulness of the training?

6. What challenges, if any, related to CTRT do residential care workers experience?

Mixed Methods Research Questions:

7. What are the effects of the CTRT intervention on the relationship between residential care workers and children of focus?

8. What are the effects of the CTRT intervention on residential care workers' perception of the children of focus's internalizing, externalizing, and total behavior problems?

9. What are the effects of the CTRT intervention on the residential care workers' symptoms of professional burnout?

Instrumentation

Achenbach System of Empirically Based Assessment Teacher's Report Form (TRF)

The TRF is a 113-item assessment of children's behavioral and emotional problems, as reported by the teacher. This assessment is expected to take between 15 and 20 minutes to complete and consists primarily (with the exception of one open-ended question) of Likert-type items that the teacher rates from 0 to 2 indicating that the statement is "not true," "somewhat or sometimes true," or "very true or often true." The TRF consists of eight syndrome subscales. These syndrome subscales can be grouped into either Internalizing Problems (within the self) or Externalizing Problems (between self and others). Internalizing Problems include the syndrome subscales: (a)

Anxious/Depressed, (b) Withdrawn/Depressed, and (c) Somatic Complaints.

Externalizing Problems include: (a) Rule-Breaking Behavior and (b) Aggressive

Behavior. The Total Problems can also be calculated. This score includes the syndrome

scores from Internalizing Problems and Externalizing Problems, a total score related to

problems designated "other," and the additional syndrome scales: (a) Social Problems,

(b) Thought Problems, and (c) Attention Problems (consisting of Inattention and

Hyperactivity-Impulsivity subscales). Internalizing and Externalizing groups were

identified via second-order factor analysis. Syndrome scales not assigned to either

Externalizing or Internalizing Problems had moderate loadings on both second-order

factors. High scores on this portion of the TRF suggest a high number of problems

(Achenbach & Rescorla, 2001).

The mean test-retest reliability over 16 days for the TRF is .90, and the syndrome

subscales are: Anxious/Depressed (r=.89), Withdrawn/Depressed (r=.60), Somatic

Complaints (r=.83), Social Problems (r=.95), Though Problems (r=.72), Attention

Problems (r=.95), Inattention (r=.96), Hyperactivity-Impulsivity (r=.92), Rule-Breaking

Behavior (r=.83), Aggressive Behavior (r=.88), Internalizing Problems (r=.86),

Externalizing Problems (r=.89), and Total Problems (r=.95). Internal consistency

reliability for problem groupings are: Internalizing Problems (α=.90), Externalizing

Problems (α=.95), and Total Problems (α=.97). Content validity for the problem items is

demonstrated by research showing that all items were scored higher for referred versus

non-referred children (p<.01). Criterion-related validity was also supported by the ability

of the scales to discriminate between referred and non-referred children (p<.01). Finally,

construct validity of the syndrome scales is supported by cross-cultural research,

correlations with mental health diagnoses, correlations with similar scales from other instruments, and genetic and biochemical research with previous versions of the assessment (Achenbach & Rescorla, 2001).

Though the TRF was designed for use by teachers in a classroom environment, it was chosen for this research, because there is no measure specific to residential care workers. The residential care worker participants in this study work with groups of children throughout the day in a teaching/learning environment. Some of the time is devoted to academics and children remain in small groups that resemble classrooms. Items were reviewed and none appeared to be problematic for use in this environment.

Child Teacher Relationship Training Skills Checklist (CTRT-SC)

The CTRT-SC is an observation form. This form has been used in other research with teachers and CTRT (e.g., Helker, 2006) and was created by a focus group of counselors and doctoral students with advanced play therapy training using the Play Therapy Skills Checklist developed by Ray (2004) as a basis. The CTRT contains 10 categories of possible responses including skills consistent with CTRT and responses outside the relationship building responses taught by CTRT. The categories of CTRT skills are: tracking, reflecting content, reflecting feelings, esteem building/encouragement, returning responsibility, relational responses, choice giving, and the A-C-T method of limit setting. These are consistent with CCPT and CPRT training and literature (Helker, 2006). Teacher directed responses are not consistent with the skills of the CTRT include instructional responses, correcting, explaining, and questioning. There is also a category designated other for any response that does not fit into the aforementioned categories.

Play therapy-trained observers complete ratings in 5-minute intervals totaling 15 minutes. During the rating time, the observer marks each time the teacher makes a response in a given category. Responses to adults are not included and responses can be to individual children, groups of children, or the class as a whole. Following the observation the teacher reports the children's activity level (designated classroom climate) on a scale of 1 to 5, with 1 and 2 equal to below average activity, 4 equal to average activity, and 4 and 5 equal to above average activity. Finally, the observer rates the teacher on his or her ability to convey the "be with" attitude or his of her "ability to put aside personal experiences and expectations and appreciate the personhood of the child, as well as the child's activities, experiences, feelings, and thoughts" (Landreth & Bratton, 2006, p. 81). A score of 1 indicates that the teacher displayed this attitude for less than half of the time and a score of 2 indicates that the teacher displayed this attitude for more than half of the time.

Though validity and reliability of this instrument have not been formally established, the consistency of the skills measured with the literature on CCPT, CPRT, and CTRT are evidence for validity. The primary observer was a doctoral level student with advanced CCPT training. This observer completed human subjects research training and was trained on the use of the CTRT-SC by the primary researcher. During the training, examples of responses were discussed until the observer indicated understanding. This primary observer completed all but three of the CTRT-SC observations. The primary researcher completed one baseline observation for Jefferson due to a scheduling conflict and an additional trained observer completed one observation during Maggie's treatment and one observation during Sue's follow-up.

The additional observer was a master's level student with play therapy training and training in human subjects research who was trained by the primary researcher and the doctoral level observer. Interobserver agreement was calculated in the training process over three separate occasions by having observers separately complete ratings of live classroom observations. In total, the observers worked together to complete the CTRT-SC eight times. Results were compared and discussed by the observers and the process repeated was repeated until an interobserver reliability of at least 80% was obtained (Kennedy, 2005). The range of interobserver reliability was from 80% to 100% with overall reliability calculated at 92.5%. The high number of agreement intervals in which no skills were observed by either observer may have inflated these results. To address this concern, the primary researcher and chair of this dissertation examined areas of disagreement between the two observers and determined that 14 of 18 areas of disagreement between the observers were within 1 point and the other four were within 2. Due to the small percentage of observations completed by the additional observer, this was determined not to be problematic. Additionally, once the treatment started, both observers were unaware of when each individual participant entered the CTRT intervention phase.

Maslach Burnout Inventory-Educators Survey (MBI-ES)

The MBI-ES (Maslach, Jackson, & Leiter, 1996) is an assessment designed to measure burnout. The MBI-ES is a variation of the original MBI in which the word recipients is changes to students. This inventory measures three dimensions of burnout including: emotional exhaustion, feelings of being emotionally and physical fatigued (9 items); depersonalization, negative and distant feelings related to teaching and students (5

items); and personal accomplishment, feelings of efficacy and meaning related to work (8 items). The 22-item assessment is measured on a 7-point Likert-scale ranging from 0 ("never") to 6 ("every day"). The three factor structure of the MBI is supported by two studies that investigated the use of the MBI with teachers (Gold, 1984; Iwanicki & Schwab, 1981). Internal consistency reliability was also reported in Gold's study: emotional exhaustion (α=.88), personal accomplishments (α=.72), and depersonalization (α=.74).

Thought the MBI-ES is a measure for teachers in the classroom, it is applicable to the RCWs' environment, because the children spend time in groups that can be similar to classroom environments. There is a teaching/learning environment throughout the day, and there are some academics during the day. Items were reviewed and seem appropriate for use in the residential treatment environment.

Measurement of Empathy in Adult-Child Interaction (MEACI)

The MEACI is an assessment designed to measure empathic interactions between adults and children in play sessions (videotaped or live). This direct observation instrument was originally designed by Stover, Guerney, and O'Connell (1971) and was adapted by Bratton (1993). Scoring takes place every 3 minutes, based on the preceding 3-minute interval, for a total of 18 minutes. There are three subscales: (a) Communication of Acceptance, (b) Allowing Child Self-Direction, and (c) Involvement. The observer rates the highest level of response for each subscale in each interval. Bratton (1993) provides directions and examples of each score and ratings are to be done by trained researchers.

Inter-rater reliability for the original MEACI (Stover et al., 1971) was examined by training six pairs of coders and having them rate play sessions independently. The average correlation is established at .92 for Communication of Acceptance, .89 for Child Self-Direction, and .89 for Parent Involvement (Carlson, 2011). Evidence of validity of the MEACI is provided by the correlation (r=.85, p<.005) between the MEACI and the original adult-child measure upon which it was based, as well as the measure's ability to detect changes in behaviors of mothers trained in Rogerian play therapy.

A doctoral student with training in CCPT scored the MEACI. The student received training on the use of the MEACI and practiced reviewing play session tapes until interrater reliability with the primary researcher was established. Videotapes of play sessions were rated separately and results were compared and discussed. The process was repeated over two separate sessions of six videos each until an interrater reliability of at least 80% was reached (Kennedy, 2005). Interrater reliability was 71% for the first training session and 83% for the second. After treatment started, the research participants' videos of the individual play session were collected and given to the rater together without identifying the chronological order in which they were completed (i.e., the play session number). This ensured that rater was not subjectively biased by the expectation that each RCW's skills would improve with each consecutive play session (i.e., demonstrating better skills in Play Session 7 than in Play Session 1).

Preventative Resources Inventory (PRI)

The PRI (McCarthy & Lambert, 2004) is an 82-item self-report inventory designed to measure people's habits associated with the prevention of stress. It consists of five scales: Perceived Control, measuring belief in one's ability to handle stressful

events; Maintaining Perspective, measuring the attitudes and beliefs associated with the prevention of stressful situations and managing emotions; Social Resourcefulness, measuring ability to use social support networks; Self-Acceptance, measuring one's ability to accept one's shortcomings; and Scanning, measuring the ability to assess for and plan to manage stressors. The Likert-scale items are 5 points and range from "strongly disagree" to "strongly agree." Internal consistency reliability has been investigated in two studies (Lambert, McCarthy, Gilbert, Sebree, & Steinley-Bumgarner, 2006; McCarthy, Lambert, Beard, & Dematatis, 2002). Results from McCarthy et al. were: Perceived Control (α=.909), Maintaining Perspective (α=.870), Social Resourcefulness (α=.873), and Self-Acceptance (α=.708). Results from Lambert et al. were: Perceived Control (α=.897), Maintaining Perspective (α=.873), Social Resourcefulness (α=.822), Self-Acceptance (α=.850), and Scanning (α=.861). Construct validity of the PRI is evidenced by confirmatory factor analysis conducted by Lambert et al., as well as the measure's negative correlations with measures of psychological dysfunction and lower levels of perceived stress.

Student Teacher Relationship Scale (STRS)

The STRS is a 28-item self-report instrument that measures a teacher's perception of his or her relationship with a given student. The measure consists of 28 5-point Likert–style items on which the teacher can rate the extent to which the statement is applicable to his or her relationship with a specific student. The 5-point scale ranges from "definitely does not apply" to "definitely applies." The approximate administration time is 5 to 10 minutes.

The STRS consists of three subscales—Conflict, Closeness, and Dependency—which are combined to form the total score to indicate the quality of the student-teacher relationship. There are 12 items in the Conflict subscale. Scores on this scale indicate the extent to which the teacher perceives the relationship with the student negatively. High scores indicate that the relationship is perceived as conflictual. The Closeness subscale consists of 11 items. High scores on this subscale indicate that the teacher perceived the relationship as warm and affectionate. Finally, the Dependency subscale, consisting of 5 items, measures the degree to which the teacher perceives dependency in the relationship with the child. High scores are equivalent to a perception of over dependency.

The STRS is normed on a population of 1,535 of children ages 4 years 1 month to 8 years 8 months, although use for research purposes with older children is considered acceptable (Pianta, 2001). Test-retest reliability is: r=.89 for the total score, r=.88 for Closeness, r=.92 for Conflict, and r=.76 for Dependency over a period of 4 weeks. Internal consistency reliability for the total score (α=.89) and the Conflict (α=.92) and Closeness (α=.86) subscales are high, but not as high for Dependency (α=.64).

Construct validity is established using exploratory factor analysis to verify the multidimensional structure of the relationship construct. The three-factor structure was verified and replicated in multiple research studies (Pianta, 2001). Further, correlations between the total score and the subscale scores were moderate to strong and in the expected direction. Finally, though not statistically significant, research with different ages of children showed differences in scores that align with what would be expected developmentally for children. Concurrent and predictive validity are established by several research studies in which measures of academic skills, behavior problems,

competency in the classroom, and relationships with peers correlate with the STRS and associate subscales as predicted (Pianta, 2001). Evidence for discriminant validity is provided by research that shows that the STRS and subscales account for variance in social and academic outcomes that is unique from measures of teacher-reported behavior problems or social competence.

The STRS is designed to be used assess the relationship between teachers and children in their classrooms. As there is no currently available measure of the relationship between residential care workers and the children with whom they work, a teacher-student measure was selected. The residential care workers spend time in a teaching/learning environment with the children throughout the day, some of which is devoted to academics. Further, items were individually reviewed for applicability to the residential treatment environment. No item appears to be inconsistent with relationships in this environment. Finally, it is possible to use the STRS weekly to gather data (R. Pianta, personal communication, October 1, 2013).

<div align="center">Participants</div>

Participants for this study were recruited from a psychiatric residential treatment program for children in the Southeastern United States. They included RCW-child pairs in which the RCW participated in the CTRT and the child was the RCW-selected child of focus (COF). The RCW participants were selected using volunteer sampling and were those who had in their classroom children appropriate in age (6 to 10 years old) for the CTRT intervention. Pseudonyms are used for RCWs in order to protect their identities. Child participants were selected by the RCW based on the criteria of being a child of the appropriate age and whom the counselor deemed an appropriate choice. Child

participants were also selected based on their stage in treatment, as they needed to be near the beginning of their time in residence to be present throughout the study.

Prior to recruiting participants, this research proposal was submitted to the University of North Carolina at Charlotte's Institutional Review Board for Human Subjects. Once approval from the University of North Carolina's Institutional Review Board was obtained, official approval from the treatment program's senior management team was obtained through collaboration with the Vice President of Clinical Operations. After both approvals were secured, participant recruitment began.

All first-shift RCWs were invited via email to participate if they met the criteria of having a child who is between the ages of 6 and 10 years old in their classroom. Following email contact, RCWs were contacted in person to invite them to participate in the study. Prior to participating in the study, the RCWs signed the informed consent. At that time, any RCW who participated in this research was invited to participate in a post-study follow-up processing group. This group was to serve the purpose of allowing them group time to process their experiences, potentially reducing undesired communication about the training during the research. None of the participants chose to participate in a group.

After the RCW participants were selected and signed the informed consent, they selected a potential COF. Children near the beginning of their time in treatment were selected in order to ensure that they were in residence during the entire time they were actively serving as COFs. Children experiencing severe behavioral difficulties were not selected. The agency counselor responsible for the selected child was consulted in the selection process in order to ensure that the child's participation was appropriate. If an

appropriate child was not available, the RCW participant remained in baseline conditions

until one was available and consent had been secured. Parent(s) or guardian(s) of the

selected children were contacted to secure informed consent for participation in the

research. Prior to the child participating in the study, the parent or guardian signed the

informed consent. Assent was obtained from the child in addition to informed consent

from the child's parent or guardian. Copies of all informed consent documents were also

filed by the residential treatment center, per their policy on research conducted in their

programs.

RCW participants were scheduled for study elements during their typical work

hours. They were paid their normal rate of pay by the agency where this study was

conducted, and coverage for their typical role was provided by the agency. Individual

participants are described based on demographic data provided, as well as their initial

qualitative interview. Additionally, data from their prestudy qualitative interview were

analyzed according to Creswell's (2009) and Braun and Clark's (2006) guidelines.

Themes related to their perception of the children in the PRTF and their jobs there are

summarized.

Jefferson

Jefferson is a 27-year-old African American male. He has completed a bachelor's

degree in the social sciences field and is enrolled in graduate school. He has 3 years of

experience in residential care, with 2.5 of them at the PRTF facility where this research

was conducted. He reported, "I've always worked with kids" and said that he has a

"passion just for…seeing…youth thrive or…succeed, achieve." He has completed

training in Therapeutic Crisis Intervention (TCI; a crisis intervention training program

created by Cornell University), child development, and the Perry (2006) NMT approach. Jefferson worked with a 7-year-old African American male as his COF.

When considering the demands of his job at the PRTF, Jefferson believes that the demands outweigh the resources provided by his employer, but that his personal resources are equal to the demands of the job. He noted, "I feel like I have the ability to…perform…at a very high level here." Jefferson's PRI suggests that his overall stress coping resources are on the higher end of the average range, as are most of his subscale scores. This suggests that he, in general, feels as though he has control over situations and can adapt, but may not feel confident about his ability to handle stressful situations. Additionally, Jefferson is able to see problems and plan for them and knows his own limits. However, he may be able to grow in areas related to understanding when to be flexible and maintaining optimism. He is able to give and receive help, believes he knows how to make others feel comfortable, is open to feedback, and able to ask others for help. He is able to see problems, gather more information to help avoid problems, and does not tend to procrastinate. He is accepting of himself, including his imperfections, believes his life is well-balanced, and uses humor to help him prevent stress.

Perception of Children in the PRTF.

- Description of Children. Jefferson described the children with whom he works as having "traumatic experiences," "aggressive. Lonely. Afraid…they've just been though, you know, so much." He noted that they will "lash out," but that "deep down inside…these kids, …they really are…happy. You know they're funny. … they're very active."

- Relationships With Children in the PRTF. Jefferson reported that the relationships with the children in the PRTF are both important and challenging to build. He described building relationships with the children as difficult stating, "It's a challenge because um they're so guarded." The importance was reflected in his description, "The teacher [RCW] and the student… have to…built relationship…to make any kind of progress." He reported taking time and expending effort to build relationships with, not only the children in his class, but the children facility-wide. He reflected, however, that sometimes even that is not enough when the symptoms of trauma appear because, "Although I've build a strong relationship with that person, it's like when they have that…flashback, it's like they're not really trying to hear."

Perception of the Job.

- Description and Resources. Jefferson explained that his job is diverse, and he often has to play different roles such as "friend" or "authoritative one" or run a variety of different therapeutic activities. He believes that one part of his job is to know the background of the children with whom he works, particularly because different things work for different children as he described, "All of them are different. Something that may work for [one child] may not work for [another]." The background information is something that he considers a resource and sometimes it is not received in "a timely manner." He reported that it would be nice to have additional resources in the form of tools for the children to manage feelings.

- Rewards. Jefferson reported rewards of the job related to seeing children make progress while they are in the PRTF. One example of progress could be in building relationships as he detailed, "seeing that kid open up. You know, and seeing that kid…be

able to trust you…you having developed a relationship with the kid, with the child."

Jefferson also described the rewards of seeing behavioral changes in the children.

> It's very rewarding to see, you know a kid who if this happened in the beginning they would you know like just blow, blow it up. You know, to blow it up. But then it's like later on, you know, if the same thing happened and to see them to be able to sit down and speak with you in a calm manner. It's, it's like it's a feeling like no other.

- Challenges. Jefferson reported the challenges of reaching all of the children in his class who have similar issues. He described this as, "I don't feel like these the kids are like the same…It's very hard to try to figure out….what works for you is gonna work…for all five." Also, he noted that some of their issues make it hard to help them, such as, "I have to kinda go against [in the process of trying to help them]…clients who…have hallucinations and different things like that."

- Personal Effects. Jefferson described this job as something where "there would never be a time, a moment where I, where I say…'Okay, my eight hours are up.'" The job is something that is difficult for him to leave behind him when he goes home. He described thinking about it after leaving and wondering what he could have done differently in some situations. The job can create positive feelings when a child makes progress, and he can consider the fact that "I had something to do with it [the progress]," but it is difficult to "create that balance" related to work and home.

Sue

Sue is a 32-year-old Caucasian female. She has 7 years of experience in residential care, 2 of which have been at the current PRTF. She has a bachelor's degree in the healthcare field and is not currently in school. She reflected, "I knew automatically that…[I] always knew I wanted to help people." She has training in TCI, NMT (Perry,

2006), and attends recreation therapy conferences for additional training. Sue worked with an 11-year-old Caucasian male COF. This was slightly outside the upper age limit of 10 for the appropriateness of CCPT. However, many of the children in the PRTF where this research was conducted display behaviors consistent with a younger age and thus are developmentally less mature than other children of their age. A consultation with the child's therapist was conducted to determine that this child's primary mode of communication was still play. As such he was determined to be appropriate for the study.

Sue believes that the demands of her current position outweigh the resources provided to her by her employer, but that her personal resources are equal to the demand of the job. She reported being open to learning new skills indicating "if there's a way for me to better myself here and learn how to handle the kids better, then you [I] should take it." Her PRI results indicate that her stress coping resources are on the lower end of the average range. The PRI results suggest that she is able to look ahead and anticipate difficult tasks and does not usually procrastinate on them. However, a sense of self-confidence and belief in her ability to handle stressful situations may be areas of growth for Sue. Further, Sue is able to understand her limits, but may relate to areas for growth identified in Maintaining a Flexible Perspective, seeing problems as opportunities for growth, and maintaining optimism. Sue has strengths related to social resourcefulness, and the PRI suggests that she believes that others perceive her as helpful, is open to feedback, and has people to rely on for help. Sue appears to be accepting of her own imperfections and uses humor to prevent stress. However, Sue may be able to grow in her understanding of who she is and feeling as though she leads a well-rounded life. Finally, Sue noted about herself, "I process things slower…and I'm a thinker."

Perception of Children in the PRTF.

- Description of Children. Sue described the children in the PRTF as having experienced trauma and being at all different levels of functioning as a result. She indicated, "So you can have a 13-year-old who's really one or two." She reported that they have many challenging behaviors. The children in the PRTF "all have different triggers" and are "highly impulsive…inappropriate…aggressive. Most of the time, really intelligent…provoking and antagonistic at the same time."

- Relationships With Children in the PRTF. Sue described herself as being "very in tune with my kids" and doing "a really good job of forming trust." She described the relationship as sometimes reciprocal in order to build trust. "They know things about me. I know things about them. And I think that helps develop trust."

Perception of the Job.

- Description and Resources. Sue described her job as one where she is responsible for creating programs to help the children deal more effectively with their trauma, in other words, "give them a positive method of coping with a bad situation." As part of that responsibility she reported a need to be very observant of the children stating, "I'm watching every detail." She believed that additional resources would be helpful in successfully doing her job including space, training, staff, and supplies. Related to staff she reported, "I think we need three staff" rather than the two who are typically present in the room.

- Rewards. The rewards of the job for Sue are related to progress, which is sometimes visible in only small steps. She stated, "Reward is…seeing, like I said, the little things and having certain people that…coming in are really difficult cases and then

they leave and you see a huge change." She also noted reciprocity in relationships with the children as a reward indicating, "you learn something from them. You…give something and you take something away as well."

- Challenges. Sue described this job as a hard one. She noted that one challenging aspect is "preventing crisis" or "dealing with one crisis and that's creating another." She also indicated that she finds program design challenging in that she has to create something that "everybody will do, that everybody can do."

- Personal Effects. Sue reported the potential for positive personal effects of the job such as "knowing I was a little part of them getting better." However, she also reported feeling frustrated at times when she does not feel like she has the resources to help the children as much as they need. She said that the job can be personally exhausting, and sometimes "you walk out of here and you can't even think anymore." She indicated that it can be difficult to find time to take breaks, which contributes to sometimes feeling "overwhelmed." Finally, she finds it difficult to say goodbye to the children she has met, "because for me, it's like I don't know what they're going into. And that worries me."

Maggie

Maggie is a 27-year-old Caucasian female. She was a recent hire and had 2 months of experience in residential care, all at the current PRTF. She has completed her Master of Arts in the education field and is currently not enrolled in school. Maggie has been a teacher in regular education in the past, but noted, "[I] realized that I like teaching but more from the…psychological perspective." Maggie has completed TCI training,

NMT (Perry, 2006) training, and developmental psychology. Maggie worked with an 8-year-old Caucasian male as her COF.

She believes the demands of her current position are equal the resources provided to her by her employer and her personal resources are equal to the demand of the job. She reported, "I have plenty of [personal] resources." Maggie's PRI results indicate that her stress coping resources are average, as are most of her subscale scores. Her strengths suggest that she is feels generally successful when she tries things and believes she can handle stressful situations, though adapting to change may be a growth area. Maggie appears to know her limits, maintain optimism, and maintain a flexible perspective though she may not always see problems as opportunities for growth. She believes in her ability to make others feel comfortable, is accepting of feedback, and able to ask for help, but may not believe others find her helpful. She is also able to see and identify problems coming and identify ways she can respond to avoid problems. However, she might struggle to plan ahead and tend to procrastinate. Finally, Maggie has a sense of who she is. However, areas for growth suggest she may have difficulty accepting her limitations, does not believe her life is well-balanced, and tends to not use humor as a stress reliever.

Maggie expressed a strong belief in the value of play, describing it as "the foundation of childhood and growing up. And so many of your skills, whether it's like fine motor, imagination, creativity, come from that." She also said that she likes "to be creative and get kids to have fun with things," which is how she indicated she handles getting the children engaged in learning.

Perception of Children in the PRTF.

- Description of Children. Maggie described the children with whom she

works as struggling significantly with academics. They have had "negative, non-existent" experiences in which "people have been frustrated [with them]." She noted a discrepancy in their physical and functional ages such that "like 10, 11, 12, and about to be 13, but their cognitive functioning is like maybe a 3- or 4-year-old," or "they'll talk and act in some ways like their chronological age but in a lot of other ways…they are still the little kid that is…trapped inside." She reported high incidence of trauma in the children's backgrounds such that "they're very easily triggered." The children may be "withdrawn" or "not know appropriate boundaries," as well as "antagonistic" and "impulsive." This is evidenced in their tendency to "just go down to that [brain] stem [response] so quickly."

- Relationships with Children in the PRTF. Maggie suggested that the relationships with the children in the PRTF are difficult to establish both because of short lengths of stay and the children's "lack of trust." She described this in detail:

> And that's I think the hardest to deal with [lack of trust] because you know a child who has grown up in a quote/unquote normal home, whatever that is, but gotten their needs met basically, they had that trust. And they're kind of, a little of that innocence is there, and they're easily trusting. But these kids you really have to figure out how you can get through to each one. And honestly just let them come to you. Cause if you force trust on them or say I'll help you I'll help, or just kind of all over them pretty much, then they'll kinda back away I think.

Perception of the Job.

- Description and Resources. Maggie described her job as "to get these kids to love learning again" and stated " [she] feel[s] like an investigator, a detective almost to just kind of see what they are interested in." She reported a need to know the children's history in order to help them. The only resources Maggie reported wanting more of would be training. She felt very supported in her work, which "makes the job easier."

- Rewards. Maggie indicated that she thinks of the rewards of the relationships

with the kids that there are "so many." She noted progress as one of the rewards and

indicated that it is sometimes slow and requires persistence, but is still rewarding. "So if

you are consistent and calm asking someone 30 times to please put the pencil back, then

next time you might only have to ask like 25 times. And then 20, and then it goes down."

- Challenges. Maggie indicated that "there are tons of challenges" including the

tendency for crises to multiply. This was described in detail:

 And then the other one and then the other one. It's like dominoes falling. And it's, it
could be a catastrophe. So you really have to watch what you say and um you can't
prevent someone from speaking. Like you can't. So it's how, it's preparing for that
moment after someone is speaking. That dealing with the consequences of that.

She also reported having plans for her work with the kids that suit all the different needs

can be challenging.

- Personal Effects. Maggie indicated the job has a personal effect on her.

She experiences things that are "hard not to take that home with you." She sometimes has

to take a moment for herself to "take a deep breath." Finally, she feels a mix of emotions

when the children leave from "happy" to "sad" to "worried" about their future.

Setting

Treatment took place at a PRTF in a major city in the Southeastern United States.

This PRTF is part of a larger children's service agency that also provides outpatient

treatment, multisystemic therapy, day treatment, and therapeutic foster care. There are

several agency locations throughout the state in which the main campus, where the

treatment was provided, is located. In PRTF, children with emotional, behavioral, and

psychological problems ages 5-14 are under the care of a psychiatrist, as well as provided

24-hour nursing on site. They reside in 6-bed treatment cottages on the main campus of

the agency.

According to statistics provided by the senior management team of the facility, in 2012, this facility served 7,027 children, of whom 75 were served in PRTF. The ethnicity of children served by the entire agency was primarily African American (54%). The ethnic makeup of the remaining served children was 29% Caucasian, 9% Hispanic, and 5% Multiracial. The majority of children served (70%) were in the custody of their biological parents. Primary diagnoses were mostly disruptive behavior disorders (23%) or attention deficit disorders (22%). Additional diagnoses included: mood disorders (14%), other (12%), adjustment disorders (10%), anxiety disorders (8%), bipolar disorders (3%), abuse (3%), relationship disorders (3%), and impulse disorders (2%). Sixty-eight percent of children served were male, and 21% were 9 years of age and under, 20% 10 to 12 years of age, 28% 13 to 15 years of age, and 22% 16 and up. The average age of children served in PRTF was slightly over 10 years of age. In this facility, restrictive interventions have dropped between October 2004 and September 2012, from approximately .05 per child per day to under .02 per child per day. In general, according to the information provided by the senior management team, outcomes data show that the programs provided by the agency are similar to statewide outcomes. Agency-wide, 51% of staff have bachelors degrees, 24% masters degrees, 16% high school diplomas, 7% associates degrees, and 2% doctoral degrees. Finally related to staff turnover, 59% of the total employees (323) experienced no change, 36% left after more than 90 days and 5% left after less than 90 days. With regard to direct care providers at the agency (270 employees), 57% experienced no change, 37% left after more than 90 days, and 6% left after less than 90 days.

The state in which this facility resides had, as of 2002, a daily average of 1,897 children under 21 years of age in 24-hour residential care each day (Ireys et al., 2006). Additionally, as of 2003, there were 817 such facilities in the state, with an average of four children per facility and 3,465 total beds. This number is vastly different from numbers reported by the Substance Abuse and Mental Health Services Administration (2012) that suggested that, as of 2008, the state in which this facility is located had 12 24-hour residential treatment facilities for children with severe emotional problems. This suggests that different definitions for residential treatment were used in each case. A finding that was highlighted by the Ireys et al. (2006) report which showed that there were 71 types of residential facilities found in 38 states.

The treatment approach used by this PRTF is the NMT (Perry, 2006). This treatment approach is based in the science of neurobiology, and the three main components of the model are: (a) a developmental history, (b) a current assessment of functioning (brain mapping), and (c) recommendations for treatment. The recommended interventions are educationally, enrichment, and therapeutically based. They are designed to be sequenced according to typical brain development and are targeted to the child's specific deficit areas, assessed through functional brain mapping conducting during the multidisciplinary assessment phase. The idea of this treatment model is to address areas that are not developed in the lowest areas of the brain (e.g., the brainstem) with appropriate interventions prior to moving into interventions that require higher levels of brain function (e.g., insight-oriented therapy). Finally, the child's relational milieu is an important factor in this treatment model and interventions that support the improvement of the relational environments are recommended.

There are a variety of roles among direct care providers at this PRTF. Some direct care providers are classified as behavioral health counselors, some as teachers, and some as recreational therapists. The teachers or recreational therapists are the primary staff members responsible for the structure of the day, and the behavioral health counselors are responsible for supporting that, as well as running assigned therapeutic activity groups (e.g., gardening). A variety of staffing structures have been in place over the last 2 years, as changes in legislation, lengths of stay, and severity of children's mental health concerns have made it necessary to restructure aspects of the programming. Currently, staff members work in two-person teams in which they are primarily responsible for six children. Two of those teams work together throughout the day. Therefore, there are four staff members (including one teacher, behavioral health counselors, and possibly a recreational therapist) responsible for 12 children. Independent of their assigned roles, direct care staff at this PRTF are expected to participate actively with children, plan activities for the children, interact with the children using their training, maintain documentation, and create a safe environment.

Prior to starting their full job duties, new hires in this PRTF participate in 2 weeks of orientation. During that time, topics such as Therapeutic Crisis Intervention (TCI; a crisis intervention training program created by Cornell University), NMT (Perry, 2006), restrictive interventions, and documentation and procedures are covered. They spend most of the time learning TCI and documentation and procedures and approximately one day learning NMT basics and one day learning about the use of restrictive interventions. During TCI training, new staff members learn a specific method for crisis intervention. They are taught how to use appropriate body language and verbal skills, such as

validating feelings and being reflective, in order to deescalate crises. This approach is the primary way that staff members are trained to interact with children in crisis.

Related to ongoing training, NMT training is continued 1 day per week for 3 weeks after the initial training. Staff members are retrained on restrictive interventions every 6 months. They receive minimal additional ongoing training in selected areas during regular staff meetings. Finally, TCI serves as the training orientation when ongoing training on interacting with the children is provided within the treatment setting (e.g., when debriefing is provided following a restrictive intervention). However, ongoing feedback from other staff members in the individual's team is not common among the staff members, and they tend to refrain from intervening in interactions between other staff members and children even if those interactions are not consistent with the approach in place.

In spite of the relational orientation of the TCI training, as well as the importance of the relationship in the NMT approach, there are challenges to consistency in the use of relational approaches. There is perceived peer-based social pressure to control the children in the facility, as well as a culture of concern for other children in situations when one escalating child may cause others to escalate. Additionally, in spite of extensive training, new staff members are not given much opportunity to practice and role-play skills taught in their orientation. Further, immediately upon completing their orientation, they become responsible for managing groups of children, a specific set of skills that is not covered in training and for which they are not afforded practice time. It was shared with me that it is sometimes challenging to support the staff members in using skills learned in training, because the skills may be inconsistent with the staff member's

personal experiences or familial or cultural background. Further complicating this process, when confronted with stressful situations, staff members tend to revert to what is most familiar rather than make a conscious choice to try out new or less familiar skills.

Treatment

Treatment was based on the CPRT protocol in Bratton et al.'s (2006) *Child Parent Relationship Therapy (CPRT) Treatment Manual* and on the CTRT model proposed by Morrison (2006). However, due to setting and methodology restrictions, the training was provided individually. There was no time that all RCWs who participated in the training were available at the same time to participate in a group, and a group would not have allowed for members to be started in the treatment phase individually and independent of one another. Minor adaptations were made to the CPRT protocol by Bratton et al. in order to accommodate RCWs' schedules and the residential treatment environment. The treatment, though manualized, is intended to be flexible according to the recipient and setting (Bratton et al., 2006; Landreth & Bratton, 2006).

The training for RCWs consisted of two phases (e.g., Morrison, 2006; see Appendix G for a brief visual summary of the study design). During Phase I the RCW participated in the equivalent of the 10-session CPRT model as in Bratton et al. (2006), which includes seven 30-minute weekly play sessions with the RCW-selected COF. During Phase II, RCWs received coaching and modeling on how to generalize the skills to the classroom/group environment. Each RCW met with the CTRT therapist for 30-45 minutes per week for supervision and training throughout Phase I and for 20 minutes per week during Phase II of the CTRT.

During Phase I, treatment was provided as is consistent with the treatment manual for CPRT (Bratton et al., 2006). Adaptations included that the first training/supervision session combined sessions 1 and 2 in the CPRT manual. After session 3, RCWs began their individual 30-minute weekly play sessions with their COF. Sessions 3 through 10 were offered to the RCW as per the outline in the CPRT manual. RCWs learned the skills of child-centered play therapy including: responding to children's feelings, building self-esteem, limit setting, encouragement, and how to conduct the weekly play sessions. RCWs' weekly play sessions were recorded and presented in the weekly training/supervision, during which they were provided with feedback aimed at helping them increase their ability to use the child-centered play therapy skills.

During Phase II, RCWs received training and coaching on how to implement the skills learned in the CTRT in their classroom/group environment. This took place during unstructured "center-time" in the RCW's classroom or at other unstructured group time. This phase of treatment lasted for 6 weeks. During this time, RCWs received 25 minutes of coaching in the classroom/group on how to use CCPT skills with multiple children two times per week. These coaching sessions were provided by the researcher who conducted the Phase I training and processed with the RCWs during their weekly meetings supervision meetings.

The primary researcher, a registered play therapist, licensed professional counselor, and national certified counselor provided all training. The primary researcher has completed three graduate level courses in play therapy, including one focused specifically on the CPRT model (Landreth & Bratton, 2006), taught under supervision a course focused on the Landreth and Bratton CPRT model, as well as participated in and

presented conference workshops on play therapy and associated topics. Additionally, meetings were held with the chair of this dissertation committee, who has extensive training in the CPRT model of filial therapy under the supervision of Sue Bratton, co-author of *Child Parent Relationship Therapy (CPRT)* (Landreth & Bratton, 2006). These meetings were used to review portions of recordings of training sessions and discuss treatment fidelity and any adaptations made to the treatment protocol.

<p align="center">Data Collection</p>

Quantitative

After all informed consent documents were provided, participants completed a demographics questionnaire and the PRI. There were four phases to this study designated: Phase A-baseline, Phase B-CTRT individual didactic and play session supervision, Phase C-classroom/group generalization coaching, and Phase A-return to baseline. During the second Phase A, all interventions were complete and individual participants were monitored to determine skill maintenance and use without ongoing intervention. The primary baseline was the use of CCPT skills in the classroom/group as measured by the CTRT-SC (see Table 1 at the end of this section for a summary of data collection by research question and Appendix G for a brief visual summary of the study design).

Phase A-baseline. Baseline was at least three weeks to allow all participants to reach stability on the CTRT-SC. During baseline, all RCWs were observed in their classroom/group at approximately the same time once per week using the CTRT-SC. The baseline period was at least three weeks to allow time for participants to conduct three weekly video-recorded play sessions with the COF to be rated using the MEACI. As each

participant remained in baseline conditions for differing periods of time, these play

sessions were conducted in the 3 weeks prior to the start of the CTRT in Phase B. These

MEACI scores served as the baseline for skills learned and demonstrated in the

individual play sessions. Though baseline measures ideally continue to be collected

throughout the baseline period for all participants on all measures, it was not appropriate

or feasible to have untrained RCWs conduct ongoing play sessions with the COF.

Therefore, only three play sessions were conducted prior to starting training. Play

sessions resumed during the CTRT intervention in Phase B, following Week 2. As

individual participants began the treatment phase (Phase B), the other participants

remained in baseline conditions with no treatment. They continued to be observed weekly

for CCPT skills in the classroom/group as measured by the CTRT-SC. Participants began

completing weekly the STRS when they began doing their play sessions.

Phase B-CTRT Treatment Phase I. Once a stable baseline for the CTRT-SC was

established, one RCW began the CTRT training. RCW start order was determined by

when a child in the RCW's classroom who was appropriate for the study became

available to participate. Prior to beginning treatment, the RCW filled out the TRF related

to the COF, as well as the MBI-ES. During this portion of the intervention, CTRT-SC

observations continued to be conducted weekly and the RCW continued to complete the

STRS on the COF weekly. Additionally, weekly play sessions (which began after Week 2

of training), were videotaped and analyzed using the MEACI.

After at least 2 weeks elapsed and another RCW could be paired with an

appropriate COF, the second RCW began to receive the CTRT intervention. Due to

length of stay of the children, securing guardian permission, staff movement within the

agency, and the entry into treatment of a child of the appropriate age, the final result was

that the second participant (Sue) started 4 weeks after the first (Jefferson) and the third

participant (Maggie) started 16 weeks after the second. Maggie is also the participant

who started the baseline late (7 weeks after the other two). Though it is recommended

that intervention begin with the second participant after all participants are stable related

to the dependent variable (Kazdin, 2011), this was not possible in this study. CCPT skills

in the classroom/group (as measured by the CTRT-SC) were the dependent variable

guiding the design of the study and skill generalization was not expected to occur until

later in treatment when CTRT began to address those skills. Additionally, CTRT is a

multi-week intervention and changes over the intervention were expected to be gradual,

not immediate. Participants continued to begin the intervention phase as described above.

Phase C-CTRT Phase II. At Week 9 of the treatment phase, the focus shifted to

classroom/group generalization skills. Prior to this shift from play sessions and individual

supervision sessions, to classroom/group generalization, each RCW completed the TRF

on their COF. Participants continued to complete the STRS on their relationship with

their COF weekly during this phase.

Phase A-Return to Baseline. Following the completion of the full CTRT,

participants entered a follow-up phase during which there was no intervention. This

phase was 6 weeks long. During this time, the CTRT-SC in-class observations continued

in addition to participants filling out the STRS weekly. Prior to this phase, participants

completed the MBI-ES. There were no other measures ongoing.

Individual Treatment Protocols.

- Jefferson. Jefferson was the first RCW to begin treatment. He spent 4 weeks

in baseline conditions during which he was observed weekly and completed three baseline play sessions prior to training and three STRS ratings. He had two missed observations during baseline due to scheduled days off. Missed observations were made up as soon as possible following the planned observation. Jefferson completed the TRF, MBI-ES, and PRI as scheduled. Jefferson spent 8 weeks in training Phase B, which started after he'd already been observed for the week, thus giving him seven weekly CTRT-SC ratings during Phase B. During Phase C, Jefferson completed training 5 of 6 weeks, with one supervision session and one in-class training missed during Week 13 due to absence. He was observed 5 of 6 weeks, with one missed week due to observer illness. Jefferson was in Phase A (follow-up) for 6 weeks. He was moved to a new location during the second week of Phase A (follow-up) and missed one follow-up observation due to the change in schedule. This move caused the loss of three STRS rating weeks due to loss of the sheet in transition and 2 weeks where Jefferson was not in the classroom with his COF.

- Sue. Sue spent 7 weeks in baseline conditions and completed seven CTRT-SC observations, with one missed and rescheduled observation due to planned vacation time. During baseline, she also completed the three baseline play sessions and three STRS ratings. Sue completed the TRF, MBI-ES, and PRI as scheduled. Sue spent 8 weeks in Phase B, during which she was observed seven times with one missed observation due to observer illness, and she completed the STRS weekly. Sue spent 6 weeks in Phase C, where she was observed 5 of 6 weeks with one missed observation due to being unable to be in the classroom due to clerical work. During Week 11 her weekly training was postponed due to challenges with classroom coverage. It was rescheduled

within the same week. She also completed the STRS weekly as scheduled. During

follow-up Sue was observed six times over 6 weeks. She completed the STRS as

scheduled.

- Maggie. Maggie began baseline conditions during Week 9 of the study. She

was added due to the loss of a participant who was moved to a classroom where he would

now interact with children appropriate for this study. Maggie spent 17 weeks in baseline

conditions during which she was observed weekly except for one week due to observer

illness and one week due to a planned vacation. During baseline, Maggie completed three

baseline play sessions and three STRS ratings. She completed the TRF, MBI-ES, and PRI

as scheduled. During Phase B, two of Maggie's weekly sessions were rescheduled within

the same week due to planned vacations. Maggie completed 3 weeks of Phase C training

and 3 weeks of follow-up due to having to leave the PRTF facility for health related

reasons. During Phase C Maggie was observed weekly for a total of three observations.

She was observed three times during follow-up, with one missed observation that was

made up as soon as possible. She completed the STRS as scheduled.

Qualitative

Qualitative data was collected in individual semi-structured interviews with the

RCWs participants. Semi-structured interviews were conducted prior to and after the

CTRT intervention. Each interview took approximately 60 minutes to complete. Pre-

interviews took place prior the start of the baseline phase, after informed consent was

obtained and demographic information collected. The post-interviews took place

following the completion of the follow-up Phase A from the quantitative portion of the

study. Member checking was completed by making both transcripts and thematic

summaries available for participants to approve. All interviews were audiotaped. An

interview protocol served as a guideline and attentive listening and probes were used.

Table 1: Dependent Variables and Data Collection

Research Question	Instrument	Responsible Person	Type of Data	Timing
What are the effects of the CTRT intervention on the RCWs' ability to generalize child centered play therapy skills the classroom/group?	CTRT-SC	observer	quantitative	ongoing
What are the effects of the CTRT intervention on the RCWs' demonstration of empathy in play sessions with their COF?	MEACI	observer	quantitative	ongoing
How do RCWs who complete CTRT perceive the training?	interview	primary investigator	qualitative	pre/post
How do RCWs who complete CTRT perceive the impact of the training?	interview	primary investigator	qualitative	pre/post
How do RCWs who complete CTRT describe the usefulness of the training?	interview	primary investigator	qualitative	pre/post
What challenges, if any, related to CTRT do RCWs experience?	interview	primary investigator	qualitative	pre/post
What are the effects of the CTRT intervention on the relationship between RCWs and COFs?	STRS/ interview	RCW	mixed	ongoing
What are the effects of the CTRT intervention on RCWs' perception of the COFs' internalizing, externalizing, and total behavior problems?	TRF/ interview	RCW	mixed	pre/post
What are the effects of the CTRT intervention on the RCWs' symptoms of professional burnout?	MBI-ES/ interview	RCW	mixed	pre/post

Data Analysis

Mixed methods research is mixed at different levels. This study is fully mixed (Leech & Onwuegbuzie, 2009), and the data were mixed in the results and interpretation phases after they were separately analyzed. Therefore, the data analysis procedures will be described as separate quantitative (e.g., Kratochwill et al. 2010) and qualitative procedures (e.g., Creswell, 2009).

Quantitative

Visual analysis is the most common way of interpreting single-case design data, though there are a variety of statistical tests that are being used by some researchers conducting single-case research (Kazdin, 2011). Data from the CTRT-SC, STRS, and MEACI were visually analyzed according to Kratochwill et al.'s (2010) recommendations in which the data were examined for changes in level, trend, and variability, as well as consistency of effect and overlap.

Percentage of data points exceeding the median (PEM; Ma, 2006) was selected as the most appropriate effect size measure for the CTRT-SC data, the STRS data and percentage of nonoverlapping data (PND; Scruggs, Mastropieri, & Casto, 1987) for the MEACI data. Research has shown that different effect size measures can yield different results (Lenz, 2013). Thus, as per the recommendations of Lenz, this selection of the effect size measure was made according to "characteristics of the distributions within the baseline phase, size of data, and the purpose" (p. 69) of this research. PEM was selected due to the desire to control for outliers found in baseline data, as well as the overall variability in the data (Lenz, 2013). PND was chosen for the MEACI data as there were no outliers. Additionally, these nonoverlap methods have been used in the counseling

literature to date. This decision was made based on the data and recommendations made in the single-case literature (e.g., Gage & Lewis, 2012; Lenz, 2013; Parker, Vannest, & Davis, 2011). Comparisons between phases were made based on expected treatment results (Parker & Brossart, 2006). For CTRT-SC data this included comparisons between baseline and Phase B, Phase C, Phase A (follow-up), and the combination of Phase C and Phase A (follow-up). This was due to CCPT skills being taught throughout the training, but generalization being the focus of Phase C. For STRS data this included comparisons between baseline and: Phase B and Phase B through Phase A (follow-up). This was due to the fact that the relationship would be expected to be most affected during the Phase I CTRT when individual play sessions were being conducted and effects would be expected to carry throughout treatment and follow-up.

The PRI was scored and used to supplement understanding of individual participants. Finally, pre and posttest measures on the MBI-ES and TRF were compared for each individual case. Statistical testing is not appropriate, as this was not group data. Qualitative

Thematic data analysis was based on procedures outlined by Creswell (2009) and Braun and Clark (2006):

1. Interviews were transcribed.

2. A sense of the data was gained by reading through the data, as well as reading transcripts while listening to the recording.

3. Interviews were coded. Initial coding was conducted inductively, but was primarily based on the research questions.

4. Codes were combined into themes.

5. Themes were reviewed for their consistency with codes and their difference from each other.

6. Additional cases were analyzed using the same procedures.

<div align="center">Summary</div>

The purpose of this research was to examine the effects of CTRT in a residential treatment environment. A mixed methods approach, consisting of a single-case experimental design as the primary methodology with a qualitative case study, was conducted in order to answer the associated research questions. Data were analyzed separately and combined in the interpretation phase of the study.

CHAPTER 4: RESULTS

The purpose of this study was to investigate the effects of child teacher relationship training (CTRT) on children and residential care workers (RCWs) in a residential treatment setting. In this mixed methods single-case design, RCWs were observed and scored weekly on the Child-Teacher Relationship Building Skills-Center Time Observation Form (CTRT-SC; Morrison, 2006) during a baseline phase, during the two treatment phases of CTRT, and during a follow-up period. They also completed the Student Teacher Relationship Scale (STRS; Pianta, 2001) weekly, the Teacher Report Form of the ASEBA School-Age Forms (TRF; Achenbach & Rescorla, 2001) before and after Phase B, the Maslach Burnout Inventory-Educators Survey (MBI-ES; Maslach, Jackson, & Leiter, 1996) prior to starting and at the end of training, and had their play sessions rated using the Measurement of Empathy in Adult-Child Interaction (MEACI; Stover, Guerney, & O'Connell, 1971). RCWs also completed pre and poststudy interviews (see Appendix I for a data collection summary). This chapter will cover the results of these quantitative and qualitative investigations into the effects of CTRT on RCWs. Results are summarized by research question within each case. Pseudonyms are used to protect RCWs' identities. Prior to covering the results by participant, the process of analysis for each research single-case design question will be revisited.

Single-Case Design Quantitative Research Questions

Generalization of Child-Centered Play Therapy Skills

The CTRT-SC was used to quantify the effects of the CTRT intervention on the RCWs' ability to generalize child-centered play therapy (CCPT) skills to the classroom and group. Data from the CTRT-SC were visually analyzed using steps outlined by Kratochwill et al. (2010). Graphed results were inspected for changes in level, trend, and variability, as well as consistency of effect and overlap. Immediacy of effect was not considered due to the expected delayed change in the dependent variable upon phase changes. The percentage of data points exceeding the median (PEM; Ma, 2006) was calculated to make comparisons based on expected treatment outcomes (Parker & Brossart, 2006). Thus it made the most sense to compare baseline (Phase A) to: Phase B (CTRT Treatment Phase I), where there would be little or no change expected; Phase C (CTRT Phase II), where change would be expected; Phase A (return to baseline/follow-up), to examine for ability to maintain skills; and Phase C (CTRT Treatment Phase II) plus Phase A (return to baseline), the cumulative phases where change would be expected (see Appendix G for a brief visual summary of the study design). The results are summarized by case and collectively with the primary focus on changes between baseline and Phase C, follow-up, and the combination of the two. This is due to the fact that generalization of CCPT skills to the classroom environment was not expected until later in the treatment, when the focus of the training shifts to skill generalization (particularly Phase C). Choosing to contrast specific phases is appropriate when expected participant performance aligns with the comparisons (Parker & Brossart, 2006).

Demonstration of Empathy

Each participant conducted seven individual play sessions with his or her child of focus (COF). These sessions were rated using the MEACI to quantify the individual participant's ability to demonstrate empathy in the play session. A decrease in score on the MEACI indicates that the demonstration of empathy is increasing within the session. A doctoral level research assistant who was unaware of the order in which the play sessions were conducted rated videos of play sessions. Data for total and subscale scores were visually analyzed using the steps outlined by Kratochwill et al. (2010). The results were graphed and inspected for changes in level, trend, and variability, as well as consistency of effect, overlap, and immediacy of effect. The percentage of non-overlapping data (PND; Scruggs, Mastropierei, & Casto, 1987) was calculated for the total score, as well as the subscales. The play sessions took place only in Phase A (baseline) and Phase B (CTRT Phase I), thus the data were compared between these two phases.

Relationship Between Residential Care Workers and Children of Focus

Data from the STRS as a whole and its subscales Conflict and Closeness were visually analyzed using steps outlined by Kratochwill et al. (2010). Graphed results were inspected for changes in level, trend, and variability, as well as consistency of effect and overlap. Immediacy of effect was not considered due to the fact that an immediate change would not be expected with this type of intervention. Comparisons between Phase A (baseline) and: Phase B (CTRT Phase I) and the entire length of treatment combined with follow-up are reported based on expected treatment effect (Parker & Brossart, 2006; see Appendix G for a brief visual summary of study design). PEM (Ma, 2006) was calculated

for the total score, as well as the Closeness and Conflict subscales. The Dependency

subscale was not considered independently of the others, as it consists of only 5 items and

has been shown to be somewhat unreliable as a standalone measure (Pianta, 2001).

<div align="center">Qualitative Research Questions</div>

Each participant participated in a poststudy semi-structured interview following

his or her completion of the full training. Data were analyzed according to Creswell's

(2009) and Braun & Clark's (2006) guidelines. Transcripts were analyzed first

individually and then cross-case analysis was completed. During this cross-case analysis

themes were generated, which will be covered during the cross-case synthesis portion of

this chapter.

<div align="center">Jefferson</div>

Jefferson is a 27-year-old African American male who had, at the time of starting

the CTRT, 2.5 years of experience at the psychiatric residential treatment facility (PRTF).

Jefferson had an additional 6 months of PRTF experience at another PRTF. His COF was

a 7-year-old African American male.

Quantitative Research Questions

Generalization of Child-Centered Play Therapy Skills. During the baseline data

collection period, Jefferson displayed 0 child-centered play therapy (CCPT) skills in 3 of

4 observations, where he used once the skills of returning responsibility and

encouragement. Due to this, the baseline was determined to be stable enough to proceed

with treatment. Visual examination for changes in level, variability, and trend in the data

was completed and the results suggested there were changes across phases (see Figure 1).

Jefferson demonstrated increasing use of CCPT skills in the classroom setting across

phases. Changes in slope of the least squares regression line show a trend toward

increasing improvement.

The level of CCPT skills demonstrated in each phase increased from M=0.50

during baseline to M=6.6 during Phase C and M=31.80 during follow-up. Further, there

was increasing slope of the least squares regression line in each phase from 0.05 during

baseline to 0.70 in Phase C, and 1.43 during follow-up. Variability of the data increased

over time, as assessed visually (see Table 2).

Table 2: CTRT-SC Descriptive Statistics for Jefferson

	Phase A (Baseline)	Phase B	Phase C	Phase A (Follow-up)
M	0.50	0.86	6.60	31.80
Mdn	0	1	1	36
range	2	3	16	22
visual variability	low	low	high	high
slope	0.05	0.08	0.70	1.43

PEM (Ma, 2006) was calculated to compare the phases. PEM was 57% for the

comparison between baseline and Phase B, 60% for the comparison between baseline and

Phase C, 100% for the comparison between baseline and Phase A (follow-up), and 73%

for the comparison between baseline and Phase C combined with Phase a (follow-up).

According to Ma (2006) as adapted from Scruggs and Mastropieri (1998) the treatment

was mildly effective in increasing CCPT skill use in the classroom in Phases B and C

separately, but very effective in the follow-up period and moderately effective in Phase C

and follow-up periods as a whole (see Figure 1).
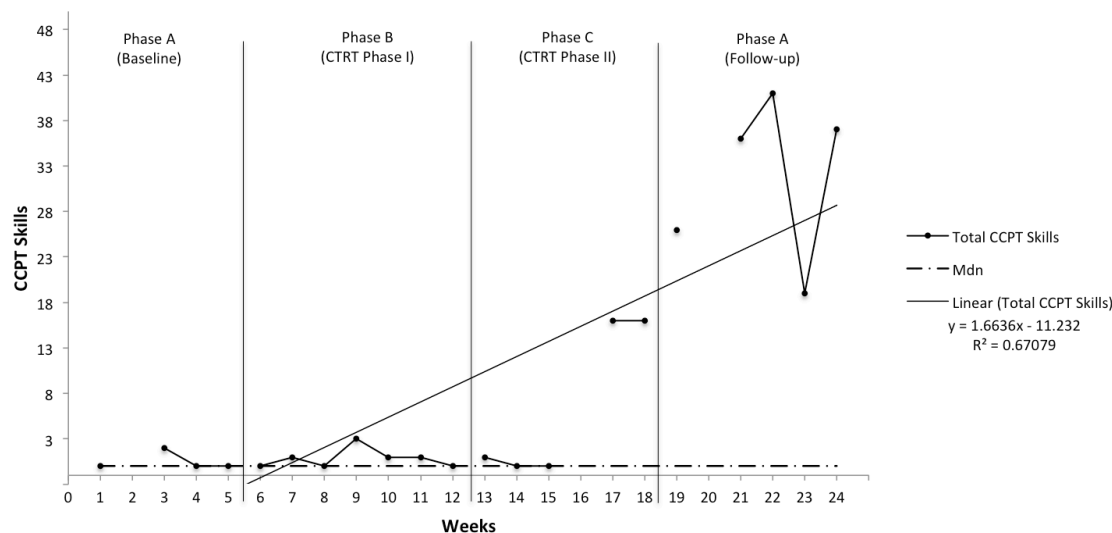
Figure 1: Visual analysis and effect size for Jefferson's CCPT skill demonstration

Demonstration of Empathy. Jefferson completed 10 total play sessions, three during the baseline phase prior to training and seven during training Phase B. These were completed weekly on the same day. One play session was delayed and made up within the same week due to technical difficulties with the recording equipment. Jefferson's total score on the MEACI decreased from $M=55.83$ during the baseline to $M=27.93$ during Phase B. Trends in the data were examined and showed a shift from a slight (-0.05) negative slope of the least squares regression line during baseline to a stronger negative slope (-2.04) during Phase B. Variability was low for both phases (see Table 3 for a summary of descriptive statistics). The effect occurred immediately, with a drop of 21 points between the last baseline play session and the first Phase B play session. PND was calculated at 100% suggesting this is a very effective treatment for increasing empathy (Scruggs & Mastropieri, 1998; see Figure H2).

Jefferson's scores for the Communication of Acceptance subscale also dropped from $M=19.5$ to $M=11.21$ between baseline and treatment. Trends in the data went from a

slightly positive slope of the least squares regression line (0.50) during the baseline to slightly negative (-0.57) during Phase B. Variability was low for both phases (see Table 3). The effect occurred immediately with a drop of 7 points between the last play session of the baseline and the first of Phase B. PND was 100% suggesting that this is a very effective treatment for increasing the communication of acceptance (Scruggs & Mastropieri, 1998; see Figure H3).

Jefferson's scores for the Allowing Self-Direction subscale also decreased from M=23.33 during baseline to M=9.86 during Phase B. Trends in the data, as indicated by the least squares regression line, were both negative, with an increase noted in Phase B (from -0.50 to -1.32). Visual inspection suggested that variability in the data were low during baseline and moderate during Phase B (see Table 3). The effect occurred immediately with a drop of 9 points between the last baseline play session and the first play session of Phase B. PND was 100% suggesting that this is a very effective treatment for increasing the adult's ability to allow self-direction by the child (Scruggs & Mastropieri, 1998; see Figure H4).

Jefferson's scores for the Involvement subscale decreased from M=13 during baseline to M=6.86 during Phase B. Trends in data, as indicated by the least squares regression line, were both negative with the slope decreasing slightly in Phase B (from -0.50 to -0.14). Visual inspection suggested data were low in variability in baseline and moderate during Phase B (see Table 3). The effect occurred immediately with a drop of 5 points between the last baseline play session and the first Phase B play session. PND was 100% suggesting that the treatment was very effective in increasing the involvement of the adult with the child (Scruggs & Mastropieri, 1998; see Figure H5).

Table 3: MEACI Descriptive Statistics for Jefferson

	Phase A (Baseline)	Phase B
Total Score		
M	55.83	27.93
Mdn	56	27
visual variability	low	low
slope	-0.50	-2.04
Acceptance		
M	19.50	11.21
Mdn	19.50	12
visual variability	low	low
slope	0.50	-0.57
Allowing		
Self-Direction		
M	23.33	9.86
Mdn	23	9
visual variability	low	moderate
slope	-0.50	-1.32
Involvement		
M	13	6.86
Mdn	13	6
visual variability	low	moderate
slope	-0.50	-0.14

Qualitative Research Questions

Perception of Training. Jefferson felt positively about the training. This positive

reaction was based in feeling like he "learned a lot" and that "overall, it was beneficial."

Although he indicated that he struggled at times to change previous patterns of behavior,

Jefferson reported, "The more I did it, the more I feel like it became easier." He stated, "I

felt like it was, mean feel like it was, it was, everything was beneficial." Jefferson

suggested better preparing children in the group prior to the training commencing in the

classroom (i.e., "letting them know what they're about to be a part of").

Perception of Impact of Training. Jefferson reported experiencing personal

growth as a result of the training, because "it just pushes you to think in a totally different

direction than you normally would…And I've always said that with change is always growth." Jefferson elaborated by stating "[the training] kinda pushed me to, you know, to realize, to think differently as in my approach to certain things or certain situations." He described his deeper understanding of the children's feelings as something he "in the beginning…didn't pay attention to" and now is "more understanding…that they really do feel like this." This increased understanding of children's feelings led Jefferson to be more intentional in his responses to children:

> And I think what happens is um by me being more in tune with you know [the children's] feelings, you know I think that kind of helps me with what my next word will be. You know to, to kinda help them through that feeling or you know I think I'm more mindful of what I'm going to say instead of just like you know um kind of saying the, the same routine thing.

Jefferson noted positive effects in his classroom in general, as well as effects on non-COFs with whom he was in contact. He noticed that the other children seemed to want to experience a similar special relationship as the relationship he had with his COF. He elaborated by explaining children in his classroom wanted to receive the "same acknowledgement" as his COF was receiving. He also noticed the skills helped him to build trust with the children in the classroom, and the skills "allow(s) me to be there for them in a way that I don't feel like I was there for them before." Jefferson described the effects on his classroom by indicating the use of the skills became very typical in his classroom, to the point that children expected him to speak to them in a certain way based on these skills. Within the classroom it "became the norm in the classroom [to use the CCPT skills]," as well as "the language in our classroom…in return I think that became the expectation [of the children]."

Though he did not think he had completely mastered the skills from the training, Jefferson was hopeful his growth would continue. He talked about continuing to use the training materials as resources, "I do still refer back to the packet that you [trainer] gave me. Just making sure that, just making sure, trying to see if what I'm doing aligns with, you know, what I learned." He noted identifying feelings as something that he expected to continue to use, with continued growth in the other skills as well.

Usefulness of Training. Jefferson's reporting on the usefulness of the skills taught in the training was focused on specific skills. He found limit setting and feelings identification to be the most useful skills, describing limit setting as "very beneficial," "a big one for me," and "my most valuable tool that I, you know, had." Further, Jefferson described the ability to use feelings identification as "one of the biggest tings that I've gotten out of the training," which has helped him to understand the children and respond accordingly. Jefferson adapted the skill of limit setting to a specific use in his environment, using limit setting as a structure to "incorporate safety rules" when teaching the children gardening and appropriate use of gardening tools. Jefferson did not find the skill of giving choices as useful as other skills, "because um I don't know. I think sometimes it kinda felt like they kind of took advantage of, you know, me, you know, giving choices and things like that. Like if almost, almost like they kind of manipulated the situation."

Jefferson found himself using the skills outside of work with a few family members. He reported specifically, "I found myself doing that [identifying feelings] more so outside of work then…You know so I think um it affects me you know not only here but you know outside of work and you know just personally."

Challenges. Jefferson reported several challenges with the training. He noted the difficulty of breaking old habits and changing from the things that came naturally to him due to being "used to doing something one way." Related to specific skills, Jefferson reported challenges with "the difference between, I guess, praising a child and encouraging a child" and trying to "wean away from that [praise]" as a primary tool for interacting with children. He also reported that it was challenging to allow his COF to lead, because he was so used to "them following me." He found entering a new classroom setting made it feel easier to use the skills, because he got to "go in there clean and using these skills you know because it was like oh this is this is Jefferson's style."

In addition, Jefferson found difficult "going from working with [his COF]…you know one-on-one, to transition[ing] into the classroom." This was due to the difficulty of managing multiple children who had "five other personalities" and "trying to figure out you know what technique would work better, best for, you know, each child," and also the fact that he did not believe "when you're working with a child, that they're always gonna be the same person." However, in spite of this challenge, Jefferson reported that he was able to resolve it by using a variety of techniques he learned in training to connect with the child.

Mixed Methods Research Questions

Relationship Effects. Jefferson completed 20 total weekly STRS ratings over 23 weeks. Week 18 was lost, and he was unable to complete weeks 19 and 20 due to changes in staffing and briefly not being in the same classroom with his COF. Jefferson's total STRS scores generally decreased in level from M=112.50 in baseline to M=107.86 in Phase B. This represents a decrease from the 43rd percentile to the 32nd percentile.

When compared to the entire length of treatment and Phase A (follow-up) combined, there was also a decrease to $M=107.25$. Trends in the data were examined and appeared to be inconsistent across phases. There was a slight negative trend in the data for Phase B and a slight positive trend in the data across the combination of all treatment and follow-up phases. Data in all phases appeared moderately variable with the exception of Phase C, which had one low outlying score of 96 (see Table 4 for a summary of descriptive statistics). PEM for the total score was calculated for each phase and for the total course of treatment and follow-up. All values were 0%, indicating that none of the values exceeded the median of the baseline phase and suggesting the treatment was ineffective (Scruggs & Mastropieri, 1998; see Figure H6).

Qualitatively, Jefferson described the effect of the training his relationship with his COF in as both improved and challenging, which both supports and refutes the quantitative findings. He noted, "I feel like he'd listen to, to me and um so I feel like it [the effects of the training] was almost kind of a good thing and…a not so good thing." In his description of the challenges in the relationship, Jefferson acknowledged that in some ways his COF seemed more independent and in others he seemed more dependent on him. "At times he [COF] became overly dependent on me." This description of the challenges in the relationship aligns with the quantitative findings.

Jefferson's STRS scores for the Conflict subscale of the STRS tended to increase across phases, from $M=22.50$ in baseline to $M=24.57$ in Phase B and $M=24.69$ in the combined treatment and follow-up phases. This is representative of an increase from the 62nd to 68th percentile from baseline to Phase B. There was a negative trend in the data for all treatment phases, though it was very slight for the combination of treatment and

follow-up (-0.10). Variability of the data was low based on visual inspection (see Table 4

for a summary of descriptive statistics). To compute PEM values below the median were

examined, due to the expected treatment effect of lowering conflict. PEM was calculated

at 0 for Phase B and 19% for the combined treatment and follow-up phases, suggesting

that the treatment was ineffective (Scruggs & Mastropieri, 1998; see Figure H7).

Qualitatively, Jefferson did not speak specifically of conflict in his relationship with his

COF. However, he reflected that he believed "he would kinda look to me to get him out

of certain things." Jefferson attributed this to his COF feeling "like 'Oh. I'm close to Mr.

Jefferson, so if I tell them something, I can, I can get away with it.'"

Jefferson's STRS scores for the Closeness subscale also decreased from M=46.75

during baseline to M=41 in Phase B and M=41.75 for the combined treatment and follow-

up phases. This was a decrease from the 60th to the 30th percentile from baseline to Phase

B. Trends in the data were similar across phases in magnitude but differed in direction

and included a slight negative trend in the data for Phase B (-0.71). Data in Phase B were

moderately variable and showed low variability elsewhere with the exception of an

outlying score of 34 in Phase C (see Table 4). PEM was computed at 0% for Phase B and

19% overall, suggesting that the treatment was ineffective (Scruggs & Mastropieri, 1998;

see Figure H8). However, the qualitative data suggested that Jefferson described the

relationship between him and his COF as close, which is not what is indicated by the

quantitative findings. He noted, "There was very high attachment. You know to me."

This was further indicated by Jefferson's statement that "there were even instances where

um he um, you know, he jokingly, but I felt like he was serious, when he would, he called

me dad."

Table 4: STRS Descriptive Statistics for Jefferson

	Phase A (Baseline)	Phase B	Phase C	Phase A (Follow-up)	Treatment-Follow-up
Total Score					
M	112.50	107.86	105	110.33	107.25
Mdn	113	107	107	110	107.50
visual variability	low	moderate	moderate	moderate	low
slope	1.20	-0.86	1.49	1.50	0.10
Conflict					
M	22.50	24.57	25.67	23	24.69
Mdn	22.50	24	26	23	24
visual variability	low	low	low	low	moderate
slope	-0.80	-0.21	-0.40	-2	-0.10
Closeness					
M	46.75	41	39.33	48.33[***]	41.75
Mdn	46.50	40	48	35	40.50
visual variability	low	moderate	low	low	moderate
slope	-0.50	-0.71	0.51	0.50	0.36

Note. *=PEM suggests mildly effective treatment; **=PEM suggests moderately effective treatment; ***=PEM suggests very effective treatment

Perception of Behavior Problems. Perceptions of behavior problems were measured quantitatively using the TRF (Achenbach & Rescorla, 2001), which each RCW completed prior to and at the completion of Phase B (CTRT Phase I). No statistical results are presented, as the data are not group data. Jefferson's COF's initial TRF scores were: 67 (clinical) for internalizing behaviors, 66 (clinical) for externalizing behaviors, and 64 for total (clinical). These scores increased slightly on the second rating, remaining clinical, to: 69 for internalizing behaviors, 68 for externalizing behaviors, and 68 for total behaviors. Qualitatively, Jefferson reported that he felt like the training was beneficial for his COF, which refutes the quantitative findings. He denied any improvements in his COF's behavior and reported that in some ways his COF's behaviors became more

challenging, such as being "more bossy to his peers" and "in play activities…he was telling me what to do because that's what we were doing in here [playroom]. So I noticed him doing that outside of the sessions that we were doing one-on-one." This supports the quantitative findings of slight behavioral deterioration. Jefferson did note that these behaviors were not largely disruptive of the classroom, nor did they cause any delay in treatment discharge.

Symptoms of Burnout. Quantitative burnout was measured using the MBI-ES (Maslach et al., 1996) which all participants took two times, once prior to training following the baseline phase and once following all training, prior to the follow-up phase. No statistical results are presented, as the data are not group data. Jefferson's scores on the three subscales of the MBI-ES for the first measurement were: 30 for the Emotional Exhaustion subscale (EE), 6 for the Depersonalization subscale (DP), and 42 for the Personal Accomplishment subscale (PA). Jefferson's scores on the three subscales correspond to high EE, low DP, and high PA. This does not suggest high burnout, though the high EE score is one component of high burnout. The second measurement yielded minimally higher scores on EE (32) and DP (7) and a slightly lower score on PA (41). This did not change the categorizations of high EE, low DP, and high PA. Qualitatively, Jefferson did not speak much about the training's effect on his ability to do his job or his feelings related to burnout. However, he noted that his understanding of feelings made "it easier for me, to kinda help them [the children]." This suggests that in this specific aspect of his job the training had an effect. The quantitative results do not support the existence of a significant effect, and his lack of discussion of this aspect of the effects of the training aligns well with the lack of large changes in the MBI-ES scores.

Summary

Jefferson perceived the CTRT positively. He found it difficult at times to break old habits, and the transition from working with an individual child to working within the group was difficult. The training pushed him to grow and think differently, whereby he gained a better understanding of feelings. He reported that the language of CTRT became the "norm" in his classroom, which aligns with the quantitative results that show Jefferson was able to successfully incorporate CCPT skills into his classroom work with children. He found the skills of limit setting and identifying feelings particularly helpful and noted that his ability to understand feelings made his job easier. However, his MBI-ES scores indicated increased symptoms of burnout, though the difference was slight and did not indicate high burnout. He did not think giving choices was helpful to him in the way the other skills were. He was also able to successfully increase his demonstration of empathy in the individual play sessions with his COF and reported a high attachment of his COF to him. He found no particular improvements in his COF's behaviors as a result of the play sessions, and in fact found him in some ways (increased dependency and difficult peer behaviors) more challenging. Finally, Jefferson described his growth in using the skills as ongoing.

<center>Sue</center>

Sue is a 32-year-old Caucasian female. She had, at the time, 7 years of experience in residential care overall and 2 years of experience at the current PRTF. She conducted play sessions with an 11-year-old Caucasian male COF.

Quantitative Research Questions

Generalization of Child-Centered Play Therapy Skills. Sue began treatment after 7 weeks under baseline conditions, when an appropriate child was available to be paired with her, and her baseline appeared stable due to the number of observations yielding zero CCPT skills. During the baseline period, 5 of 7 observations yielded no demonstration of CCPT skills. Visual examination for changes in level, variability, and trend in the data was completed and the results suggested there were changes across phases (see Figure 2). Sue demonstrated increasing use of CCPT skills in the classroom setting across phases. Changes in slope of the least squares regression line show a trend toward increasing improvement.

The level of CCPT skills demonstrated increased from $M=0.29$ during baseline to $M=1.6$ during Phase C and $M=3.67$ during follow-up. The slope of the least squares regression line changed from slightly negative in baseline to 0.57 during Phase C and 1.09 during follow-up. Variability of the data was similar during baseline and Phase B, but increased through Phase C and follow-up (see Table 5).

Table 5: CTRT-SC Descriptive Statistics for Sue

	Phase A (Baseline)	Phase B	Phase C	Phase A (Follow-up)
M	0.29	0.14	1.6	3.67
Mdn	0	0	1	2.5
range	1	0.86	6	9
visual variability	low	low	moderate	high
slope	-0.04	0.07	0.57	1.09

PEM was 14% when baseline and Phase B were compared, suggesting that this point, the treatment was ineffective in producing the use of CCPT skills in the classroom. The

Phase C PEM was 60%; the follow-up PEM was 67%; and the combined Phase C and follow-up PEM was 64%. All of these are considered suggestive of a mildly effective treatment (Scruggs & Mastropieri, 1998; see Figure 2).
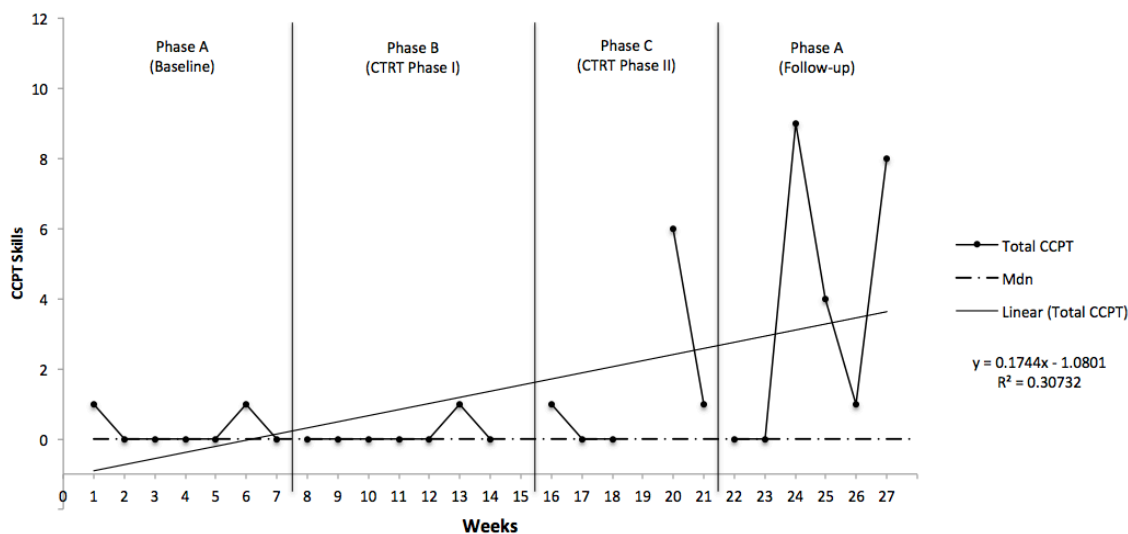
Figure 2: Visual analysis and effect size for Sue's CCPT skill demonstration

Demonstration of Empathy. Sue completed 10 play sessions, three during the baseline phase and seven during Phase B training. Baseline play sessions were once per week, with two sessions being made up within the same week due to scheduling issues. Phase B play sessions also took place weekly with one missed due to illness and made up the following day. Sue's total score on the MEACI decreased from M=48.83 during baseline to M=29.21 during Phase B. Trends in the data were both negative, as indicated by the least squares regression line, with the slope decreasing slightly during Phase B (from -1.75 to -1.30). Visual inspection of variability suggested that both phases were low (see Table 6). The treatment effect was immediately observed with a 14-point decrease occurring between the final baseline play session and the first Phase B session.

PND was calculated at 100% suggesting a very effective treatment for increasing

empathy (Scruggs & Mastropieri, 1998; see Figure H2).

Sue's scores on the Communication of Acceptance subscale of the MEACI also

decreased between phases from M=17.83 during baseline to M=12.07 during Phase B.

Trends in the data, as indicated by the least squares regression line, were both positive,

but very slight in Phase B (1.25 during baseline and .13 in Phase B). Variability of the

data based on visual inspection suggested that variability was low in both phases (see

Table 6). The treatment effect was immediate with a decrease of 7 points between the last

baseline play session and the first of Phase B. PND was 100% suggesting that this was a

very effective treatment for increasing the communication of acceptance (Scruggs &

Mastropieri, 1998; see Figure H3).

Sue's scores on the Allowing Self-Direction subscale also decreased from M=19

during the baseline play sessions to M= 9.28 during Phase B. Trends in the data, as

indicated by the least squares regression line, were both negative, but less so for Phase B

(-3 during baseline and -0.93 for Phase B). Variability of the data based on visual

inspection was low for baseline and moderate for Phase B (see Table 6). The treatment

effect was immediately observable with a drop of 4 points between the last baseline play

session and the first Phase B play session. PND was 100% suggesting that the treatment

was very effective at increasing the Sue's ability to allow the child self-direction

(Scruggs & Mastropieri, 1998; see Figure H4).

Sue also demonstrated an increase in her involvement with the child with the

score dropping from M=12 during baseline to M=7.86 during Phase B. There was no

trend and no variability in the data during baseline and a slight negative trend (-0.50), as

indicated by the least squares regression line, with moderate variability during Phase B.

(see Table 6). The treatment effect was immediate with a drop of 3 points from baseline

to Phase B. PND was 100% suggesting that this was a very effective treatment for

increasing Sue's involvement with the child (Scruggs & Mastropieri, 1998; see Figure

H5).

Table 6: MEACI Descriptive Statistics for Sue

	Phase A (Baseline)	Phase B
Total Score		
M	48.83	29.21
Mdn	48	29.50
visual variability	low	low
slope	-1.75	-1.30
Acceptance		
M	17.83	12.07
Mdn	17	12
visual variability	low	low
slope	1.25	0.13
Allowing Self-Direction		
M	19	9.29
Mdn	19	9
visual variability	low	moderate
slope	-3	-0.93
Involvement		
M	12	7.86
Mdn	12	8
visual variability	none	moderate
slope	0	-0.50

Qualitative Research Questions

Perception of Training. Sue reported positive reactions to the training. She noted,

"It was a good added piece to something I was missing." Further she reflected that she

thought this type of training would be beneficial to others with whom she worked. The

processes of observing the trainer use the skills was important to her during the training,

and she reported that there were times when "I wish you [the trainer] could've saw those… moments [when] you could've said, 'Ok this is a better way you could have done this,' because that's how I learn the best."

She provided suggestions for changes to the training in two areas, the transitional period for the COF at the end of the play sessions and training modifications to help increase her skills. Related to the transition time for the COF, Sue noted that she believed "that really affects the kid" and the end of the play sessions "signifies people leave…like things end." She recommended making "it more gradual" and having a "time period where you're still working with that child outside of the playroom. So it's in a setting where there's people around, but yet still focused kind of on him and gradually go to the group." Sue reported that due to the fact that her workday requires her to work with children of all ages, in situations ranging from contained in a classroom to spread across an outdoor space, training needed to take place in a variety of settings. She stated:

> There was different levels to it. Where I think some of your sessions that were in the room shoulda been during that time where you could, where we could see all the things that we go through in the day, because it's not just we're sitting in the class with this one group. It's not like that…well I woulda liked to see you do that so that I can pick up on how that works.

Sue also reported that she thought ongoing refreshers would be useful, because "with everything that's going on here, sometimes you get caught up and you forget. You know. And you lose that skill, and I don't wanna lose that skill."

Perception of Impact of Training. Sue also talked about growth experienced as a result of the training. She reported insights into her own typical reactions including how the training allowed her to "see a different side to me" wherein she was able to "stay calmer and not react so quickly to the situation in a negative way." She experienced more

self-control and a decrease in her frustration reflected in an "ability to manage or not become as frustrated in chaotic situations." She further elaborated that the training "allows me to go to that [skills learned] first instead of what would normally come out of my mouth." In addition, Sue found that the skills helped her with "recognizing and being more aware of the patterns of the kids."

Sue reported effects on non-COFs related to being able to build relationships with the children. She described using the skills to help a child see that she was "someone who was really here to help." She also noted the importance of using the skills to help build relationships with non-COFs, "And also it helps, you know, form relationships with whoever [sic] you're working with in the area of trust. And if you're working with this population, it's everything."

Classroom effects noted by Sue were centered on how using the skills are "another tool that I can use to pretty much prevent a crisis" in groups where the children react quickly to each other:

> With those being so highly reactive, if you don't stop the one that's starting quickly, you lose them all. And so it's really important to be aware of those other skills you can use…where the 'I know you're upset, I know you're expressing the feeling.' With them, that's the main thing. They want to know that you hear them.

Sue noted ongoing development related to the training:

> I think the better that I get at it and the more aware of the moments I can use it, because that for me is something I don't always think of right away in the moment. You know it's like oh and it hits me but it like, I'm kind of like all scattered at first. And then when I get, you know, my bearings I'm like oh I can use this. So being more in tune when I can use it um and doing it quickly. I think it will have an effect on keeping the room and myself stable.

Usefulness of Training. Sue believed the skills learned in the training could "be used in a lot of different situations and with a lot of different populations." She also

thought that they were useful in allowing "your client to understand that you hear them. That you are listening. That you, you see them. That you want to make a difference to them. And…that can never be wrong." In addition to finding the skills generally useful, she was mindful of how different skills seemed to work more effectively for some children. Specifically, she found limit setting and choice giving to be helpful "in that moment when I'm frustrated and I say, 'Okay, you can choose to do this or you can do this." She did not specify any skills as less useful than others, nor did she describe instances of adapting the skills to her environment. Sue reported generalizing the skills outside of work in time spent with her niece and nephew.

Challenges. Sue reported that she felt challenged by the process it took for her to think through a response and give it and not be concerned about doing it perfectly. She found it difficult to "change the whole language of things that I'm used to." She reported that wording was hard to master and "having that thought process in the moment was very difficult for me."

Sue experienced the transition from individual work to working with a group as challenging for a variety of reasons. First, she noted the effect of number of children and the challenges of managing multiple children in a variety of environments. More specifically, she noted, "It's just hard to do when it's one person to six kids. Scattered." She also believed that the children responded differently to different skills and it was sometimes hard to get the child's attention. She felt more comfortable using the skills one-on-one because she believed them to be "build for like two people to three people."

Second, and also related to the number of children, was a concern for the potential to have an emerging crisis. This made it difficult to determine the appropriate time to set

a limit, as compared to the playroom where there is more freedom, "you want to give them a little bit of freedom, but yet you don't want them to get out of hand, which they will in 2 seconds."

Third, Sue reported that it was more challenging to use the skills in less contained environments such as outside which she described as, "There's too much going on there...And, and especially with this group." She noted that observations were primarily done during times when skill use was challenging and expressed frustration, "I felt like, well first of all, the situations when he'd [the observer] come made it really difficult to use those skills...and from the paperwork it looks like I'm not doing it. But it's not necessarily the case. You know like?" This suggests that Sue's perception was that she was using the skills, but not at the times when she was being observed, because those times were more difficult for her based on number of children, the children's location (i.e., "scattered" versus contained), and the environment (i.e., outside).

Mixed Methods Research Questions

Relationship Effects. Sue completed 23 STRS ratings over 23 weeks. There were no incomplete or missed assessments. Sue's total STRS scores increased in level from M=92 during baseline to M=98 in Phase B and M=97.35 for combined treatment and follow-up phases. This represents an increase from the 13th percentile to the 18th percentile between baseline and Phase B. Differences in trend between baseline (0.50) and Phase B (0.45), as well as baseline and total treatment plus follow-up (0.08) were minimal and all trends were positive. Variability, assessed visually, was low for most phases, including Phase B and treatment through follow-up. Phase C was highly variable (see Table 7 for a summary of all descriptive statistics). PEM for the total treatment

through follow-up was 85% suggesting a moderately effective treatment. PEM for Phase B was 100% suggesting the treatment was very effective (Scruggs & Mastropieri, 1998; see Figure H6 and Table 7).

Qualitatively, Sue reported that she was "taking away a new relationship with [her COF]" in which she got "to know [COF] for who he really is." She reported that he was more responsive to her than others as evidenced by her ability to communicate with him through a simple look. She said, "I can look at him and be like (makes a face), and he'll, he'll, almost like he snaps back into who he is…Like, 'Oh. What am I doing?'" This qualitative evidence supports the quantitative data suggesting an improvement in the relationship.

Sue's STRS scores on the Conflict subscale of the STRS decreased in level from M=34.67 during baseline to M=30.38 during Phase B and M=31.40 for all treatment through follow-up. This represents a change from the 84th percentile during baseline to the 79th in Phase B. Trends in the data were minimal and the differences between baseline and Phase B, as well as baseline and total treatment through follow-up were -0.04 and 0.18 respectively. Visually the data appear to be highly variable in only Phase C, moderately variable throughout treatment and follow-up, and minimally variable during other phases, including Phase B (see Table 7 for a summary of descriptive statistics). To compute PEM, values below the median were examined, due to the expected treatment effect of decreasing conflict scores. PEM was 88% for Phase B, a moderate effect and 60% overall, a mild effect (Scruggs & Mastropieri, 1998; see Figure H7 and Table 7). Qualitatively, Sue's experience of being able to communicate with her COF via a look indicates decreased conflict in their relationship.

Sue's STRS scores for the Closeness subscale increased in level from M=35.33 during baseline to M=37.75 in Phase B and M=38.50 throughout treatment and follow-up. This represents a change from the 15th to the 22nd percentile between baseline and Phase B. Trends in the data were similar across phases in magnitude with the exception of Phase C. Phase A (follow-up) had a slight negative trend in the data. Variability based on visual inspection ranged from low to high and was moderate for both Phase B and the treatment through follow-up periods (see Table 7 for a summary of descriptive statistics). PEM for Phase B was 75%, indicating the treatment was moderately effective (Scruggs & Mastropieri, 1998) and 80% for the entire treatment and follow-up phases, also moderate (Scruggs & Mastropieri, 1998; see Figure H8 and Table 7).

Qualitatively, Sue described increased closeness in her relationship with her COF. This was described as increased trust and instances where her COF would come to talk to her rather than go "into crisis" as he used to. In describing the trust that was built between her and her COF, Sue attributed it directly to the training, "So the trust, the trust is still there...And that's the effects of that [training] because he doesn't trust anybody." This qualitative evidence supports the evidence of a quantitative increase in the closeness in the relationship.

Table 7: STRS Descriptive Statistics for Sue

	Phase A (Baseline)	Phase B	Phase C	Phase A (Follow-up)	Treatment-Follow-up
Total Score					
M	92	98***	98*	95.83**	97.35**
Mdn	93	98.5	97	97	98
visual variability	low	low	high	low	low
slope	0.50	0.45	3.20	1.57	0.08
Conflict					
M	34.67	30.38**	30*	34.4	31.40*
Mdn	33	30.5	31	35	31
visual variability	low	low	high	low	moderate
slope	0.00	-0.04	-1.60	-0.49	0.18
Closeness					
M	35.33	37.75**	38.17*	39.83***	38.50**
Mdn	35	37.5	37	40.5	38
visual variability	low	moderate	high	low	moderate
slope	0.50	0.62	1.63	-0.20	0.21

Note. *=PEM suggests mildly effective treatment; **=PEM suggests moderately effective treatment; ***=PEM suggests very effective treatment

Perception of Behavior Problems. Perceptions of behavior problems were measured quantitatively using the TRF (Achenbach & Rescorla, 2001), which each RCW completed prior to and at the completion of Phase B (CTRT Phase I). No statistical results are presented, as the data are not group data. Sue's COF's initial scores on the TRF were: 83 (clinical) for internalizing behaviors, 72 (clinical) for externalizing behaviors, and 83 (clinical) for total. The second TRF administration yielded decreases on all scores, though all remained in the clinical range: internalizing behaviors were 73, externalizing behaviors 69, and total behaviors 75.

Qualitatively, Sue reflected that she thought her COF had been "really, really affected" by play sessions. She noted that he seemed more able to trust others and was

able to "just be him. To not have to pretend…in the playroom he was him." She reported

an increase in her COF's ability to care about others and the development of a

"conscience like where he didn't have that before coming in…Now he feels bad when he

does something wrong." Sue also noted that, in addition to her COF's behavioral

changes, her perceptions of him had changed from when he first came in. "My perception

of him was like oh God (laughs). This kid is going to be off-the-wall." However, "during

the play sessions, that front melted away." This qualitative data supports the quantitative

data that suggests an improvement in Sue's perception of her COF's behaviors. Sue

described a specific behavioral challenge for her COF in the ending of the play sessions,

noting that the trust seemed to decrease for a period of time, as well as his responsiveness

to her. She attributed that to a "disappointment factor" following the end of the play

sessions.

Symptoms of Burnout. Quantitative burnout was measured using the MBI-ES

(Maslach et al., 1996) which all participants took two times, once just prior to training

following the baseline phase and once following all training, just prior to the follow-up

phase. No statistical results will be presented, as the data are not group data. Sue's scores

on the three subscales of the MBI-ES for the first measurement were: 23 for EE, 2 for

DP, and 43 for PA. These are considered moderate EE, low DP, and high PA. This is not

indicative of high or low burnout, according to scoring guidelines. For the second

measurement Sue's scores increased on both the EE and DP subscales, suggesting

increasing symptoms of burnout. The scores were 39 (high) and 9 (moderate)

respectively. Sue's PA score decreased to 32, which is classified as moderate. Though

this suggests increasing burnout, this is still not indicative of high burnout. The

qualitative data provided by Sue contradicts some aspects of this quantitative data, as she reported a decrease in stress related to one of the specific effects of the training. She noted that this was because the skills learned helped her respond in a way that was less likely to escalate children. She stated, "It's a decrease in stress because the way I am handling something, it doesn't come out…the way it typically would…and gives me something to say instead of…[saying something that would contribute to] escalating them."

Summary

Sue perceived the CTRT positively. She sometimes found it difficult to change her old habits and the transition from working with one child to the group was difficult. She also reported a need for the training to have a transition time for the COF following the ending of the individual play sessions. Sue reported personal growth as a result of the training, including the ability to better manage frustration. Sue found the training useful, particularly limit setting and giving choices. She also reported the skills help her prevent crisis. Sue successfully integrated the CCPT skills into her classroom, though not at a high rate. Sue experienced increased closeness in her relationship with her COF, for which the quantitative and qualitative data provided evidence. She also perceived her COF more positively and found some aspects of his behavior (ability to care about others) improved. This was supported by decreased scores on the TRF, though all remained in the clinical range. Sue described continuing to work on her skills learned in CTRT.

Maggie

Maggie is a 27-year-old Caucasian female. She only had about 2 months of residential treatment experience at the time of the training. She conducted individual play sessions with an 8-year-old Caucasian male.

Quantitative Research Questions

Generalization of Child-Centered Play Therapy Skills. Maggie started treatment after 17 weeks (15 observations completed) in baseline conditions, during which she demonstrated a slightly higher level of CCPT skills ($M=1$) when compared to other participants, but still demonstrated no CCPT skills in the majority of the weeks (10 of 15). Skills used during the baseline period included: encouragement (seven times), reflection of content (five times), and choice giving (three times). Visual examination for changes in level, variability, and trend in the data was completed and the results suggested there were changes across phases. Maggie demonstrated increasing use of CCPT skills in the classroom setting across phases. Changes in slope of the least squares regression line show a variable but increasing trend toward improvement.

The level of CCPT skills demonstrated by Maggie increased from $M=1$ to $M=40.33$ in Phase C, and $M=38.33$ during follow-up. The slope of the least squares regression line changed from .08 during baseline to 18.50 during Phase C and 7.5 during follow-up. Variability of the data were high in Phase C, but decreased again during follow-up (see Table 8).

Table 8: CTRT-SC Descriptive Statistics for Maggie

	Phase A (Baseline)	Phase B	Phase C	Phase A (Follow-up)
M	1	2.14	40.33	38.33
Mdn	0	2	40	38
range	6	3	75	15
visual variability	low	low	high	low
slope	0.08	-0.36	18.50	7.50

PEM was calculated at 100% for all phase comparisons. All of Maggie's Phase B, Phase C, and follow-up CCPT skill demonstration exceeded the median. This suggests that, in Maggie's case, this was a very effective (Scruggs & Mastropieri, 1998) treatment for increasing CCPT skills in the classroom; see Figure 3).

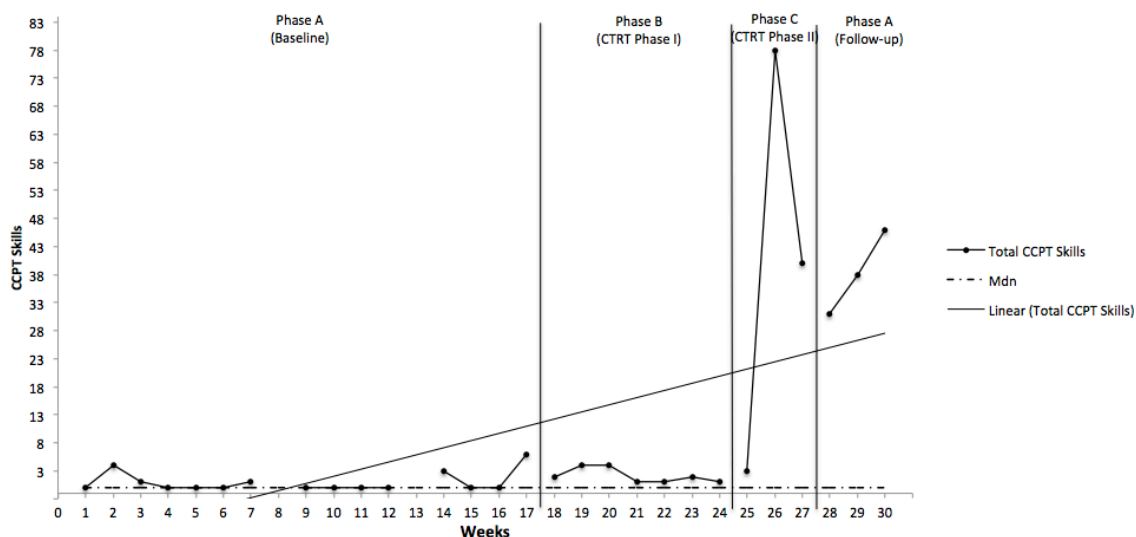Figure 3: Visual analysis and effect size for Maggie's CCPT skill demonstration

Demonstration of Empathy. Maggie completed 10 play sessions, three during baseline and seven during Phase B. These baseline play sessions were completed weekly, but were unable to be scheduled on the same day. Efforts were made to space the play sessions such that they were completed approximately 1 week apart. Phase B play

sessions were scheduled once per week. Three were rescheduled within the same week due to scheduling issues, but were spaced as close to a week apart as possible. Maggie's total MEACI score decreased from *M*=45.84 during baseline to *M*=25.14 during Phase B. Trends in the data, based on the least squares regression line, went from positive (3.50) to negative (-0.86) and variability was low in both phases (see Table 9). The treatment effect was immediately observable with a decrease of 24 points between the last baseline play session and the first Phase B play session. PND was 100% suggesting that this treatment was very effective at increasing Maggie's communication of empathy (Scruggs & Mastropieri, 1998; see Figure H2).

Maggie's scores on the Communication of Acceptance subscale also decreased from *M*=15.17 during baseline to *M*=10.29 during Phase B. Trends in the data, based on the least squares regression line, were positive (2.50) during baseline and slightly negative (-0.43) during Phase B. Variability was low during both phase (see Table 9). Treatment effect was immediate with a decrease of 7 points between the last play session of the baseline phase and the first of Phase B. PND was 100% suggesting that this treatment was very effective at increasing Maggie's communication of acceptance (Scruggs & Mastropieri, 1998; see Figure H3).

Maggie's scores on Allowing Self-Direction also decreased from *M*=19 during baseline to *M*=8.86 during Phase B. Trends in the data, based on the least squares regression line, were positive (1) during baseline and negative (-0.43) during Phase B. Visual inspection indicated low variability during baseline, but moderate variability during Phase B (see Table 9). The treatment effect was immediate with a decrease of 11 points between the last baseline play session and the first Phase B play session. PND was

100% suggesting that the treatment was very effective at increasing Maggie's allowance

of the child's self-direction (Scruggs & Mastropieri, 1998; see Figure H4).

Maggie's scores on the Involvement subscale also decreased from *M*=11.67

during baseline to *M*=6 during Phase B. Trends in the data, based on the least squares

regression line, did not exist for either of these phases. Visual assessment of variability

suggested that the variability was low during baseline and the Phase B data were not

variable at all (see Table 9). The treatment effect was immediate with a drop of 6 points

between the last baseline play session and the first Phase B play session. PND was 100%

suggesting that this treatment was very effective at increasing Maggie's involvement with

the child (Scruggs & Mastropieri, 1998; see Figure H5).

Table 9: MEACI Descriptive Statistics for Maggie

	Phase A (Baseline)	Phase B
Total Score		
M	45.83	25.14
Mdn	46.50	24
visual variability	low	low
slope	3.50	-0.86
Acceptance		
M	15.17	10.29
Mdn	14.50	10
visual variability	low	low
slope	2.50	-0.43
Allowing Self-Direction		
M	19	8.86
Mdn	19	8
visual variability	low	moderate
slope	1	-0.43
Involvement		
M	11.67	6
Mdn	12	6
visual variability	low	none
slope	0	0

Qualitative Research Questions

Perception of Training. Maggie expressed enthusiasm for the training stating, "And I was pretty pumped that there is this, this whole kind of revolution going on almost." She believed "it was just such a great approach to be thinking about," which she found overall to be "more genuine." Maggie really found the structure of the training helpful. She liked that the training was broken up into pieces and described it as follows:

> And breaking it down like we did um instead of just saying 'hey here's all of play therapy, let's just work on it all at once.' Breaking it down like we did and using, focusing on skills and building on it. I thought it was like scaffolded perfectly. That really helped cause it was natural once I got the hang of one thing, the next thing that followed, it built upon that foundation. And so I found that very helpful.

She also liked having some basic knowledge of all the skills at the outset, even though they were not covered in detail until later. She reported that this allowed her to make mistakes, which were helpful in her learning process, which initially took a little more effort. "Yeah it does take a little more effort and you, for me I had to really think about the situation…[I] wasn't able to respond quickly enough cause I hadn't had enough practice." Maggie also liked having the supervision meetings and receiving feedback closely following the in-class training, "while it's fresh."

Maggie believed that all parts of the training had value, but offered several suggestions to improve it. She reported she would like to see more of the classroom training. She also noted that "an overview training for all staff" would be beneficial to help create an environment where "the staff [are] trained or at least familiar with the techniques and, you know, having a leader [fully trained in the CTRT skills] in the, in the classroom." She believed that an environment where all staff members were at least aware of the skills being taught would facilitate her skill development. Finally, Maggie

expressed a need for "a step, not really a step-down program, but like after you have so much of one-on-one time, maybe two kids, and then maybe three, and then in a classroom. Like, you know, a little more of a gradual transition." This was because she was concerned about how her COF handled the transition at the end of the individual play sessions.

Perception of Impact of Training. Maggie stated that this training was a good fit "definitely for my personality and how I am" and that the training had the effect of "opening my eyes to a whole new way of approaching children." She reported several areas of personal growth including being more present and listening "a lot better." She felt "empowered" by the training.

She also reported growth in the area of awareness related to the children in the facility. One example was an increased awareness of the effects children experience as a result of interactions between them and the adults in the facility. In the same vein, she noted, "thinking about his [COF's] behaviors throughout everything is, is very valuable." She demonstrated awareness of her personal responses to the children when she talked about the need to "give yourself a couple of minutes before the play session…just like decompress" when "you and that kid were butting heads all day."

Maggie noted being more intentional in responses to children, "It made me think twice...It made me think twice about my response to almost like every situation." This was a change from her past behavior "where I would've probably been, not intentionally, but probably said something that kinda shut the kid down. It made me think twice about that."

Classroom effects described by Maggie included the skills as useful in preventing classroom crisis. She noted "a more calming effect in the classroom" where although "it didn't fix everything," it helped create an "encouraging, like supportive environment." When thinking of the idea of training everyone in the facility on these skills she stated:

> I think this could really decrease the amount of crisis we have because you know what they all, or not all of them, but most of them start at a point where it can be diffused. Early-er. But it boils up, and it's because I think our language and everything is not necessarily the language we should be using. I think this language would help.

She further noted this in describing specific in-class effects "so even if there is frustration, it didn't ever seem to get to the level where it had when we weren't using these techniques."

Related to effects on non-COFs Maggie observed that it helped the children feel "empowered," and "it was really cool to see how it affected each child so differently." As far as building relationships with the children, Maggie believed it helped her connect with the children, reporting:

> Like it's almost like unlocking a part of the kid. And they're like, 'Oh. They kinda understand me.' And you get into a place with them where you normally wouldn't be allowed to go, cause you're a grown up, and they're a kid. Like I feel like it more, it provides more of a connection and just kind of like, an, a, an understanding, like another level of understanding almost.

Maggie planned to continue to work on the skills. She wanted to challenge herself to continue to work on her use of the skills in groups. It was important to her "to you know kinda keep on top of it and keep it recent and not just let it fade away cause I really believe in it."

Usefulness of Training. Maggie found the skills learned in the training useful stating, "I think these techniques can be maximized in a lot of ways." In describing

specific uses of skills, she described "talking it out. Whether you go out in the hall or a little corner in the room, you know something and just really getting the feelings out, so it won't, you know you're not just putting a Band-Aid over it and eventually it piles up." She also used the skills to communicate acceptance to the children as described, "it just provides just a comfortable um inviting environment where you're valued no matter what. You're not judged based on your, you know, feelings, desires, wants, needs, whatever." She reported using feelings identification with the children when they are angry. Additionally, Maggie identified ways she used the skills to let children lead "instead of saying, "Here well let me do this and you do that" I would say, "well, how can I help you?" or "what would you like me to do?"

She also adapted letting the child lead for her work with the classroom and described some of the interactions with children where the use of this skill helped deescalate conflicts between them. She reflected that her way of intervening as little as possible and letting the kids "come up with a solution" was "kind of an extension of the play therapy. It's, it's, the kid led." Further, she found it useful that "it's not just like they give you, 'Okay here are 10 responses that you can use, and do not waver from this.' Like it gives you suggestions, but you can use that language so many different ways."

Maggie described her use of skills as all encompassing noting, "It has transcended into like most aspects of my life," and "I've kind of expanded it to any interaction that I have." She reported using it with children and adults, people she knows well and people with whom she has chance encounters. She stated that she plans to use it with her own children some day.

Challenges. Maggie found the change in language challenging indicating "the language is completely the opposite of what we were taught in orientation, what I was taught in school, everything." She reported a process in which she experienced not doing "it [right] the first, second, third time." Additional challenges were around the issue of environmental support for her learning the skills. These included explaining and justifying the skills to others, such as why play sessions with the COF were not rewards or consequences, as well as the challenges of a learning the skills when others are not trained. She reported having both partners in the classroom "having a knowledge of the approach" would have been helpful and potentially allowed her to have more time to formulate a response due to her partner's awareness of the skills. She summarized this by saying, "And so it's hard when your partner is sitting in the room, you know he or she doesn't really have an idea what you're doing. Isn't sure when to step in."

Maggie also struggled some with the transition from individual training to classroom use, noting the effects of having six children as providing a challenge. She reported feeling more confident in one-on-one interactions. Her request for expansion of the classroom portion of the training was based on it being "such a challenge."

Mixed Methods Research Questions

Relationship Effects. Maggie completed 17 STRS ratings over the course of 17 weeks. There were no missed weeks. Maggie's total STRS score decreased in level from M=107 during baseline to M=106.13 during Phase B and M=102.64 during treatment and follow-up inclusive. The change from baseline to Phase B represents a decrease from the 31st to the 29th percentile. Trends in the data were variable across phases, with a shift from -4.50 during the baseline to 1.11 during Phase B and -0.96 across treatment and

follow-up. Data variability assessed visually was moderate in all phases from baseline through Phase C and low in follow-up and overall treatment through follow-up (see Table 10 for a summary of all descriptive statistics). PEM for the total score was calculated at 38% for Phase B and 20% for the treatment through follow-up period. This suggests that the treatment was ineffective (Scruggs & Mastropieri, 1998; see Figure H6). Qualitatively, Maggie described her relationship with her COF as improving because of the training. She reported being "invested" in the relationship. This contradicts the quantitative data.

Maggie's STRS scores for the Conflict subscale of the STRS increased in level in all phases as compared to baseline. Baseline level was $M=22.67$ and the levels for Phase B and treatment through follow-up were $M=28.25$ and $M=29.50$ respectively. Trends in the data were variable, with the positive trend in baseline (1.50) shifting to a slight negative trend (-0.81) in Phase B. There was a slight positive trend in the Conflict subscale scores when treatment and follow-up were considered collectively. Data variability was determined via visual inspection to be moderate for both Phase B and the treatment through follow-up data (see Table 10 for a summary). PEM was calculated considering data points below the median from baseline, as the treatment would have been expected to reduce conflict scores. PEM was 0% for Phase B and 0% for treatment through follow-up, suggesting that the treatment was ineffective (Scruggs & Mastropieri, 1998; see Figure H7). Qualitatively, Maggie reported she sometimes felt frustrated because her COF was not improving as much as she had hoped. Describing the context of that feeling further as "it's like, you know, you know I've worked so hard and I thought we were doing good and you were loving these play sessions and you know we had a

great day yesterday and then it's all to heck." She reported in spite of knowing she should

not, sometimes she would take it personally that her COF was not improving as much as

she had hoped. This qualitative evidence supports the quantitative increase in conflict in

the relationship.

Maggie's STRS scores on the Closeness subscale increased in level from

M=40.67 during baseline to M=47.13 during Phase B. This represents a shift from the

30th to the 60th percentile. The shift in level from baseline (M=40.67) to the overall

treatment and follow-up (M=45.43) was smaller, but still positive. The change in trend

from -4 during baseline to 0.63 in Phase B represents a visually significant change.

However, the baseline variability is somewhat higher than other phases due to an outlier

score of 34 at Week 3. Additionally, the treatment through follow-up showed a slight

negative trend (-0.41) overall. Data variability in all treatment phases appeared low, as

well as in the inspection of the data during all treatment and follow-up (see Table 10 for a

summary of descriptive statistics). PEM was 100% for Phase B and 71% for the total

treatment and follow-up time. This suggests a very effective treatment and a moderately

effective treatment respectively (Scruggs & Mastropieri, 1998; see Figure H8 and Table

10). Qualitatively, Maggie reported an increase in closeness stating, "I felt very

connected" and, "We did. We got close." She also reported feeling somewhat protective

of her COF as a result of this closeness that developed during the play sessions

indicating, "I would get protective of him." This qualitative data supports the quantitative

data.

Table 10: STRS Descriptive Statistics for Maggie

	Phase A (Baseline)	Phase B	Phase C	Phase A (Follow-up)	Treatment-Follow-up
Total Score					
M	107	106.13	104	92	102.64
Mdn	110	105.5	103	92	103
visual variability	moderate	moderate	moderate	low	low
slope	-4.50	1.11	-2.50	-5	-0.96
Conflict					
M	22.67	28.25	27.67	34.67	29.50
Mdn	23	27.5	27	36	29
visual variability	low	moderate	low	low	moderate
slope	1.50	-0.81	0	3	0.32
Closeness					
M	40.67	47.13[***]	45[*]	41.33	45.43[**]
Mdn	43	47.5	44	42	45.50
visual variability	high	low	low	low	low
slope	-4	0.63	-2.50	-2	-0.41

Note. *=PEM suggests mildly effective treatment; **=PEM suggests moderately effective treatment; ***=PEM suggests very effective treatment

Perception of Behavior Problems. Perceptions of behavior problems were measured quantitatively using the TRF (Achenbach & Rescorla, 2001), which each RCW completed prior to and at the completion of Phase B (CTRT Phase I). No statistical results are presented, as the data are not group data. Maggie's COF's scores on the first administration of the TRF were: 55 for internalizing behaviors, 63 (borderline) for externalizing behaviors, and 62 (borderline) for total behaviors. On the second administration the scores changed slightly, with two increasing (externalizing and total) and one decreasing (internalizing): internalizing 53, externalizing 66 (clinical), and total 63 (clinical). Maggie noted that changes in her COF were inconsistent and said, "I had hoped that it would've had a little bit more of an impact." Sometimes she thought he was

improving and other times she believed he was not, but she stated that he was not getting any worse overall. However, she stated, "Sometimes it [changes in behavior] was almost dramatic in a negative way." She reported noticing positive changes in his behaviors when he was by himself, but not in the group environment. "I saw him change as an individual, like when he was kinda by himself." However, "it was still like the peer interaction piece…it almost became more difficult at times."

In the play sessions, about which she reported her COF was "really excited," she perceived him as innocent. Further, she observed, "whenever we would go back in right afterward, he was just a lot calmer." This suggests that she was able to notice immediate effects of the play sessions, but that the overall effects were inconsistent.

Maggie's COF had some difficulty with the transition from the individual play sessions to the classroom environment. She attributed this to the loss of the play sessions suggesting, "I feel like there's this other part about a loss or you know something that I'm like well did, was it too much? And then taken away?" One other struggle mentioned was when Maggie was leaving her job. She noted during that time her COF was "having a really rough time…everything would set him off." This inconsistency in improvement with continued challenging behaviors in some environments supports the inconsistent quantitative evidence with some improvement and some deterioration, both of which were relatively small.

Symptoms of Burnout. Quantitative burnout was measured using the MBI-ES (Maslach et al., 1996) which all participants took two times, once just prior to training following the baseline phase and once following all training, just prior to the follow-up phase. No statistical results are presented, as the data are not group data. Maggie's scores

on the first administration of the MBI-ES were: 28 for EE (high), 6 for DP (low), and 40 for PA (high). This is not indicative of high or low burnout, according to scoring guidelines. However, the high EE score is one component of high burnout. For the second measurement Maggie's scores increased for both the EE (35) and DP (12) subscales and decreased slightly for the PA (39) subscale. The EE rating remained high, while the DP rating increased to moderate. PA remained high. Although this still does not indicate burnout, according to the scoring guidelines, the high EE score and increasing DP score are moving in the direction of what would be considered high burnout.

The qualitative evidence does not support this change evidenced by the quantitative data, as Maggie described the training as making "my job easier and…more manageable to me." She also reported the training has the potential to reduce stress. This was noted in her description of the training having a "calming effect" and being "a good stress reliever and it's calming. Because it's not, you know not just with the kids, but just for yourself, too."

Summary

Maggie perceived the CTRT positively. She believed it was structured well as far as her personal learning, but noted she would have liked to see a transition time for the COF following the individual play sessions as well as having the other staff have some knowledge of the approach. Maggie sometimes found it difficult to change her old ways of responding, as well as transition from work with one child to the whole group. She reported personal growth in the area of being more present, a better listener, and more intentional in her responses. She found the training useful, particularly identifying feelings and letting the child lead. She also thought the skills were useful in helping to

create a calm environment which has the potential to reduce crisis. Maggie successfully integrated the CCPT skills into her classroom. She experienced closeness in her relationship with her COF, which was described qualitatively and supported quantitatively by the STRS Closeness subscale scores. She did not think her COF improved as much as she had hoped as a result of the play sessions, and any improvements she noticed were largely when he was not around peers. She reported he still had difficulties when with other peers. The STRS Conflict subscale score indicating the treatment was ineffective, as well as the TRF, which had little change, but decreased slightly in the total score, corroborate this description of inconsistency. Overall, Maggie's MBI-ES scores indicated increasing burnout, which was contrary to qualitative evidence in which she noted the CTRT made her job easier and reduced stress. Maggie hoped to continue working on these skills and improving her use of them.

<center>Cross-Case Synthesis</center>

After being considered and analyzed as separate cases, the qualitative and quantitative data were considered together. Qualitative data were organized into themes and compared across participants. This section will cover the cross-case comparisons organized by research question.

Quantitative Research Questions

Generalization of Child-Centered Play Therapy Skills. Kratochwill et al. (2010) suggest visual analysis of level, trend, variability, overlap, immediacy of effect, and consistency of data pattern before determining if a treatment is effective. Considered collectively via visual inspection all three cases demonstrated a change in level, though it was much higher for Maggie and Jefferson than Sue (see Figure H1). All participants also

demonstrated changes in trend of the data with the baseline phases having slopes very close to zero and the treatment phases, particularly Phases C and follow-up having positive and sometimes steep slopes. Variability was inconsistent across the cases and in two of the three (Jefferson and Sue) increased over the course of treatment and with Maggie increased into Phase C and then decreased in follow-up (see Figure H1).

Related to overlap, these three cases demonstrated a range of effectiveness according to the PEM individually. Results indicated that the treatment showed at least some effectiveness during Phase B in increasing CCPT skills in the classroom for two participants (Jefferson and Maggie) and was ineffective at increasing CCPT skills in the classroom for Sue. During Phase C, the treatment was mildly effective for two participants (Jefferson and Sue), and very effective for the third (Maggie). During Phase A (follow-up), the treatment was very effective for two participants (Jefferson and Maggie) and mildly effective for Sue. The combination of Phase C and the follow-up yielded PEMs that suggest a range of effectiveness: mild for Sue, moderate for Jefferson, and very effective for Maggie. When the data were examined for data patterns, the following similarity emerged. Change appeared to take place approximately halfway through Phase C (CTRT Phase II) and continue throughout Phase A (follow-up; see Figure H1).

Demonstration of Empathy. Kratochwill et al. (2010) suggest visual analysis of level, trend, variability, overlap, immediacy of effect, and consistency of data pattern before determining if a treatment is effective. Considered collectively all of these cases show a change in level from baseline to Phase B for the total as well as subscale scores (see Figures I2-I5). Changes in trend were more variable across cases, but in most cases a

negative trend was observed in the Phase B data, suggesting that the scores were decreasing and that there was an increasing treatment effect. Variability was generally low (see Figures I2-I5). The changes in scores were consistent across participants for the total and subscale scores. These changes occurred between the last baseline play session and the first Phase B play session. The treatment effect was immediately and consistently observable. Finally, the PND was 100% for the total score and all subscales across participants, suggesting a very effective treatment (Scruggs & Mastropieri, 1998). Collectively, these scores represent consistent changes in level with no data overlap between phases.

Qualitative Research Questions

Perception of Training. Data from analysis of the poststudy interview resulted in the generation of themes. The generated themes were: (a) *general reactions*, (b) *learning*, and (c) *suggestions for change*. The following section includes a comparison of participants based on these themes and their responses within those themes.

- General Reactions. All three participants reflected positively on their experiences with the training. Jefferson experienced the training as something in which "I learned a lot" and that was "beneficial to me." Sue "thought that it was a good added piece to something I was missing." Maggie described the training as "this was just, it was so, it was just so great." These positive reflections carried over into Sue and Maggie's reported recommendation of the training to others. Maggie reported that she "would highly recommend it" and Sue that she thought it "would be really good to learn for everybody here." No one recommended the removal of any specific part of the training, with Jefferson stating, "I felt like it was, I mean…everything was beneficial," and

Maggie reporting, "It was all valuable." Overall, this theme of participants' *general reactions* to the training suggested they perceived the training as helpful and beneficial to them, and possibly beneficial to others.

- Learning. All three participants talked to some extent about the process of learning throughout the training, though it was most prominent in Maggie's reflections on the training. Maggie found the structure of the training helpful to her learning process from having follow-up meetings with the trainer shortly after practice sessions to the way skills built on each other.

Both Maggie and Jefferson reflected a learning process characterized by becoming more comfortable with the skills over time, which requires practice. Maggie noted, "Yeah it does take a little more effort and you, for me I had to really think about the situation…[I] wasn't able to respond quickly enough cause I hadn't had enough practice." Jefferson reflected on the results of that process stating, "I realize well the more I did it, the more I felt like it became easier." All three participants reflected to some extent on the process of working to change the way they were used to doing things.

Both Maggie and Sue reflected on the importance of the trainer in the learning process. Maggie spoke of the proximity of the supervision by the trainer to practicing the skills. Sue made reference to this by noting other situations in which she would have liked to have the trainer present so that she could observe the trainer's way of handling a situation (e.g., "I woulda liked to see you do that so that I can pick up on how that works"). This specific mention of the importance of the trainer was not present in Jefferson's interview. Overall, the three participants all reflected on their *learning* during the training process.

- Suggestions for Change. Two of the three participants had suggestions related to changing what was offered in the training itself, but Jefferson did not make any suggestions related to the training offerings. He reported thinking it would be appropriate to provide "more prep for the kids [non-COFs in the classroom]. Just as far as like letting them know what they are about to be involved in." Maggie and Sue both reported a desire to see a better transition period for the COF following the individual play sessions included in Phase B of the training. Sue spoke the most strongly about this:

> And when talking about what things need to change with this, it's that transition period. Because that really affects the kid. To go especially a kid like [her COF] who his, it's like a roller coaster ride. You know like I'm really excited somebody's seeing me somebody's noticing me someone's taking the time to be with me. It's gone. And that was really hard for [her COF]. And I think um that, that kind of signifies people leave. You know what I mean? Like things end. Um.

Both Maggie and Sue expressed a desire for that change to be gradual for their COFs, with Maggie noting a structure that resembled a "step-down program" where "after you have so much of one-on-one time, maybe two kids, and then maybe three and then in a classroom." Jefferson did not identify a need for a transition time. Maggie and Sue also reported a desire for more training in the group environment, which was not identified by Jefferson. According to Maggie, "to have like more time to do it in the classroom too would be really, I think, very, very beneficial." Sue's concerns for more group training time were related to a desire to have training within all the different groups and environments in which she works.

There were two reflections that were unique to the individual participant. Maggie reflected on something different from the other participants, suggesting that she would like to see at least an overview training for the entire staff so there would be additional

support in using the skills learned in the training. Additionally, Sue would like to see ongoing "refreshers" integrated into the training process.

Overall, all three participants had *suggestions for change* during their individual interviews. Some suggested changes were the same across participants (e.g., Maggie and Sue both wanted more group training and a gradual transition from individual play sessions to group work for their COFs) and some unique to one participant (e.g., Sue's suggestion for ongoing "refreshers"). Jefferson did not make any specific suggestions for changes to the training itself.

- Summary. The themes related to the participants perceptions of the training included: (a) *general reactions,* (b) *learning,* (c) and *suggestions for change*. Collectively, the participants reflected on their experiences with the training as positive and described experiences related to *learning* during the training. They made *suggestions for change* such as including more training on using the skills in groups (Maggie and Sue) and creating a better transition period for the COF (Maggie and Sue) between individual play sessions in Phase B and the classroom focus found in Phase C (see Appendix G for study structure).

Perception of Impact of Training. Data from analysis of the poststudy interview resulted in the generation of themes. The generated themes were: (a) *personal growth/development insight and awareness*, (b) *continued development*, (c) *effects on non-children of focus* and (d) *effects in the classroom*. The following section includes a comparison of participants based on these themes and their responses within those themes.

- Personal Growth/Development of Insight and Awareness. All three

participants reflected on their own personal growth and new awareness gained as a result

of the training. As a general reflection on this development of awareness, Jefferson

stated, "I think it made me more, in a sense, aware of um of certain things, just things that

I don't feel, like in the beginning I didn't pay attention to." More specifically Sue became

more aware of the children's patterns reflecting, "It's helped too um recognizing and

being more aware of the patterns of the kids." Similarly, Maggie reported being more in

tune with children's behaviors noting, "Thinking about his [COF's] behaviors throughout

everything is, is very valuable." Both Maggie and Jefferson reported an increased

understanding of the children's feelings with Jefferson noting, "I think it makes me more

understanding of um that they really do feel like this." Maggie further explored this

concept reflecting on how specific responses might affect a child:

> Like if they're frustrated, they're not just frustrated, most, 99% of the time they're not just frustrated, because they just want to be a pill. They… There's like… I mean sometimes yes, but there is usually a solid reason, and it's deep down and so it's kind of like peeling an onion. And I know we've used this analogy a lot. But like, you know, frustrated over cutting something out isn't just about cutting it out. It's something deeper than that. And so responding in a way that just shuts it down, that's not helping. It's probably even making it worse.

All three participants reported that the training helped them choose better

responses to children. Jefferson noted:

> And I think what happens is um by me being more in tune with you know feelings, you know I think that kind of helps me with what my next word will be. You know to, to kinda help them through that feeling or you know I think I'm more mindful of what I'm going to say instead of just like you know um kind of saying the, the same routine thing.

Maggie reported the concept of thinking twice before speaking, "So, it made me think

twice...it made me think twice about my response to almost like every situation." Finally,

Sue experienced this ability to choose better responses to children as "something that allows me to stay calmer and not react so quickly to the situation in a negative way."

Overall, each participant reported growing personally as a result of this training, both in specific understandings of children and increases in self-awareness or insight. Personal growth in general included reflections such as, Jefferson felt "more understanding," Sue less "frustrated in chaotic situations" and Maggie more "empowered" and "present." These changes were all described as a result of the training itself.

- Continued Development. All three participants reflected on the fact that they have not mastered the skills learned in the training and are still growing in their use of them. They also reported a plan to continue working on their proficiency in using the skills from the training. Jefferson reported that he didn't "feel like I've quite mastered it yet," that he "still refer[s] back to the packet [given to him in the training]," and believes that at some point he will develop increased proficiency in the skills. Sue reported that she, too, was continuing to work on the skills and is working on "having that awareness of, 'Wait don't say that, replace it with this instead,'" which she notes to be "an ongoing process." Maggie plans to "keep on top of it and keep it recent and not just let it fade away, cause I really believe in it."

- Effects on Non-Children of Focus. The effects that participants noticed on children who were not their COFs were both specific to their relationships with those children, as well as general observations of the effect of their use of the skills learned in training on non-COFs. Jefferson and Sue focused primarily on their relationships with non-COFs, and Maggie focused on both general observations and relationships. Maggie

talked about her use of the skills affecting the children's ability to resolve conflict among themselves, that children felt "empowered," and though "not every kid got the same out of it…it didn't hurt anything." In other words, this difference was not negative. Specific to relationships with non-COFs all participants noticed effects, particularly in the area of building trust. Jefferson reported that he was able to create trust with non-COFs by "making sure that you know, um I acknowledge feelings because…it creates a trust." Sue, too, noticed the effect of the training on non-COFs in the area of trust stating, "And also it helps, you know, form relationships with whoever you're working with in the area of trust. And if you're working with this population, it's everything." Maggie reported similar effects in relationships with non-COFs:

> Like it's almost like unlocking a part of the kid. And they're like, 'Oh. They kinda understand me.' And you get into a place with them where you normally wouldn't be allowed to go, cause you're a grown up, and they're a kid. Like I feel like it more, it provides more of a connection and just kind of like, an, a, an understanding, like another level of understanding almost.

This suggests that in the area of *effects on non-children of focus*, the participants seemed to find that the children were better able to trust and connect with them.

- Effects in the Classroom. All three participants noticed effects of the training on their classroom environment. For Jefferson, this was reflected in the description of the skills becoming "the language in our classroom," as well as the "norm in the classroom." Maggie and Sue talked of the ability to use the skills learned in the training in the classroom to prevent crisis escalation. Sue agreed this was somewhat of a domino effect that could happen in the classroom:

> With those being so highly reactive, if you don't stop the one that's starting quickly, you lose them all. And so it's really important to be aware of those other skills you can use…where the 'I know you're upset, I know you're expressing the feeling.' With them, that's the main thing. They want to know that you hear them.

Maggie described the situation similarly:

> I think this could really decrease the amount of crisis we have because you know what they all, or not all of them, but most of them start at a point where it can be diffused. Early-er. But it boils up, and it's because I think our language and everything is not necessarily the language we should be using. I think this language would help.

Both Maggie and Sue thought these skills could prevent children being removed from the room and according to Maggie, "[skill use] creates almost just more of like a calm environment. And an encouraging, like supportive environment." Although all three participants noticed effects of the training in their classroom, this crisis prevention aspect was unique to Maggie and Sue, but was emphasized by both of them.

- Summary. Overall, all three participants reflected on their *personal growth/development of insight and awareness* as a result of the training. They plan to continue to work on improving their use of the skills learned in the training as reflected within the *continued development* theme. Further, they noticed *effects in the classroom* related to their training, as well as positive *effects on non-children of focus*.

Usefulness of Training. Data from analysis of the poststudy interview resulted in the generation of themes. The generated themes were: (a) *usefulness of skills*, (b) *adapting skills for the environment*, (c) *non-work generalization of skills*. The following section includes a comparison of participants based on these themes and their responses within those themes.

- Usefulness of Skills. All three participants described the skills as useful for them. These descriptions were both general and related to specific skills. Jefferson, unlike Maggie and Sue, did not describe the usefulness of the skills in general, but reflected on the use of specific skills. Generally speaking, Maggie described using the skills in

conversations with children, "Like I get a lot more from just kinda sitting and like really being focused and intent and using like encouraging responses or responses that open the conversation rather than close it," and Sue reported using "the skills in chaotic situations" as something beneficial to her. Participants touched on their use of specific skills, too. Jefferson found limits useful and described them as "my most valuable tool…that I had." He also described identifying feelings as "one of the biggest things that I've gotten out of the, the training." Maggie, too, found the use of identifying feelings helpful and described specific situations in which she used this skill. She also reported situations in which she let the children lead such as, "instead of saying 'here let me do this and you do that,' I would say, 'Well, how can I help you?' or 'What would you like me to do?'" As far as specific skills, Sue found limit setting and choice giving helpful and described her use of them.

Only Jefferson reported finding a skill less useful. He reported the following related to giving choices:

> One thing that I felt like was not so valuable is the, the choice, like giving the choices. Um. Just because um I don't know I think sometimes it kinda felt like they kind of took advantage of, you know, me, you know, giving choices and things like that. Like if almost, almost like they kind of manipulated the situation.

In summary, the participants found the skills useful in both general and specific ways, and one participant found choice giving to be less useful than the other skills. Maggie and Sue spoke of the skills in general, as well as mentioned some specific skills, and Jefferson spoke of only specific skills and his use of them. Specifically, the three participants described together their use of skills such as identifying feelings, giving choices, setting limits, and letting the child lead.

- Adapting the Skills for the Environment. Two participants, Maggie and Jefferson, described ways that they adapted the skills to suit their specific environment. Jefferson described adapting the way he structured teaching the children gardening by using a limit setting structure to explain the guidelines for the use of gardening tools reporting, "It was very beneficial for me you know to try to, you know, incorporate safety rules by setting limits." Maggie used letting the child lead in a variety of situations, rather than taking control and solving the problem, which she described as "kind of an extension of the play therapy. It's, it's, the kid led." She also noted that she appreciated the adaptability of the skills, because "it gives you suggestions, but you can use that language so many different ways." Though only two of three participants talked about this, *adapting skills for the environment* suggests that participants were able to take these skills beyond their original use and apply them to different situations in their workday.

- Non-Work Generalization of Skills. All three participants described situations in which they used their skills learned in training outside of their work environment. All three reported using skills with family members. Maggie described this as a more all-encompassing than the other two participants, stating, "It has transcended into like most aspects of my life," and "I've kind of expanded it to any interaction that I have."

- Summary. In describing the usefulness of the training, participants seemed to find it useful. They spoke of the *usefulness of skills* in general (Maggie and Sue) and specific terms (all three participants). Only Jefferson found a specific skill not as useful as others. Two participants (Jefferson and Maggie) seemed able to adapt the skills to some extent and use them in ways that were suited to their specific work with children. Finally, all three participants described instances of *non-work generalization of skills.*

This suggests that the participants found the training useful and were able to describe specific instances of its usefulness.

Challenges. Data from analysis of the poststudy interview resulted in the generation of themes. The generated themes were: *challenges of learning skills* and *challenges of generalizing skills to groups.* The following section includes a comparison of participants based on these themes and their responses within those themes.

- Challenges of Learning Skills. All three participants experienced challenges related to learning the skills, noting the effect of changing old ways of doing things. Jefferson said he was "used to doing something one way" and the CTRT was different. Sue described it as changing "the whole language of things that I'm used to," and Maggie indicated her experience as dealing with "language [that] is completed the opposite of what we were taught in orientation, what I was taught in school, everything." Unique to Maggie was the experience of integrating the skills in the environment. She noted, "And so it's hard when your partner is sitting in the room, you know he or she doesn't really have an idea what you're doing. Isn't sure when to step in."

- Challenges of Generalizing Skills to Groups. One challenge reported by all three participants was the challenge of transitioning from working with their individual COF to working within the group. Jefferson described this specifically as the "one-on-one to transition into the classroom." Per Sue, the number of children carried an inherent risk of crisis escalation not present in individual sessions, and she had to decide more carefully how to use the skills, such as limit setting. She reported, "You want to give them a little bit of freedom, but yet you don't want them to get out of hand." Maggie, too,

experienced this noting the effects of having six children to deal with as more challenging.

- Summary. All three participants reported *challenges of learning skills* and *challenges of generalizing skills to groups*. The *challenges of learning skills* were similar across participants and were related to changing old habits for all three participants and the environment for Maggie. All three participants also experienced *challenges of generalizing skills to groups* which were affected by the number of children (all three) and the changing nature of their daily activities (Sue).

Mixed Methods Research Questions

Relationship Effects. Overall, based on the PEM only 1 of 3 participants (Sue) showed a positive result on the STRS total score (PEM of 100% in Phase B and of 85% for treatment through follow-up). This is congruent with qualitative data where she reported she took "away a new [positive] relationship with [COF]." However, Jefferson and Maggie's lack of STRS total score effects were inconsistent with qualitative data as they too reflected positively on their overall relationships with their COFs noting "very high attachment" (Jefferson) and "We got close" (Maggie).

Only Sue showed positive results on the Conflict subscale of the STRS with a PEM of 88% in Phase B and 60% for treatment through follow-up. This too was supported by her description of being able to communicate with her COF and help him correct misbehavior with merely a look. The lack of improvement in the conflict subscale for Jefferson and Maggie is supported by their perception of ongoing challenges in their relationships with their COFs. Maggie noted some frustration with a lack of progress and

Jefferson reported that his COF sometimes looked to him to "get him out of certain things."

Finally, 2 of 3 participants (Sue and Maggie) showed positive results on the Closeness subscale according to PEM during Phase B with Sue at 75% and Maggie at 100%, as well as treatment through follow-up with Sue at 80% and Maggie at 71%. Qualitatively, all three participants described a closer relationship with their COF in some way. This description was congruent with the STRS Closeness subscale scores for Sue and Maggie, in which there was a score increase, but not congruent with Jefferson's score, which decreased. The closer relationship was described by Jefferson as his COF having "very high attachment," by Sue as a "new [positive] relationship with [COF]," and Maggie as, "We got close."

Overall, there were some results that were supported both quantitatively and qualitatively (e.g., closeness in the relationship for Maggie and Sue). There were some results that were conflicting (e.g., overall relationship perceptions for Jefferson and Maggie). Results were inconsistent across many of the scales of the STRS, and there is not enough information to determine a treatment effect with quantitative data alone (see Figures I6-I8).

Perception of Behavior Problems. TRF results for Jefferson indicated a perception of increased problematic behaviors related to his COF. Though he reported the play sessions were beneficial for his COF, he denied behavioral improvements and noted an increase in some challenging behaviors (e.g., "I found him to be more bossy to his peers"). The quantitative and qualitative evidence largely support each other, in spite of Jefferson's indication that the play sessions were beneficial for his COF.

Like Jefferson, Maggie's perception of her COFs behaviors was consistent with the TRF total score increasing. Although this increase was only one point, it resulted in a change from borderline to clinical range. Maggie reported, "I had hoped to see more…of a…I don't know if transformation's the right word, when he was playing with others I still kept seeing the same behaviors like reoccurring." Sue's perception of her COF's behaviors was also consistent between quantitative and qualitative data, and her perception of her COF's behaviors was the only one that improved across the TRF scores, though it remained clinical. She reported perceiving him differently and noticing a "big change."

Overall, 2 of 3 of the participants' perceptions of their COFs behaviors deteriorated. The quantitative and qualitative data were consistent in all cases. Finally, the COF/participant pair that experienced improved TRF scores (Sue and her COF) remained in the clinical range.

Symptoms of Burnout. The quantitative and qualitative data related to RCWs' experiences with burnout were somewhat contradictory. Each participant reported some positive job-related effect of the CTRT including: "Understanding their feelings…makes it easier for me to kinda help them," (Jefferson); "It's a decrease in stress," (Sue); and "It made my job easier and made it more manageable to me," (Maggie). However, Jefferson's MBI-ES scores increased slightly with Emotional Exhaustion remaining high (one symptom of burnout); Sue's increased indicating increasing burnout, which was not yet high; and Maggie's also increased indicating increasing, but not yet high, burnout. Overall, there was conflicting evidence related to the effects of the CTRT intervention on symptoms of burnout.

Summary

Overall, the quantitative and qualitative data supports that participants were able to integrate the CTRT skills into their classrooms and increase their demonstration of empathy in play sessions with their COF. The qualitative data showed that participants experienced the training as positive and had some suggestions for its improvement. There were some challenges in learning the skills, but all participants hoped to keep growing in their ability to use them. They reported feeling closer to their COF, though this was not consistently supported quantitatively. The changes in perceptions of their COFs' behaviors were not evidenced quantitatively and inconsistent across participants qualitatively. Finally, the effect on their symptoms of burnout was not quantitatively evident, though each described at least one positive job-related effect of the training. Overall, there were benefits to the training including, skill use, participant reactions, increased demonstration of empathy, and some challenges including, inconsistent effects on COF behaviors, and questionable effect on symptoms of burnout.

CHAPTER 5: DISCUSSION

The purpose of this study was to investigate the effects of Child Teacher Relationship Training (CTRT; Morrison, 2006) in a residential treatment environment. More specifically, the purpose of this research was to investigate three main components of the effects of CTRT in residential care for children and adolescents: (a) effects on the relationship between the child of focus and the residential care worker (RCW) participants, (b) ability of RCWs to use relationship skills learned in the training when interacting with groups of children, and (c) the effects of CTRT as perceived by RCWs. The research design was fully mixed concurrent dominant status mixed methods approach (Leech & Onwuegbuzie, 2009). This mixed methods design included both a multiple baseline across participants single-case experimental research design, which was the dominant methodology, and a holistic multiple-case study (Yin, 2014). By mixing methods, this study was able to best examine the experiences of the participating RCWs, the effects of the CTRT on the RCWs and the children in residential treatment, and the relationship between the RCWs and children in residential treatment. The following chapter will include a discussion of the results. First there is a brief summary of the results as a whole. Following that, this chapter is organized by research question to best situate the findings in the existing literature. Within each section, the results will be briefly summarized, prior to the exploration of those results. Additionally, study limitations will be presented, along with contributions of the study, recommendations for adapting CTRT further, and recommendations for future research.

Discussion of Results

Quantitative Research Questions

Generalization of Child-Centered Play Therapy Skills. All three participants were able to demonstrate child-centered play therapy (CCPT) skills in the classroom per the Child-Teacher Relationship Building Skills-Center Time Observation Form (CTRT-SC; Morrison, 2006). Changes began to occur approximately midway through Phase C, the portion of training devoted to classroom skills (see Appendix G for study phases and Figure H1 for total CCPT skills). This was Week 4 for Jefferson, Week 4 for Sue, and Week 2 for Maggie (who only had a 3-week Phase C training). The treatment ranged from mildly effective to very effective (Scruggs & Mastropieri, 1998) based on the percentage of data points exceeding the mean (PEM; Ma, 2006), and Jefferson and Maggie's use of skills was much higher than Sue's (see Figure H1).

Both Maggie and Jefferson were able to increase their use of CCPT skills to a higher number of skills per CTRT-SC observation in Phase C and Phase A (Follow-up) than Sue (see Appendix G for study phases and Appendix H1 for total CCPT skills). There are several possible explanations for this. Sue reported in her prestudy interview that "I process things slower, so like and I'm a thinker." She also shared throughout training that it takes her longer to process her thoughts and thus articulate her responses. In her poststudy interview she stated, "Having that thought process in the moment was very difficult for me." Additionally, both Maggie and Jefferson have an educational background (social sciences and education respectively), as well as a more extensive history of work with children that may have affected the ease with which they increased their use of skills quickly.

In addition, Sue indicated the times she was observed were times that felt very challenging to her related to using the skills, "I felt like, well first of all, the situations when he'd [the observer] come made it really difficult to use those skills...and from the paperwork it looks like I'm not doing it. But it's not necessarily the case." It is possible that Sue was using the skills more frequently as she described, but in other situations and in more contained environments. Further, it is possible she needed a bit more time and practice to increase her comfort with the skills. This was consistent with reflections that Maggie made throughout the training process that described her experience of generalizing the skills to different environments. As she learned to generalize the skills in the classroom, she would indicate that she was becoming more comfortable using them in one role (e.g., unstructured time with small groups of kids) and decide to focus on her next challenge (e.g., instructional time), followed by her next challenge (e.g., transition times). Also, some of the participants reflected to me during the training that they felt most comfortable practicing the skills with their own group of children, as opposed to when they were with groups they did not know as well. This suggests that it may have been challenging for the participants to generalize the skills in different environments and with different children, and they may have needed more support and training across situations, particularly as all were able successfully use CCPT skills to demonstrate empathy in individual play sessions.

Also of note is the fact that each participant's results related to demonstrating CCPT skills in the classroom appeared to be trending upward. The slope for Phases C and A (Follow-up) were positive and larger than Phase A (Baseline) or Phase B (see Appendix G for study phases and Tables 2, 5, 8 and Figure H1). Only Maggie

experienced a higher positive slope for CCPT skills in Phase C than Phase A (Follow-

up), and the positive trend in her skill acquisition in Phase C was much greater than Sue

or Jefferson. Collectively, it seems as though the participants were continuing to get more

comfortable with and use the skills more, even during the non-intervention phase. This is

supported by their reflections that they were continuing to grow in the use of skills (e.g.,

Sue's reference to an "ongoing process" of learning and Jefferson's indication that he

"still refer[s] back to the packet [given to him in the training]").

The RCWs' ability to demonstrate CCPT skills in the classroom is consistent with

findings in the CTRT literature that suggest that teachers are able to generalize the skills

to a classroom environment (Helker & Ray, 2009; Post, McAllister, Sheely, Hess, &

Flowers, 2004). Additionally, the RCWs in this study were able to maintain those skills

during the no intervention follow-up Phase A (6 weeks for Jefferson and Sue and 3 weeks

for Maggie). This is also consistent with the findings from Helker and Ray (2009) in

which teachers maintained skills during the no intervention follow-up period of 10

weeks.

Demonstration of Empathy. All three participants were also able to demonstrate

increased empathy during their individual play sessions. Each participant's scores

decreased on the Measurement of Empathy In Adult-Child Interactions (MEACI;

Bratton, 1993; Stover, Guerney, & O'Connell, 1971). The treatment was very effective

(Scruggs & Mastropieri, 1998) based on the percentage of non-overlapping data (PND;

Scruggs, Mastropierei, & Casto, 1987) of 100% for all participants on the total and all

subscale scores (see Figures H2-H5). These changes were immediate upon the start of the

CTRT intervention and did not return to baseline levels at any point during the

intervention. Though this was not a qualitative or mixed methods research question, the qualitative data did support the MEACI results, with each participant expressing during the poststudy interview a new understanding of the children's feelings. Jefferson described himself as "more in tune with feelings" following the training; Sue described a situation where she was talking with a child and "using the skills…to…show that I saw her emotion;" and Maggie expressed her understanding that children's emotions are real and should not be ignored, "They're not just frustrated because they just want to be a pill…there is usually a solid reason…And so responding in a way that shuts it down, that's not helping."

These results are consistent with what was found with undergraduate teacher trainees (Brown, 2000) and teachers of deaf and hard of hearing children (Smith & Landreth, 2004), where participants who received training scored lower on the MEACI total score and all subscale scores when compared to control group participants. This is also consistent with Post et al. (2004) where teachers with training scored lower on the MEACI total score when pretest and posttest scores were compared. Finally, this is consistent with findings in the Child Parent Relationship Therapy (CPRT; Landreth & Bratton, 2006) literature in which parents dealing with a wide variety of issues are able to demonstrate increased empathy (e.g., Carnes-Holt, 2010; Costas & Landreth, 1997; Landreth & Lobaugh, 1998).

Qualitative Research Questions

Perception of Training. The themes generated in the analysis of the poststudy interviews were: (a) *general reactions*, (b) *learning*, and (c) *suggestions for change*. All three participants perceived the training as positive, which is similar to teachers in

Sepulveda, Garza, and Morrison's (2011) study of teacher perceptions of CTRT, as well

as the parents in several CPRT studies (e.g., Bavin-Hoffman, Jennings, & Landreth,

1996; Wickstrom, 2009). Although participants from this study did not mention the time

commitment for the training, as participants in Morrison and Bratton (2010) did, their

positive perceptions of the training (e.g., Jefferson's reflection that "I learned a lot," and

Maggie's that "everything was beneficial") are consistent with participants from

Morrison and Bratton who thought that completing the training was worthwhile.

The RCWs in this study talked about learning the skills and reflected that they had

to change the way they were used to doing things. Maggie and Sue's reflections related to

the importance of the trainer's role are consistent with findings from Sepulveda et al.

(2011) where Head Start teachers reported the value of their trainers and feeling

supported by their trainers. Maggie and Sue focused more on the importance of support

by the trainer in the training process noting that trainer feedback close to in-class practice

(Maggie) and the importance of seeing the trainer demonstrate skills in situations with

which she struggled (Sue) were important.

All participants had suggestions for change, but the ones related to the training

itself were from only Maggie and Sue, who reported a need for their child of focus (COF)

to have a transitional period between the individual play sessions and the classroom

training. Both believed that the ending of these sessions was difficult for their COF

particularly based on the common occurrence of traumatic experiences in the children's

lives, which have interrupted the children's attachment relationships. This is

understandable considering research indicates many children have experienced multiple

residential placements (Bettman, Lundahl, Wright, Jasperson, & McRoberts, 2011;

Connor Doerfler, Toscano, Volungis, & Steingard, 2004), abuse (Bettman et al., 2011; Connor et al., 2004), separation from biological parents (Connor et al., 2004; Sternberg et al., 2013), or some type of recent trauma (Bettman et al., 2011), attachment disruptions (Walter, 2007), and qualify for at least one, if not more than one, mental health diagnosis (Connor et al., 2004; Handwerk et al., 2006; Sternberg et al., 2013). It can be argued that this transition would be more difficult for children dealing with these types of complex issues.

Maggie and Sue expressed a desire for, or stated the benefit of, more training in the classroom or group environment. This aligns with the fact that all three participants found the transition from individual to group, as well as the need to change established response patterns, challenging for a variety of reasons. Further, participants were able to use the skills very effectively to demonstrate empathy in play sessions. They may have experienced a desire to use the skills in the classroom with the same level of effectiveness leading them to wanting more training in the classroom. In the CTRT model in Helker and Ray's (2009) research, the classroom phase continues for 10 weeks, and teachers are trained multiple times per week. In this study, RCWs received in-class training two times per week for 25 minutes and supervision for approximately 20 minutes per week for 6 weeks (except Maggie whose training had to be shortened). This was due to the training environment and resources available for coverage, as well as the challenges of finding consistent times where there was unstructured time happening in the classroom. A plausible explanation for the findings is that the time spent in classroom training is not enough for the RCWs to feel entirely confident in their use of the skills in the classroom. Also, the diversity of roles and environments with which the RCWs are faced on a daily

basis may have added additional challenges, suggesting that additional training could have a focus on use of skills in different environments.

Maggie reported a desire for an additional training for all staff members as a change for the training indicating, "It's hard when your partner is sitting in the room, you know he or she doesn't really have an idea what you're doing. Isn't sure when to step in." Maggie also noted that having both partners in the classroom "having a knowledge of the approach" would have been helpful. When considered within the context of general systems theory (von Bertanlanffy, 1968) and cybernetics (Wiener, 1948), as well as the concepts related to change in the family therapy literature (e.g., as in strategic family therapy; Haley, 1976), it is explicable how the participants' attempts at changing their way of interacting with children in the classroom environment may have been difficult, when others were not aware of, nor practicing the same approach. In fact, the concept of organizational resistance to change suggests that organizations too have a tendency toward homeostasis (as summarized by Ijaz, 2012 with information from Lewin, 1947). Further, employees may experience skepticism about the change, which leads them to resist change (Stanley, Meyer, & Topolnytsky, 2005). Maggie might have experienced organizational dynamics such as these in her attempts to change, which might have prompted her reflections about her experience of trying to use the new CCPT skills in an environment which was, at best, unaware of her efforts. Although Jefferson did not offer many suggestions for changing the training, he did suggest a change that was unique to him. He reported that he would have liked to see "more prep for the kids" related to them being in the classroom while the training was going on with him.

Perception of Impact of Training. Themes related to the RCWs' perception of the impact of the training were: (a) *personal growth/development insight and awareness*, (b) *continued development*, (c) *effects on non-children of focus* and (d) *effects in the classroom*. All three participants reflected on some aspect of personal growth/development of insight and awareness. Some of this awareness was related to the children and their behaviors, such as Jefferson being more "aware of…certain things…that…in the beginning I didn't pay attention to." Sue was more aware of the "patterns of the kids," and Maggie found "thinking about his [her COF's] behaviors…very valuable." This awareness experienced by the participants can be explained by the emphasis CTRT places on helping the RCWs communicate the healing messages "I am here…I hear you…I understand…I care" (Landreth, 2012, pp. 209-210). Learning to communicate these messages can lead RCWs to be more in-tune and attentive to the children in their care, sometimes in general and sometimes more specifically, as in Maggie and Jefferson's professed increased understanding of children's feelings.

Further, all three participants reported some growth in intentionality of their responses to children, thinking twice like Maggie, being "more mindful of what I'm going to say" like Jefferson, and choosing responses that help her "stay calmer and not react so quickly to the situation in a negative way" like Sue. During their training in Phase B (see Appendix G), participants learned a variety of new skills to better communicate with children and were encouraged to understand the messages communicated by those skills. It appears they may have been thinking about responses to children that would be the most helpful. CPRT literature on parent experiences indicates

that parents report better parent-child communication (Bavin-Hoffman et al., 1996; Edwards, Sullivan, Meany-Walen, & Kantor, 2010), as well as the learning of new ways to relate to their child (Wickstrom, 2009). The concept of intentionality in communication or thinking twice, aligns with the idea that the RCWs may have been experiencing similar improvements in communication and implementation of new ways of relating to children.

Participants' development of insight and awareness and their general positive reaction to the training may explain participants' reported commitment to continue working on the skills. With regard to learning the skills, the fact that they felt they had more room for growth and a need to continue working on the skills may also have been a function of making a change in the treatment environment and trying to implement new behaviors that were different from those around them. This may have proven challenging for several reasons including: (a) not having the positive influence or teamwork of co-workers trying to use the CCPT skills too, (b) being more tempted to revert to past response patterns (which all three participants mentioned were hard to break) because they are being modeled by co-workers, or (c) the organizational tendency toward homeostasis (as summarized by Ijaz, 2012 with information from Lewin, 1947). Therefore, this change process may take more time than the length of the training and require the "ongoing refreshers" requested by Sue.

Research in CTRT suggests that all children in the classroom, not just COFs may experience changes as a result of CTRT (Helker & Ray, 2009). Helker and Ray found that non-COFs in their study experienced a decrease in the teachers' perceptions externalizing behaviors. Though for this study no measures were completed on non-

COFs, the RCWs reported that they were better able to build relationships with children in their care, as well as create trust, which per their initial interviews is both important and difficult. In light of the fact that the relationship is considered a key factor in success of residential treatment (Moses, 2000) this has the potential to be an important finding.

All three participants noticed effects of the training on the classroom environment. Jefferson noted that it became the "norm in the classroom," which is corroborated by his frequent use of the skills per the CTRT-SC. This is consistent with literature that suggests that teachers are able to master the skills of play therapy (Helker & Ray, 2009; Post et al., 2004). Further, related to the theme of *adapting skills for the environment*, Jefferson noted how he began to use a limit setting structure to communicate rules for gardening with the children, which further suggests the integration of skills such that it became "the language in our classroom."

Maggie and Sue noted changes in their classroom that were different from Jefferson. They reflected on the ability to use the skills to prevent crisis escalation, which according to Sue can happen when one child goes into crisis and the others follow. They reported that the skills, as described specifically by Maggie, created "almost just more of like a calm environment." This seemed to be a relevant issue for both of them, as they both mentioned in their prestudy interviews the idea of crisis and the fact that the children have triggers. This specific reference to crisis prevention is not found in the existing literature on CTRT. However, crisis prevention, along with creating "a calm environment" (Maggie) and being "aware of those other skills you can use [when one child is starting to escalate]" (Sue) could be thought of as classroom management skills. In this light, findings from Sepulveda et al. (2011) indicating that teachers feel more

confident in classroom management skills are similar to the experiences of Maggie and Sue. Given that the children entering residential treatment do so with significant difficulties (Bettman et al., 2011; Connor et al., 2004; Handwerk et al., 2006; Sternberg et al., 2013; Trout et al., 2008), this ability to create a calmer environment and help deescalate crisis seems important. Finally, this is important in the context of the literature on seclusion and restraint in psychiatric facilities, where reduction of these types of interventions is desirable (Gaskin, Elsom, & Happell; Scanlan, 2010) and in context of the facility where this research was conducted where reducing restrictive interventions is an ongoing goal of the program (personal communication, Vice President of Clinical Operations, February 24, 2015).

Usefulness of Training. Themes related to the participants' description of the usefulness of the training were: (a) *usefulness of skills*, (b) *adapting skills for the environment*, (c) *non-work generalization of skills*. All participants described the usefulness of the skills, with Jefferson focusing on the specific skill usefulness and Sue and Maggie speaking about specific skills and general usefulness of the skills. Again the idea of crisis was present in Sue's reflection that she uses "the skills in chaotic situations." Similarly, Sue and Jefferson found limit setting useful, this is important in light of research supporting that children in residential care tend to have high rates of externalizing behaviors (Bettman et al., 2011; Connor et al., 2004; Handwerk et al., 2006; Sternberg et al., 2013; Trout et al., 2008). This high rate of externalizing behaviors was also evident in the three COFs in this study, two of whom were perceived by the RCWs as in the clinical range on the first Teacher Report From of the ASEBA School-Age

Forms (TRF; Achenbach & rescorla, 2001) administration and one of whom was considered borderline.

Maggie and Jefferson found the use of feelings identification helpful, and all three participants mentioned using this skill. Identifying feelings can be an aspect of crisis de-escalation, as reflected by Sue, "They want to know that you hear them," and crisis de-escalation techniques such as "therapeutic communication" (Gaskin et al., 2007, p. 300) and clients "processing with staff" (Masters, Bellonci, & the Work Group on Quality Issues, 2002, p. 13S) are recommended for the management of behaviors that can lead to restrictive interventions. Maggie found letting children lead to be helpful and adapted some of her strategies in the classroom to let children lead more. This is also important in light of the recommendation to avoid restrictive interventions by avoiding power struggles (Masters et al., 2002).

Jefferson indicated he did not find providing choices as helpful as the other skills. His interpretation was that the children seemed to know they would get something out of the choices. This suggests that there was a possible need for more training around how to use choices, as choices given are supposed to be acceptable to both the adult and child (Landreth & Bratton, 2006) and thus would not feel manipulative.

All three participants reported that they experienced some level of using the skills outside of their work environment. Given the training's emphasis on skill generalization to the classroom, this suggests that this ability to generalize the skills across environments was, at the very least, emerging. Maggie expressed this in the most all-encompassing way stating, "It has transcended into like most aspects of my life." The other two participants did not indicate reaching that level of integration. This is

potentially related to Maggie's background in education and her embracing play as a vital part of development per her prestudy interview. This may have predisposed her to be more open to learning the skills taught during CTRT and thus more able to reach a level of integration unlike the other two participants.

Challenges. All three participants experienced challenges related to transitioning from working with individuals to working with groups and in learning the skills in general. They found changing their habits difficult at times, as the skills were different from what they reported having been taught or what they were used to. This can be explained by the fact that this was the first time this intervention was implemented in their work environment, and they had not been taught these specific skills in their training process. Although many of the skills taught in CTRT align well with the treatment approach in place in this facility (Neurosequential Model of Therapeutics; Perry, 2006), parts of their training process (Therapeutic Crisis Intervention), and the job expectations (staff should use their training and interact with the children throughout the day), the perceived social pressure to maintain control may interfere with participants' comfort with trying out new skills. Also, the environment does not include regular structured reinforcement of the skills taught during orientation (e.g., validating feelings and being reflective), nor is peer support among the staff members for the use of those skills prevalent. These skills, although aligned with CTRT, are not consistently reinforced as the standard for how interactions with children should take place.

Further, the challenge of transitioning from individual work to group may be related to the idea of potential crisis that was reflected in Sue and Maggie's prestudy interview, as well as throughout their poststudy interviews. Children in residential care

have a variety of challenging behaviors, including externalizing behaviors (Bettman et al., 2011; Connor et al., 2004; Handwerk et al., 2006; Sternberg et al., 2013; Trout et al., 2008), possibly making transitions particularly difficult to handle and fear of loss of control by the adult high, particularly where there may be perceptions of organizational pressure to maintain control. Also, Maggie's experience related to the environment being challenging (e.g., her partner did not understand what she was doing) can be explained by the tendency of organizations and individuals within them to prefer homeostasis (as summarized by Ijaz, 2012 with information from Lewin, 1947).

Mixed Method Research Questions

Relationship Effects. Sue reported taking "away a new [positive] relationship with [her COF]." This was congruent with her Student Teacher Relationship Scale (STRS; Pianta, 2001) data total score (PEM of 100% in Phase B and 85% for Phase B through Phase A follow-up), as well as her results on the Closeness subscale (PEM of 75% in Phase B and 80% for Phase B through Phase A follow-up). Although she did not show improved relationship according to the STRS total score, Maggie's Closeness subscale score (PEM 100% for Phase B and 71% for Phase B though Phase A follow-up), as well as her qualitative reflection on the relationship, "We did. We got close," were indicative of a closer relationship between her and her COF (see Appendix H6-H8). There is no literature that investigates the relationship between teacher and student in CTRT. However, this is consistent with CPRT literature, where relationship improvement is almost exclusively measured using the Parent Stress Index (Abidin, 1995) and relationships show improvement (e.g., Bratton & Landreth, 1995; Carnes-Holt, 2010,

Ceballos & Bratton, 2010), as well as increases in parental acceptance (e.g., Bratton & Landreth, 1995, Costas & Landreth, 1999, Tew et al., 2002).

Jefferson did not show positive results on the STRS total score or any subscale scores. Maggie did not show positive results on the STRS total score or the STRS Conflict subscale. However, both reflected positively on changes in their relationship with their respective COFs, and Jefferson reflected during his training sessions on how greatly he would be affected when his COF's discharge date came. In fact he became tearful when thinking about it. It is interesting to note that both Jefferson and Maggie perceived ongoing challenging behaviors from their COF, with Jefferson noting, "I found him to be more bossy to his peers" and Maggie reporting sometimes feeling frustrated by the lack of improvement or inconsistency in the change in her COF. It seems possible that Maggie's high expectations for her COF's improvement may have affected her ratings on the STRS, making her less aware of small changes that may have been happening, but still able to articulate an improvement in the relationship qualitatively. Jefferson's, as well as Maggie's, perception of COFs' behaviors continuing to be challenging in several ways may have affected the scores on the STRS as well. Finally, many of the children in residential care have experienced multiple residential placements (Bettman et al., 2011; Connor et al., 2004), abuse (Bettman et al., 2011; Connor et al., 2004), separation from biological parents (Connor et al., 2004; Sternberg et al., 2013), some type of recent trauma (Bettman et al., 2011), attachment disruptions (Walter, 2007), and qualify for at least one, if not more than one, mental health diagnosis (Connor et al., 2004; Handwerk et al., 2006; Sternberg et al., 2013). It is possible that many of these attachment disruptive experiences may have caused the COFs to behave in ways contrary to what

would typically be observed in a deepening relationship. This would allow for RCWs experienced with this type of pattern to recognize it and still feel closer to the child (as reflected qualitatively), but also still be dealing with the relationship challenges measured by STRS. It is also possible that past attachment disruptions experienced by the COFs could delay their ability to form strong relationship bonds and cause them to test relationships. This concept of the challenge of building relationships with the children because of their past experiences and lack of trust was reflected by both Maggie and Jefferson in their prestudy interviews.

One additional possible explanation for Maggie's STRS scores specifically are her departure from the organization and the last weeks of her employment there aligning with the last weeks of her involvement in the study. In fact, she noted in her poststudy interview that her COF's behaviors were really challenging during this period which she described, "My last days full-time, was the last period where he was just having a really rough time. Every, everything would set him off." This is consistent with the STRS ratings in Figures H6-H8 where the total score is increasing, along with the conflict score, and the closeness score is decreasing. Both Maggie and her COF may have been struggling with her impending departure, about which her COF was aware at this point. This too could be related to past attachment disruptions and anxiety about the loss of an important relationship.

In Carlson's (2011) dissertation, focused on teachers and play-based teacher consultation, there were some similar results with use of the STRS. Only 5 of 8 teachers reported improvement in one or more scores from the STRS following individual play sessions with a child. Given that the research in CPRT overwhelmingly suggests

improvements in relationship as measured by increased parental acceptance (e.g., Bratton & Landreth, 1995, Costas & Landreth, 1999, Tew et al., 2002), it seems appropriate to question the effectiveness of using the STRS to measure changes in the relationship in CTRT or other play-based teacher training models. Finally, it is of note that in this study, the STRS was used weekly, an application that has not been attempted in past research. Though the originator of the instrument communicated it is possible to use it this way (R. Pianta, personal communication, October 1, 2013), perhaps scores did not reflect accurately changes in the relationship.

Perception of Behavior Problems. Children who have participated in CTRT have demonstrated a significant decrease in the perception by teachers of behavior problems (e.g., Post et al., 2004; Smith & Landreth, 2004). This is consistent with CPRT literature that suggests the same (e.g., Smith & Landreth, 2003; Tew et al., 2002). In this study, only Sue's perception of her COFs behaviors improved (according to the TRF scores), though all remained in the clinical range. Her qualitative reflections were also consistent with this.

Of the other two, only one rating decreased (internalizing behaviors for Maggie's rating of her COF). This supports qualitative reflections by both Maggie and Jefferson in which they continued to perceive some of their COFs' behaviors as challenging, though both had some positive things to say about the training's effect on their COF (e.g., Maggie noted changes when her COF "was kinda by himself" and Jefferson stated, "It was beneficial to [COF]"). One possible explanation for this is that they felt closer to their COF (as evidenced by their qualitative reflections) and were thus more attentive and in-tune with their COFs' behaviors, noticing things that they did not note during the first

TRF rating. Another possible explanation lies in the severity of the issues children in residential treatment face (e.g., Connor et al., 2004; Handwerk et al., 2006; Sternberg et al., 2013). The children may have needed more play sessions to see the effects seen in other literature with less involved cases.

Finally, there are many other contributors to children's behaviors in residential treatment. Impending discharge, new children in the class, and/or new staff members often cause a disruption in the children's lives. The children in this facility are almost always on medications, and I have observed the effects of medication changes on many children. The COFs in this study may have been affected by medication changes or other factors at any point during this study, which may have in turn affected their TRF scores.

Symptoms of Burnout. The quantitative and qualitative data related to RCWs' experiences with burnout were contradictory. Each participant reported some positive job-related effect of the CTRT including: "understanding their feelings…makes it easier for me to kinda help them," (Jefferson); "it's a decrease in stress," (Sue); and "it made my job easier and made it more manageable to me," (Maggie). However, Jefferson's Maslach Burnout Inventory-Educator's Survey (MBI-ES; Maslach, Jackson, & Leiter, 1996) scores increased slightly with Emotional Exhaustion (EE) remaining high (one symptom of burnout); Sue and Maggie also reported an increase in burnout, although the increase was not reflective of high burnout.

Of note is that Sue's scores worsened in each assigned level category for each subscale, which resulted in her being placed in different nominal categories for each of the elements of burnout (moderate to high on EE, low to moderate on DP, and high to moderate on PA). At the time that Sue took the second MBI-ES she was reporting,

anecdotally, high stress in her classroom due to having a particularly reactive group of children in her care. She even joked that she should not be taking the inventory at that time. This may have resulted in inflated indicators of burnout that were not consistent with her typical feelings of burnout. Also related to a specific participant, Maggie was very new in her job at the point she took her first MBI-ES. She described feeling that the resources were equal to the demands of the job and feeling very supported. It seems possible that she was settling into more accurate perceptions of the job and demands of the job, resulting in higher symptoms of burnout on the second administration of the MBI-ES.

All participants experienced a decrease in Personal Accomplishment (PA) on the MBI-ES. This subscale has to do with feelings of efficacy and meaning related to work. Given that they had learned new skills, which were described as different from their past ways of interacting with children, it seems possible that they may have felt less efficacious at work while trying to incorporate new skills into their daily routine. Also, CTRT is designed to help adults become more aware of and responsive to children's feelings. Participants were able to do this successfully by demonstrating empathy in individual play sessions, and all three talked about increased responsiveness to children (e.g., understanding feelings and communicating understanding to the children). This increased awareness of children's feelings may have been difficult for participants as they became more aware of the children's feelings. This may have influenced the Emotional Exhaustion subscale, on which all three participants experienced increases. Thus, it seems possible that CTRT could have the potential to increase burnout symptoms in the short-term.

This training was provided differently from the way CPRT and CTRT would typically be provided. Due to being a single-case design, training had to be provided individually rather than in groups. The group process aspect of CPRT is considered a unique and important component of the training (Landreth & Bratton, 2006). Further, according to Seti (2008) social support from co-workers is a significant factor in reduction of burnout in RCWs. Without this piece, participants may not have experienced the support of others in the same way that group participants do, thus leading to less dramatic treatment effects in the area of burnout.

The measure used in this study differs from what is typically used in the literature to measure caregiver effects (parental stress), which typically yields positive results in CPRT (e.g., Ceballos & Bratton, 2010, Lee & Landreth, 2003; Tew, Landreth, Joiner, & Solt, 2002). The similar concept prevalent in residential treatment literature is burnout, which is influenced by a variety of factors including: (a) personal characteristics such as age, years of experience, and personality traits; (b) job/role characteristics such as time in direct contact with clients, boredom related to the job, and role stress (including role ambiguity and role conflict); and (c) organizational characteristics such as social support from co-workers and supervisors, organizational environment, lack of autonomy, lack of advancement opportunities, and lack of recognition (Seti, 2008). According to Seti (2008) the most significant job/role variable in burnout is role stress, in which workers experience role conflict, when incompatible demands are simultaneously placed on workers and role ambiguity when expectations related to job roles are unclear (Harrison, 1980).

It is very possible that the RCWs in this study were experiencing many of these contributors to burnout. Many of these factors are things over which CTRT would have no effect (e.g., age, years of experience) or little effect unless it was implemented agency-wide. The atmosphere in the residential treatment facility where this research was conducted is in constant flux. There are new children adjusting to entering the treatment program, children being discharged regularly, and some days there are multiple crises. Further, when regular staff are out, PRN staff substitute, which causes additional chaos. The facility is characterized by an oftentimes-unavoidable lack of stability. During the time this research was conducted, the daily schedule and treatment structure was modified several times, which caused the roles of many staff members to change.

None of these factors are addressed through CTRT. Therefore, it stands to reason that the MBI-ES may not be an accurate measure of the job-related effects of CTRT on RCWs. Finally, the MBI-ES is not designed to be given so closely in succession and although participants were instructed to adjust the time period for which they were responding, it may be that this instrument gives an accurate reading of burnout over a longer period of time, but not over a short period of time like what was needed to assess the second assessment period. A better measure may be one that looks at perceived stress at a specific time rather than burnout, which is something that builds up over time and may not be prone to improvement over short timeframes.

Contributions of the Study

This is the first identified study that has explored the use of CTRT with RCWs working in psychiatric residential treatment with children and adolescents. As such, it represents a unique contribution to the understanding of the usefulness of this approach

across a variety of settings, as well as new treatment approach with positive results that can be integrated into residential treatment settings. This research also contributes to the sparse research on this adaptation of CPRT, as several of the existing publications in the literature stem from one research study (e.g., Helker & Ray and Morrison & Bratton, 2010).

Further, this study contributes to the developing field of single-case experimental research, as well as mixed methodology research, which has implications in the field of counselor education and research. Single-case design is becoming more prevalent in the counseling literature (e.g., *Journal for Counseling and Development*'s call for manuscripts for a special section on single-case research designs) and this study contributes to the development of single-case design as a viable practice-based research method in counseling. Finally, this study provides evidence for the possible effectiveness of what amounts to a consultation model, which has the potential to help counselors expand their influence through paraprofessional training and build better relationships with the professionals and paraprofessionals responsible for children.

<div align="center">Limitations</div>

Although this study makes contributions to the literature, it is affected by limitations. The first of these are related to assessments used. Several of the assessments were used more frequently than originally intended by the creator (e.g., MBI-ES twice within a short period of time, STRS weekly, and TRF within a short time). This may have caused the assessments not to accurately reflect the information being sought and affected their validity. Additionally, some of the assessments were self-report, which may have been influenced by demand characteristics. It would not have been hard for participants

to ascertain the purpose of this study and try to be good participants by giving what they believed to be desirable answers. Further, the participants each developed a long-standing relationship with me, as the researcher and trainer in the CTRT. Although they were encouraged to be honest in answering all quantitative and qualitative data, they may have wanted to please me, another aspect of demand characteristics. Finally, researcher bias may have affected interviews in spite of efforts to be objective. I may have inadvertently responded differently to some answers given by participants and influenced their responses.

The treatment environment where this study was conducted caused a variety of adjustments to be made to this research. The selection of start date for participants was affected significantly by the availability of a child. RCW participants could only start in the training when a suitable child was newly admitted, expected to remain for the treatment duration, and consent was received. This did not allow RCWs to choose a child from their classroom independent from all of these factors and did not allow them to start on a regular schedule into the treatment conditions. The general nature of this treatment environment is chaotic. Children are coming and going from the facility as some are discharged and others are enrolled in the treatment. Sometimes staff members are moved around, as happened with Jefferson toward the end of his training period. This staff movement also affected the study when a new participant had to be added to replace one moved to a classroom of children too old for the study. Occasionally, observations were missed due to staffing issues such as vacations or unexpected changes in activities in the program. The nature of this environment also affected in-class training, which sometimes

had to be flexible to accommodate the schedule of the group. All of this may have affected both the training and the assessments.

Finally, this training was conducted individually, not in groups per the training manual (Bratton et al., 2006). This represents a difference from other CPRT/CTRT literature, where training was conducted in groups. The group support inherent in this model was not possible to achieve.

<div align="center">Recommendations for Adapting CTRT to Residential Care</div>

Based on the experiences in this study, it seems that several modifications could be made to the CTRT intervention to make it more applicable to the residential treatment environment. First, it may be advisable to have some type of transitional period for the COF. This was suggested by two of three participants (Maggie and Sue) based on their observations of their individual COFs. This could include adding a few play sessions and spacing them gradually farther apart or intentionally including the COF in the classroom training by starting the RCW working with just the COF during center time, then with two children (including the COF), and so on.

Second, it may be helpful to begin the in class training sooner. Practicing the skills both individually and in groups may help the RCWs feel more confident in their mastery of the skills in groups. Psychiatric residential treatment provides services to some of the most intense cases of children needing mental health services (Connor et al., 2004; Handwerk et al., 2006; Sternberg et al., 2013), and it seems likely that more support earlier would allow the skill use in the classroom to be even more integrated. Further, two of three participants (Maggie and Sue) suggested longer in-class training.

One additional way to address the challenges faced in the individual to group transition would be to incorporate some use of group play sessions during the first phase of training. These could potentially replace some of the individual play sessions in order to keep the training reasonable in length. This would allow the trainee to begin practicing the skills with additional children in a more controlled environment (the playroom) versus the classroom. In addition to addressing the individual to group transition, this could help with the transition recommended for the COF by providing a time period where the COF would be participating in group play sessions with another child.

Finally, this was a long training conducted in a changing environment. It may be helpful to shorten the training, providing a shorter initial introduction to the skills. It is also possible that starting the classroom portion while the individual portion is occurring or providing some or all of the portions more frequently for a shorter time period would help shorten the training. Depending on the goals of the training (e.g., primary focus on participant skill acquisition versus a desire for improved behavior in COFs) the potential for COFs to have more play sessions in order to see behavioral effects would need to be considered. In situations where positive behavioral outcomes are desired or a focus, it may be necessary to provide additional play sessions or additional support to trainees in ongoing relationship building with individual COFs.

Finally, it seems useful to provide all staff members with overview training. This would provide support for any staff members currently learning the training, either so that they can learn it individually or until other staff members are completely trained. One participant (Maggie) suggested training point people completely and others in an abbreviated way. A model like this may be feasible.

Recommendations for Research

The current research had positive outcomes in skill demonstration, as well as participants' experiences of the training. This seems to suggest that further research is warranted. As this was a mixed methods design focused on individual experiences, a group experimental design is desirable. Further, it would be useful to investigate the effects of CTRT in residential care when the RCWs could participate in group training rather than individual training. One factor noted by Maggie that may be worth investigating is the concept of environmental support for new behaviors. Research into what organizational factors support the implementation of a relationship building approach could help counselors better understand what it takes to integrate a CTRT approach systemically. This may include organizational culture, leadership, or organizational structure. It may also be useful to investigate the role of individual culture in adopting the skills in a treatment environment.

As far as effects on COFs, further investigation into the effect of the play sessions on COFs would be useful. In this study, the RCWs' perception of the COFs' behavior problems was not consistently or significantly impacted. As children in residential care experience such a complex set of problems (Bettman et al., 2011; Connor et al., 2004; Handwerk et al., 2006; Sternberg et al., 2013; Trout et al., 2008), it would be helpful to know if incorporating more play sessions would allow for the effect of improvement in behavior problems to become more apparent. Similarly, given the complexity of issues faced by children in residential treatments, it would be recommendable to research the effectiveness of a combination of different play therapy interventions (e.g. CPRT with caregivers, CTRT with RCWs, and play therapy by a trained play therapist) on the

internalizing and externalizing behaviors of children in residential care. Also, many of these recommendations, as well as existing literature, are focused on perceptions of children's behaviors. It may be useful to objectively assess children's behavioral outcomes or develop a measure of children's perceptions of experiences with the interventions. Finally, research on the proposed modifications (e.g., starting classroom training earlier) would be useful to determine how outcomes would be affected.

Finally, this research is one study at the very beginning of investigating the effects of adapting CPRT for non-parents. The literature has investigated its use with teachers, and this study investigated use with RWCs working with children and adolescents. Further research is recommended to determine what other populations for which CPRT adaptations, such as CTRT may be useful.

Conclusion

In conclusion, this research found that CTRT is a potentially effective intervention to increase RCWs' use of CCPT skills in the classroom, as well as communication of empathy in individual play sessions. The qualitative results suggest primarily positive responses on the part of the RCW participants and they did see some changes in their relationship with their COF. Overall, this study provides information that suggests that CTRT has the potential to be an effective intervention in residential care for children and adolescents, and it warrants further research investigation.

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APPENDIX A: RESIDENTIAL CARE WORKER INFORMED CONSENT

The University of North Carolina at Charlotte
9201 University City Blvd.
Charlotte, NC 28223
Department of Counseling
(704) 687-8960
Fax (704) 687-1033

INFORMED CONSENT FOR RESIDENTIAL CARE WORKERS

You are being invited to participate in a research study entitled The Effects of Child Teacher Relationship Training (CTRT) on Residential Care Workers: A Mixed Methods Study. The following informed consent will cover your rights as a participant, the procedures, benefits, and risks of the study. It is important that you read and understand the following explanation before agreeing to participate in this research study.

Your participation is entirely voluntary and you may choose to withdraw, without penalty, from the study at any point. If you choose not to participate in this study, this too will have no penalty. Regardless of your decision to participate or not participate or any withdrawal from this study, your employment at/relationship with Alexander Youth Network will not be affected in any way.

Purpose of the study:
The purpose of this study is to investigate the effects of Child Teacher Relationship Training in the residential treatment environment. Research shows that the relationship between residential care workers and the children in residential treatment is essential in treatment. Additionally, research shows that the job of the residential care worker is stressful. The purpose of CTRT is to help participants learn and use skills that contribute to building positive relationships with children and that can potentially reduce care worker's stress.

CTRT:
CTRT is a teacher-training model that focuses on play-based skills to help teachers manage children's behavior. The training is designed to help create a positive adult-child relationship. This intervention is designed for use with teachers, but will be adapted for the residential environment. Masters or doctoral level counseling students who have training in play therapy and CTRT will provide training.

Duration of the study:
Your active participation in the training portion of this study will consist of 17 weeks. This will include 11 weeks in active training in CTRT. However, due to the design of this study, each participant will begin the CTRT at a different time. Thus you will have at least a 3-week period prior to the start of the training during which you will participate in some components of the study (i.e., complete a short weekly assessment, conduct 3 play sessions, and be observed in the group setting) but not the training. You may have between 2 and 6 additional weeks prior to starting the study, during which you will be asked to complete a short weekly assessment and will be observed in the group setting. You will be informed of your participation start date once all participants have been enrolled.

Description of the study and procedures:
If you decide to participate you will be randomly assigned an order in which you will begin training. All requirements of this research will be scheduled as appropriate to minimize disruption to your daily routines. This will be done in consultation with you and your employer. The procedural steps are as follows:
1. Complete a demographics questionnaire and the Preventative Resources Inventory, which is expected to take approximately 10 minutes, as well as a one-on-one video or audiotaped interview that is expected to take no more than 60 minutes.
2. Prior to the start of the CTRT phase, you will be observed weekly for short periods of time in group time with the children once per week. During the period of time prior to starting the training portion, you will complete 3 video recorded play-based interactions with a child (one per week for 3 weeks). Time spent in this phase will vary depending on training order for individual participants.
3. Training weeks: You will complete 11 total weeks of training. For the first 8, you will have individual training for 30-45 minutes per week. During weeks 2-8, you will conduct 1 weekly 30-minute play session. During weeks 9-11, you will continue to meet individually for training sessions for approximately 20 minutes per week and will receive 25 minutes of in-group/class coaching 2 times per week. You will continue to be observed weekly.
4. Following your participation in the training portion of the study, group/classroom observations will continue for 3 weeks. After this 3-week period, you will complete a one-on-one interview, expected to take no more than 60 minutes.
5. Throughout this training you will be asked to complete different assessments: The Maslach Burnout Inventory (2 times; 10 minutes each); The Teacher Report Form (2 times; 15 minutes each); and the Student Teacher Relationship Survey (weekly throughout the study; 10 minutes each).
6. Complete follow-up video or audiotaped interview of 30 minutes if needed to clarify responses.
7. You will be asked not to communicate with others at your place of employment about this training for the duration of the research. Following the completion of the study, you may, if desired, participate in a follow-up debriefing session to discuss your experiences with other participants.

Description of risks or discomfort:
There are no foreseen risks associated with this study.

Description of participant or others' benefits:
You will receive compensation for your time (training and play sessions conducted on-site) equal to that of your existing rate of pay. Interviews will not receive compensation, but will be scheduled at your convenience. There will be no additional financial benefits provided by the researcher or UNCC. Additional benefits may arise. Research suggests many possible beneficial outcomes from this training. These include improved relationships with the children for whom you are responsible and an increased ability to manage their emotional and behavioral needs.

Confidentiality:
All information you provide will be kept confidential and your identity will not be disclosed. All data will be kept in a locked filing cabinet and/or password protected. Only the principal investigator, trainer, or research assistants will review video recordings of play or video/audiotapes of training sessions.

Investigator and review information:
The principal investigator in this study is Emily Donald, doctoral student (ejfornwa@uncc.edu). The responsible faculty member is Dr. Peggy Ceballos, Assistant Professor (pceballos@uncc.edu). If you have any questions about this study please contact Emily Donald (ejfornwa@uncc.edu).

UNCC's Institutional Review Board has approved this research protocol and form for one year beginning on (date). UNC Charlotte wants to make sure you are treated in a fair and respectful manner. Contact the university's Research Compliance Office (704-687-1871; uncc-irb@uncc.edu) if you have any questions about how you are treated as study participant.

I have read the information in this consent form. I have had the chance to ask questions about this study, and those questions have been answered to my satisfaction. I am at least 18 years of age. I agree to participate in this research project. I understand that I will receive a copy of this form after it has been signed by me and the principal investigator of this research study. I understand my rights and voluntarily consent to participate in this research. I understand that I can withdraw that consent at any time.

_____

Participant's name (PLEASE PRINT)

_____

Participant's signature and date

_____

Investigator's signature and date

APPENDIX B: CHILD PARTICIPANT INFORMED CONSENT

The University of North Carolina at Charlotte
9201 University City Blvd.
Charlotte, NC 28223
Department of Counseling
(704) 687-8960
Fax (704) 687-1033

INFORMED CONSENT

Your child is being invited to participate in a research study entitled The Effects of Child Teacher Relationship Training (CTRT) on Residential Care Workers: A Mixed Methods Study. The following informed consent will cover your parental rights as a participant, the procedures, benefits, and risks of the study. It is important that you read and understand the following explanation before agreeing to participate in this research study.

Your decision to allow your child to participate is entirely voluntary and you/your child may choose to withdraw from the study at any point without penalty. Your decision to allow your child to participate or not participate in this study, as well as any decision to withdraw, will have no effect on the services you and your child are receiving at Alexander Youth Network.

Purpose of the study:
The purpose of this study is to investigate the effects of Child Teacher Relationship Training in the residential treatment environment, particularly on the residential care workers. Research shows that the relationship between residential care workers and the children in residential treatment is essential in treatment.

CTRT:
CTRT is a teacher-training model that focuses on play-based skills to help teachers manage children's behavior. The training is designed to create a positive adult-child relationship. This intervention is designed for use with teachers, but will be adapted for the residential environment. Masters or doctoral level counseling students who have training in play therapy and CTRT will provide training.

Duration of the study:
Your child's participation in the study will be for 10 weeks. During this time (s)he will participate in weekly 30 minutes play sessions with one of the residential care workers.

Description of the study and procedures:
If you decide you want your child to participate, your child will receive weekly one-on-one play sessions for 30 minutes. These play sessions will take place with one of the residential care workers on site and will be video recorded for research and supervision purposes. During the time your child is participating in the play sessions, the residential care worker will be engaged in a training program to help him or her learn relationship-building skills to use in the play sessions. (S)he will receive weekly instruction and supervision related to the skills, and video recordings of play sessions will be reviewed in the weekly training sessions. Additionally, video recordings will be reviewed to assess skill development of the residential care worker. Training sessions will be conducted one-on-one with a masters or doctoral level counseling student with advanced training in counseling with children. During this time, the residential care worker will receive feedback only on his or her use of skills and the relationship building process. Focus will not be on your child and his or her behavior. The purpose of this training is solely to build skills for the residential care workers. Finally, the caregiver conducting the play sessions will fill out several questionnaires related to the study, some of which will be related to his or her relationship with your child. One of these assessments will assess the residential care worker's perceptions of your child's behaviors in general and the other will assess his or her perception of the relationship between him/herself and your child. In addition, brief demographic data will be collected as part of one assessment (e.g., gender, age, ethnicity, birthdate, grade in school). The data collected will be stored in a locked file cabinet and will be destroyed following the entry of the data electronically. All electronic data will be de-identified and assigned a code number. All video recordings will be destroyed following the treatment and all electronic data will be password protected.

Description of risks or discomfort:
There are no foreseen risks associated with this study.

Description of participant or others' benefits:
Benefits may arise from the training. Research suggests many possible beneficial outcomes from this training. These include improved relationships between children and caregivers, as well as improvements in children's behaviors. Research suggests that the relationship between children and caregivers is important in residential treatment, thus there may be benefits that arise from the potential improvement in the relationship between your child and the residential staff member. Finally, your child will receive weekly one-on-one focused attention from a caregiver who is learning relationship skills. This may provide some positive benefit.

Confidentiality:
All information you provide will be kept confidential and your identity/that of your child will not be disclosed. All data and video recordings will be kept in a locked filing cabinet and/or password protected. Only the principal investigator, trainer, or research assistants will review video recordings of play sessions. A code number will be used in place of your child's name on questionnaires and video recordings. The only exceptions to confidentiality are: 1) a child discloses abuse, neglect, or exploitation, 2) the child is a

danger to him or herself or to someone else, 3) a court orders disclosure of information, or 4) the parent or legal guardian requests release of information. Video recordings of play sessions will be destroyed following the completion of the research, unless you give permission for them to be used for training and educational purposes.

Investigator and review information:

The principal investigator in this study is Emily Donald, doctoral student (ejfornwa@uncc.edu). The responsible faculty member is Dr. Peggy Ceballos, Assistant Professor (pceballos@uncc.edu). If you have any questions about this study please contact Emily Donald (ejfornwa@uncc.edu).

UNCC's Institutional Review Board has approved this research protocol and form for one year beginning on (date). UNC Charlotte wants to make sure you are treated in a fair and respectful manner. Contact the university's Research Compliance Office (704-687-1871; uncc-irb@uncc.edu) if you have any questions about how you are treated as study participant.

I have read the information in this consent form. I have had the chance to ask questions about this study, and those questions have been answered to my satisfaction. I am at least 18 years of age. I agree to allow my child to participate in this research project. I understand that I will receive a copy of this form after it has been signed by me and the principal investigator of this research study. I understand my rights and voluntarily consent to have my child participate in this research. I understand that I can withdraw that consent at any time. A copy of this form will be maintained as part of your child's treatment record.

_____

Child's name (PLEASE PRINT)

_____

Parent/guardian's name (PLEASE PRINT)

_____

Parent/guardian's signature and date

_____

Investigator's signature and date

APPENDIX C: CHILD ASSENT FORM

The University of North Carolina at Charlotte
9201 University City Blvd.
Charlotte, NC 28223
Department of Counseling
(704) 687-8960
Fax (704) 687-1033

RESEARCH ASSENT

You are being invited to participate in a research study about a new training for the staff members in residential care. The purpose of this study is to see if staff can learn to use special skills to help them relate to children better. The decision to participate in this research is up to you. If you decide to participate you will have 10 play sessions, once per week, with one of your caregivers. During those sessions, (s)he will practice some ways of saying and doing things that help build better relationships with kids. The sessions will be videotaped, but will not be shared with people who are not part of doing this research. However, if during these play sessions you share that someone has hurt or is hurting you or that you might hurt yourself or someone else that will need to be shared. Also, a judge or parent/guardian can ask for information. It is not expected that you will experience anything unpleasant related to these play sessions, and you will probably enjoy them. If you have any questions, you can ask them at any time.

_____
Participant's signature and date

_____
Investigator's signature and date

APPENDIX D: DEMOGRAPHICS FORM

The University of North Carolina at Charlotte
9201 University City Blvd.
Charlotte, NC 28223
Department of Counseling
(704) 687-8960
Fax (704) 687-1033

Please provide the following information:

Name:_____

Age:_____ Gender: _____ Ethnicity:_____

Years of experience in residential care:_____ Years at this facility:_____

Highest level of education completed:_____ Focus: _____

Currently in school?_____

What training have you completed related to your current position?_____

_____

_____

_____

_____

_____

Do you believe that your employer provides enough resources for you to handle the

demands of your job? Please circle the description below that best describes the

relationship between the resources provided to you and the demands of your job.

R>D	R=D	D>R
Resources Outweigh Demands	Resources Equal to Demands	Demands Outweigh Resources

Now consider your personal resources (personal qualities, skills, experiences, abilities,

training, financial resources, etc.) in addition to the resources you receive from your

employer. Do you believe that the total resources available to you from both sources are

sufficient to handle the demands of your current position? Please circle the best

description.

R>D	R=D	D>R
Resources Outweigh Demands	Resources Equal to Demands	Demands Outweigh Resources

APPENDIX E: INTERVIEW PROTOCOL-PRE

Introduction:

1. Tell me about yourself.

2. Tell me about your background that led your current position here.

3. Tell me about the process of deciding to participate in this research.

Job:

4. Describe your job.

    a. Challenges?

    b. Rewards?

5. Describe your perception of your ability to do this job with the resources you have.

6. Are there things that would make your job easier?

Children:

7. Describe the children with whom you work.

8. Describe your relationships with the children here.

    a. Challenges?

    b. Rewards?

9. Are there things that would help you in your work with the children here?

Closing:

10. Is there anything else you'd like share?

APPENDIX F: INTERVIEW PROTOCOL-POST

Experience of training:

1. Tell me about what it was like to complete this training.

    a. Challenges?

Effects of training:

2. Tell me about the effects of this training.

    a. On you?

        i. On you ability to do your job?

    b. On your child of focus?

        i. Behaviors?

    c. In your classroom?

    d. In any other setting?

3. If not described already, describe the effect this training has had on your relationships?

    a. With your child of focus?

    b. With other children?

4. Are there any additional effects of this training you'd like to share?

Usefulness of training:

5. How have you used what you've learned in this training?

6. How do you see the long-term usefulness of this training?

Closing Questions:

7. Describe the most/least valuable part of this experience.

8. What would you tell a friend who was considering completing a training like this one?

9. What are your suggestions to improve the training/make it more applicable to this environment?

10. What have I not asked that you'd like to share?

APPENDIX G: DESCRIPTION OF STUDY PHASES

| Phase	Description	Data Collected
Prior to start	not applicable	RCW informed consent, COF informed consent, COF Assent, demographics, PRI, prestudy interview
Phase A	baseline; no intervention	weekly STRS and CTRT-SC; 3 play sessions
Prior to Phase B	not applicable	TRF #1; MBI-ES #1
Phase B	CTRT Phase I-weekly training to work with individual COF	weekly STRS and CTRT-SC; 7 play sessions
Prior to Phase C	not applicable	TRF #2
Phase C	CTRT Phase II-weekly training to work in classroom and bi-weekly in-class training	weekly STRS and CTRT-SC
Prior to Phase A	not applicable	MBI-ES #2
Phase A	return to baseline; no intervention	weekly STRS and CTRT-SC

APPENDIX H: SINGLE CASE DESIGN FIGURES
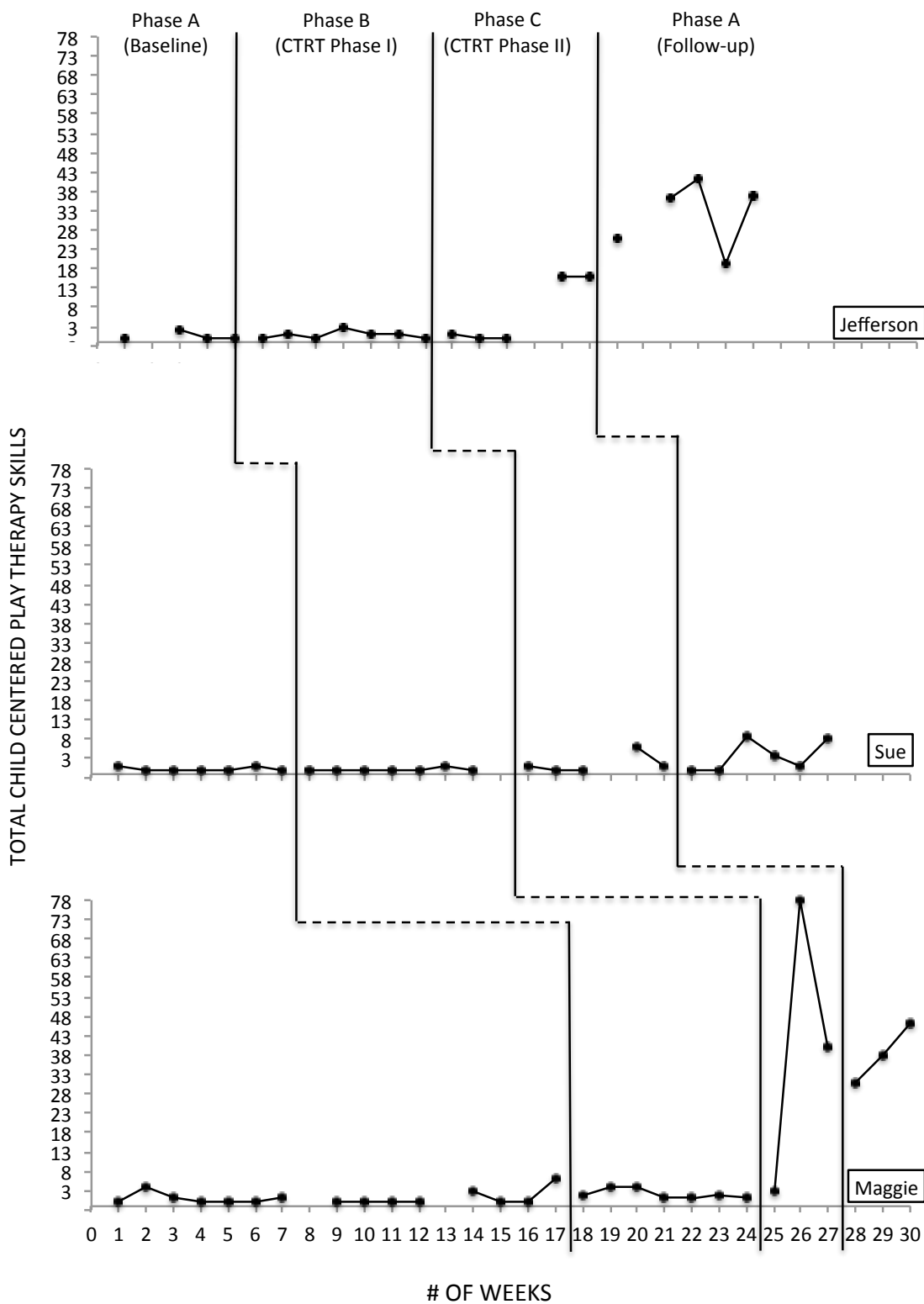
Figure H1: Use of child-centered play therapy skills in the classroom across phases. The start of Maggie's baseline was delayed and Jefferson and Sue's were simultaneous.
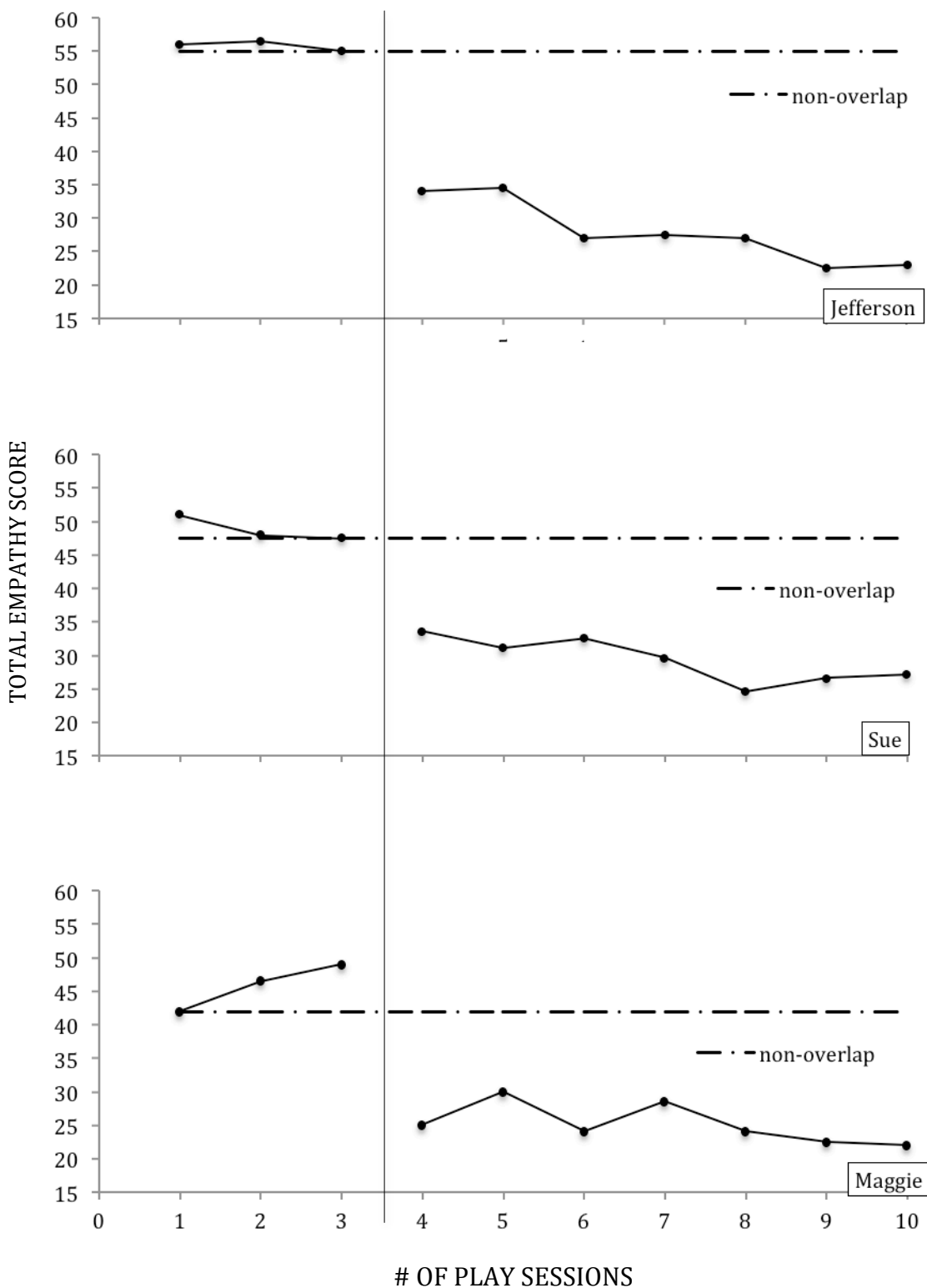
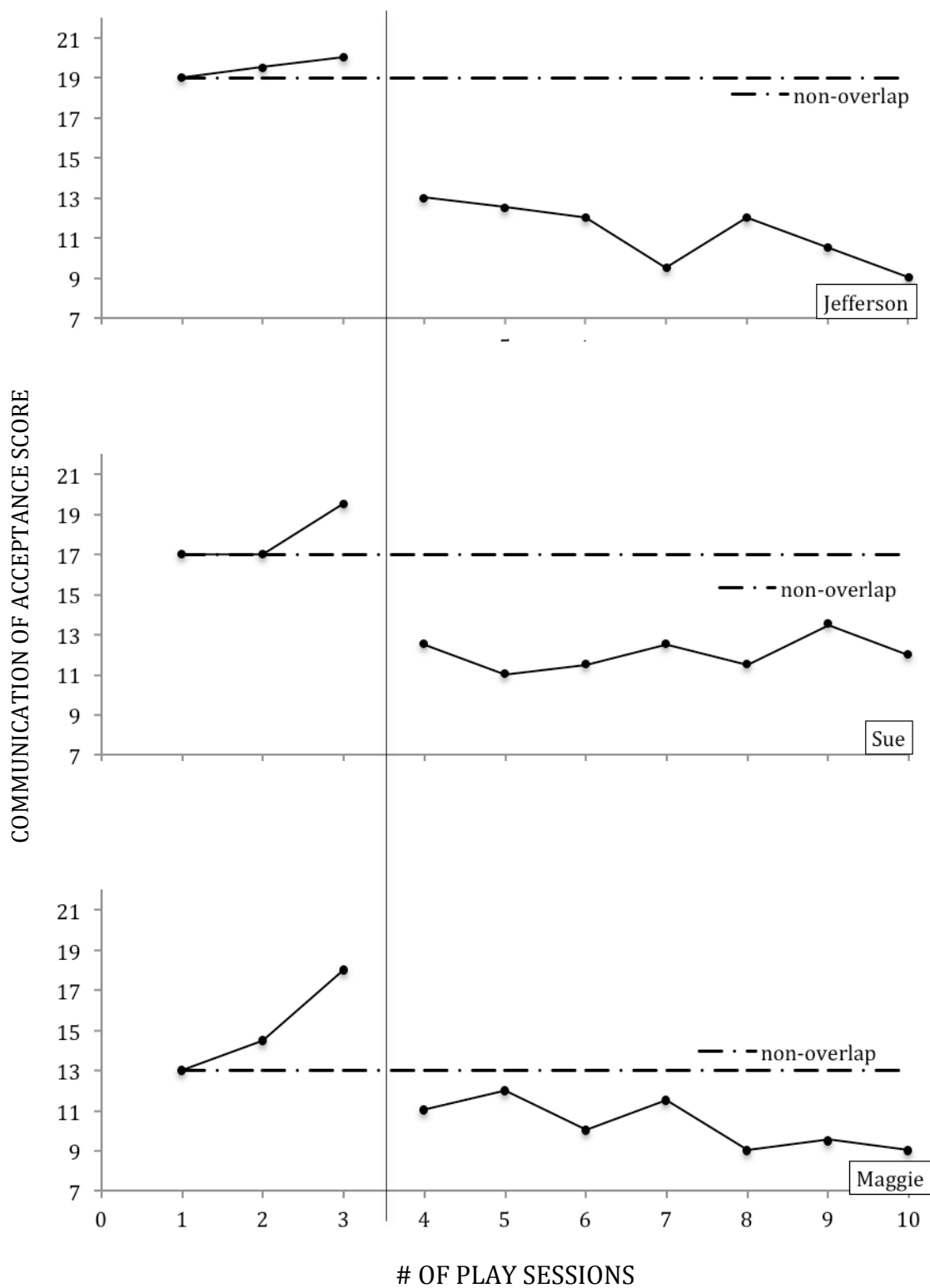Figure H2: Total MEACI scores across phases for all participants.

Figure H3: MEACI Communication of Acceptance scores across phases for all participants.
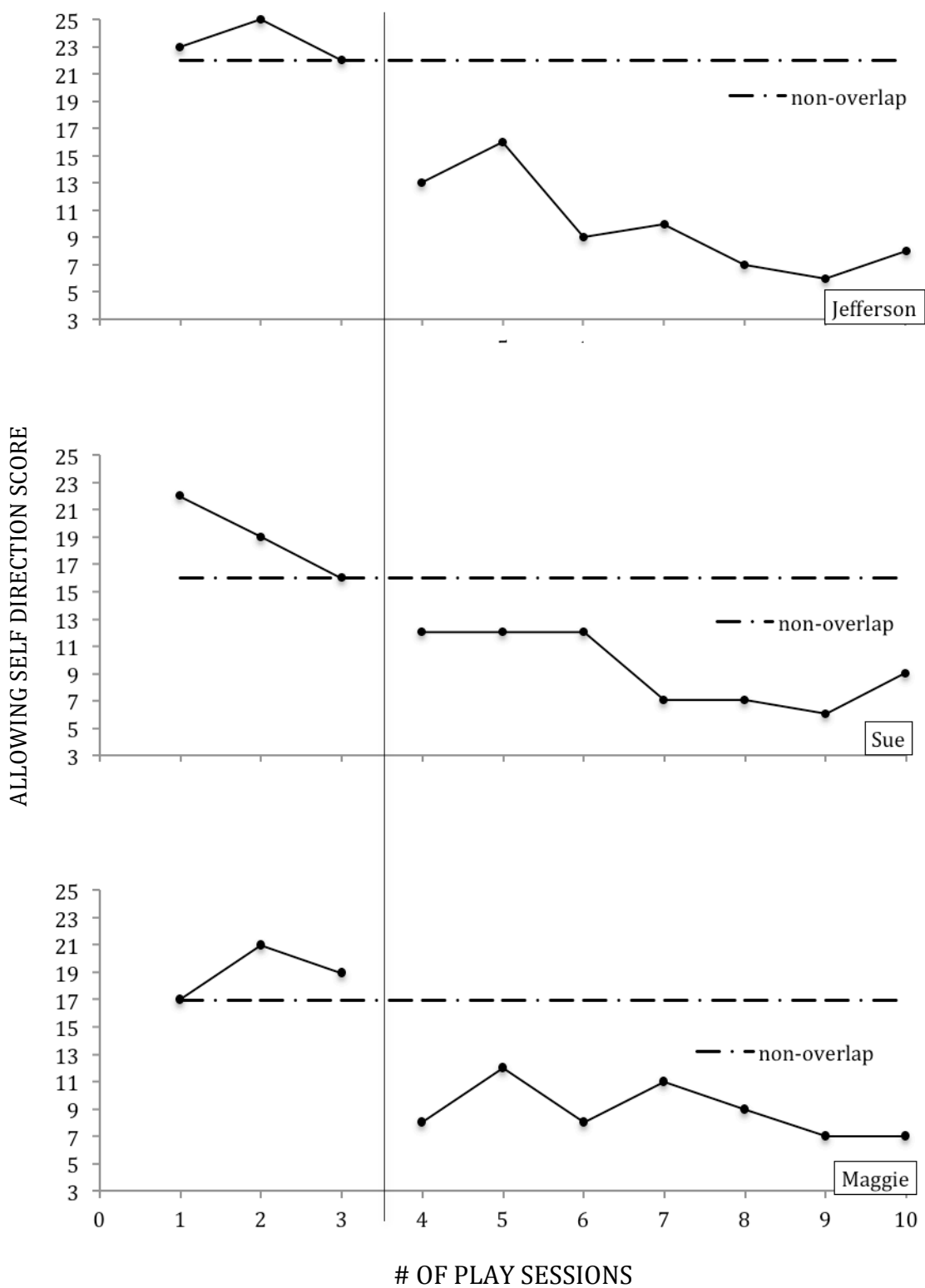
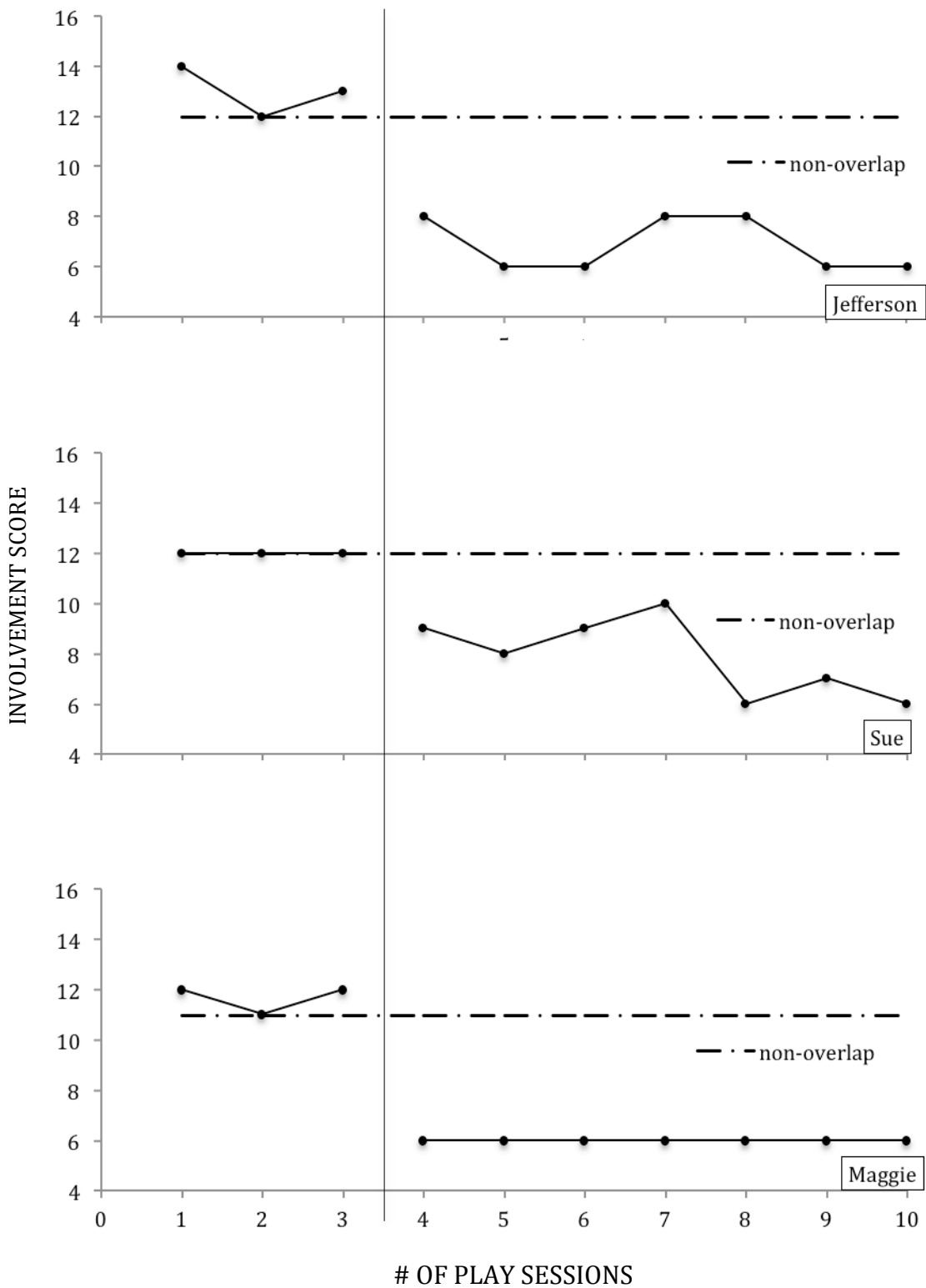Figure H4: MEACI Allowing Self-Direction scores across phases for all participants.

Figure H5: MEACI Involvement scores across phases for all participants.
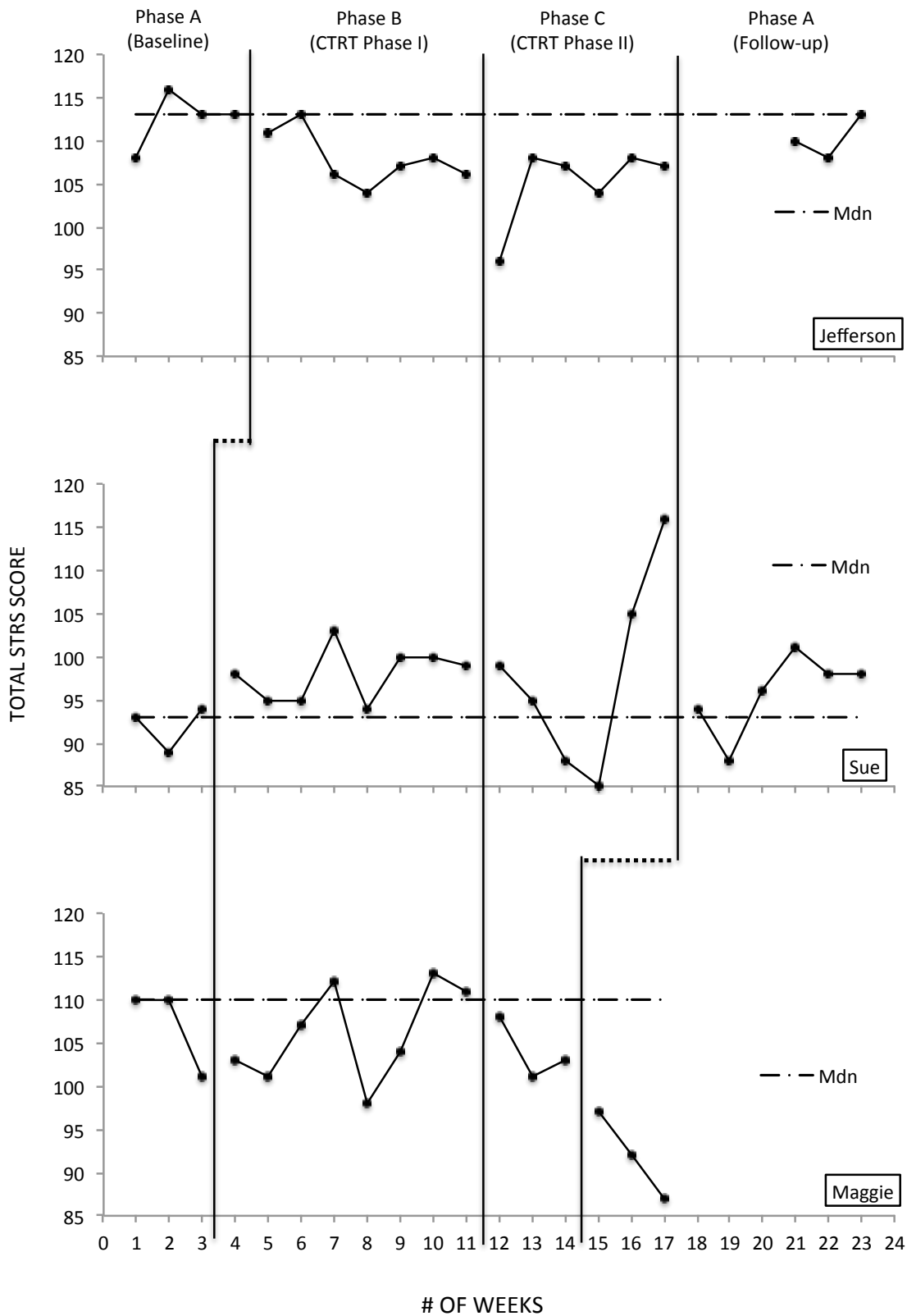
Figure H6: Total SRTS scores across phases for all participants. The start of Maggie's baseline was delayed and Jefferson and Sue's were simultaneous.
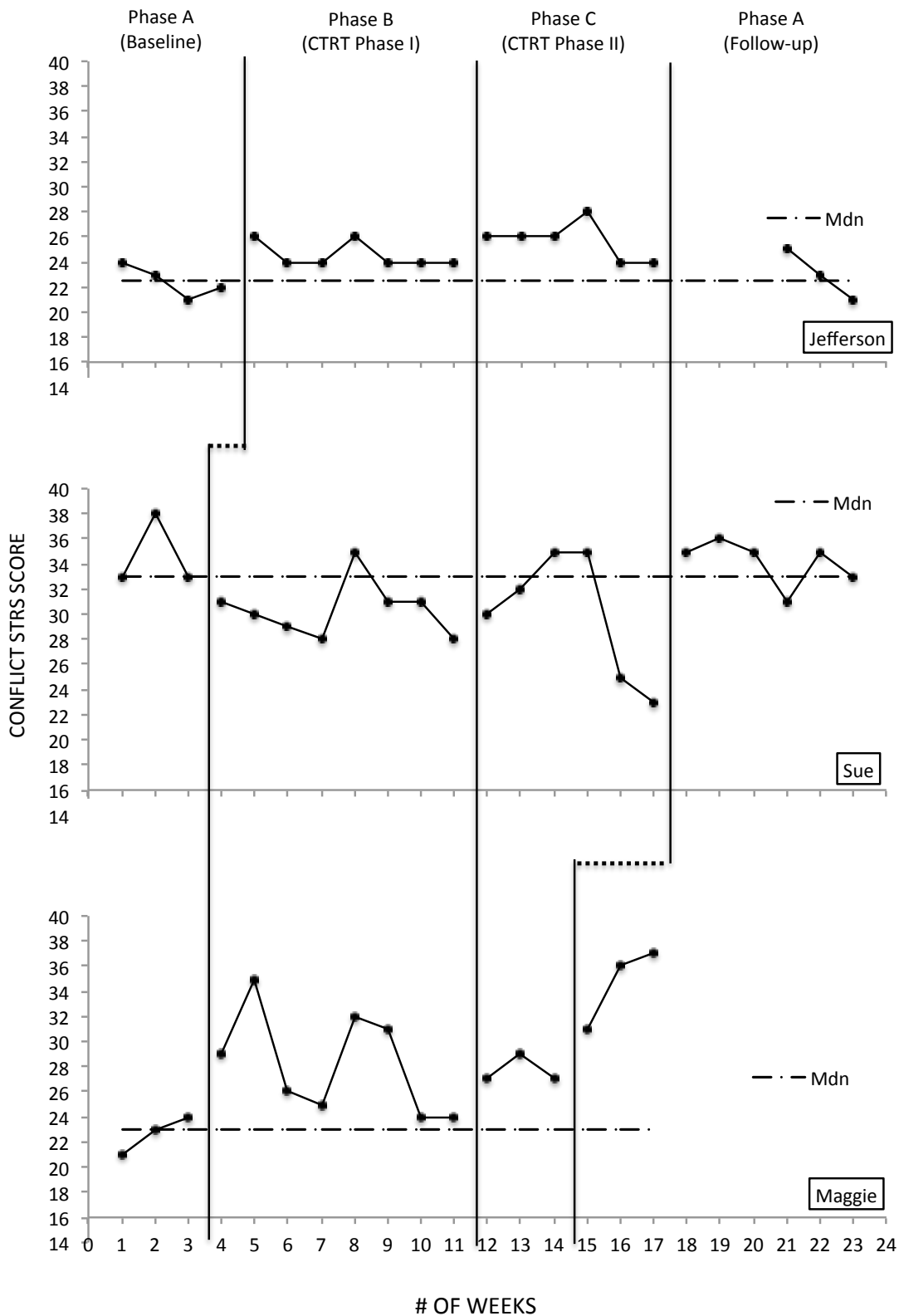
Figure H7: SRTS Conflict subscale scores across phases for all participants. The start of Maggie's baseline was delayed and Jefferson and Sue's were simultaneous.
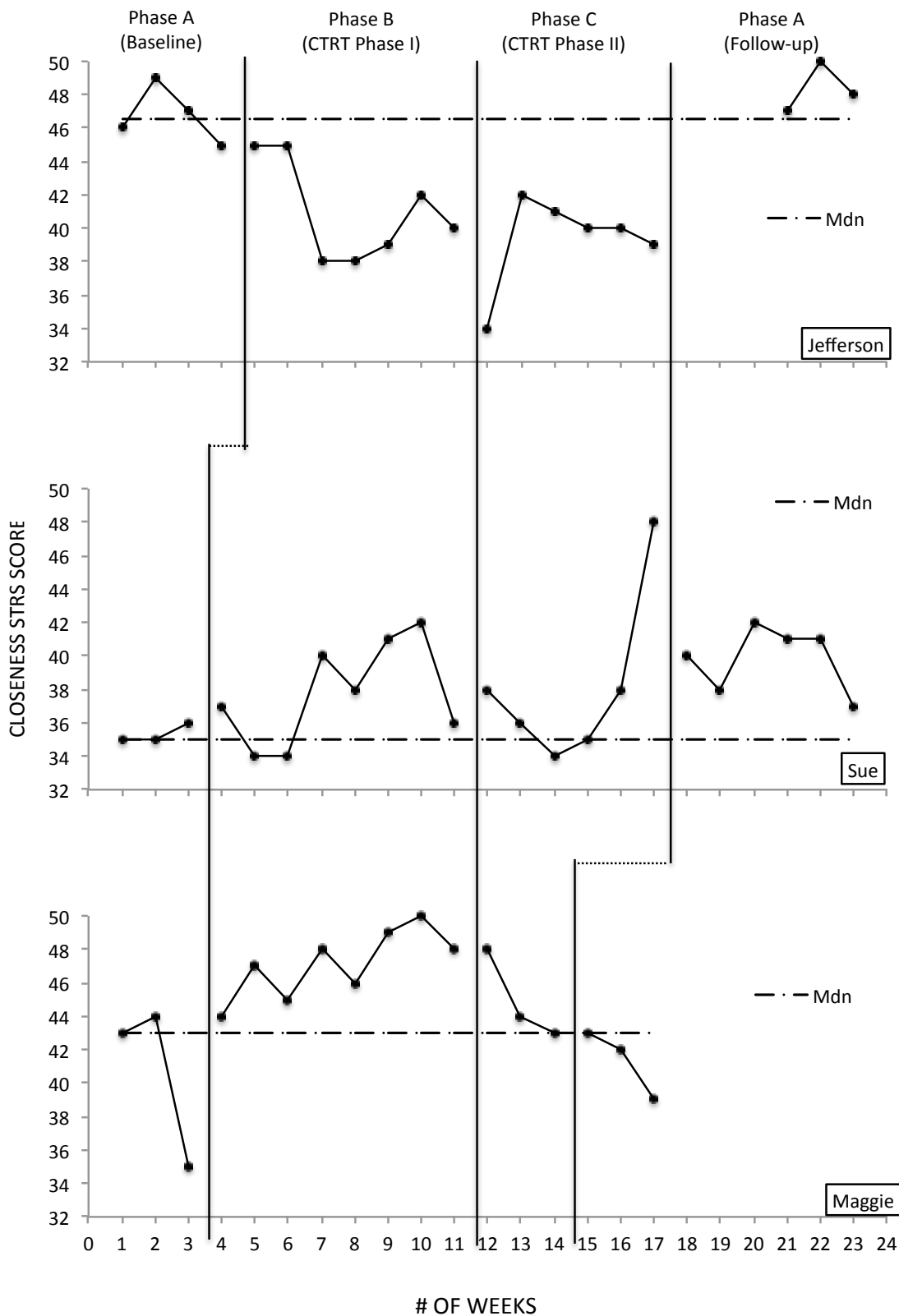
Figure H8: SRTS Closeness subscale scores across phases for all participants. The start of Maggie's baseline was delayed and Jefferson and Sue's were simultaneous.

APPENDIX I: DATA COLLECTION CHECKLIST

	Participant 1	Participant 2	Participant 3	Participant 4
Prior to Study Start				
Informed Consent				
COF Informed Consent				
COF Assent				
Demographics				
PRI				
prestudy interview				
Baseline				
Week 1				
CTRT-SC				
STRS				
play session video				
Week 2				
CTRT-SC				
STRS				
play session video				
Week 3				
CTRT-SC				
STRS				

play session video				
Prior to Phase B				
TRF				
MBI-ES				
Phase B-CTRT Phase I				
Week 1				
CTRT-SC				
STRS				
Week 2				
CTRT-SC				
STRS				
play session video				
Week 3				
CTRT-SC				
STRS				
play session video				
Week 4				
CTRT-SC				
STRS				
play session video				
Week 5				

CTRT-SC				
STRS				
play session video				
Week 6				
CTRT-SC				
STRS				
play session video				
Week 7				
CTRT-SC				
STRS				
play session video				
Week 8				
CTRT-SC				
STRS				
play session video				
Prior to Phase C				
TRF				
Phase C-CTRT Phase II				
Week 9				
CTRT-SC				
STRS				

Week 10				
CTRT-SC				
STRS				
Week 11				
CTRT-SC				
STRS				
Prior to Phase A Return				
MBI-ES				
Phase A-Return to Baseline				
Week 1				
CTRT-SC				
STRS				
Week 2				
CTRT-SC				
STRS				
Week 3				
CTRT-SC				
STRS				
After Study Completion				
poststudy interview				