

**EFFICACY OF CHILD-CENTERED PLAY THERAPY IN POVERTY
ENVIRONMENTS**

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June 24, 2024

TABLE OF CONTENTS

Background	3
Introduction	4
CCPT in Schools	8
Negative Impacts of Poverty on Children	11
CCPT as an Early Intervention	18
Conclusion.....	28
References	31

Background

I decided to study play therapy after hearing about it in Dr. Rowniski's PSYC 432: Childhood Psychopathologies class. I remember writing it down and thinking, "what an interesting topic!" Everyone knows children love to play but using that as a way to also provide psychological help is an incredible step for the psychology community. I have always loved working with children. I grew up with 13 younger first cousins, and as the second oldest of everyone, have been able to watch almost everyone grow up. Some now are pre-kinder ages while I am a senior undergraduate. I have been able to coach youth recreation league sports, babysit, and volunteer as a "big" for Big Brothers Big Sisters. My future aspirations include working in juvenile court as an attorney and hopefully a magistrate if the opportunity arises. Children are the most important asset to our future, and I strive to be able to help provide the best life situations for as many as I can. Studying child-centered play therapy allowed me to learn about a form of therapy I wasn't familiar about before college. I chose reviewing the efficacy of child-centered play therapy within poverty environments because of my hometown of Memphis, Tennessee. According to Delavega & Blumenthal (2023), who wrote the annual *Memphis Poverty Fact Sheet*, the poverty rates for children under 18 in the Memphis city area were higher compared to Shelby County, Tennessee, and the United States at 21.4% overall and 32.7%, respectively. Children still "bear the brunt of poverty and suffer the consequences" in Memphis (Delavega & Blumenthal, 2023). In 2023, Memphis was tied with New Orleans for #1 in poverty for both overall and childhood percentages. This statistic is extremely disheartening. While so many factors go into poverty, one person cannot help them all. I decided with my passions, I would argue for the efficacy of play therapy for children in poverty environments so that they

may be better equipped to break the cycle of poverty. Children's mental health must be a priority to have a future society with lower rates of poverty.

Introduction

This paper aims to argue child-centered play therapy as an effective therapeutic method for children who live in poverty environments.

History of CCPT

Child-centered play therapy, or CCPT, has developed by Virginia Axline in the later 1940s (Bratton et al., 2009). Axline was a student under Carl Rogers, a well-known American psychologist, known for his work in humanistic psychology, and importantly to this paper, developing person-centered approaches to psychotherapy ("Carl Rogers," 2021). While focusing on the client in therapy seems like an obvious approach today, Rogers helped propel the idea forward in the early 1940s and make it a foundational psychological approach. He believed human beings are intrinsically drawn "toward achieving positive psychological functioning" (Yao & Kabir, 2023, para. 2). Axline later worked alongside Rogers and took his teaching to outline her own approach for children, child-centered play therapy. It is based on the "belief in the individual's natural strivings for growth and the individual's capacity for self-direction," which bears resemblance to Rogers humanistic way of thinking (Landreth, 1993, p.18). Although there is history of play being utilized earlier in psychology, Virginia Axline took this activity and helped spur the creation of what we now in North America call child-centered play therapy, by applying nondirective techniques to play therapy (Bratton et al., 2009). Overall, CCPT is a person-centered therapy that adopts play as the medium in which the child communicates.

Medium of CCPT

Communication can be hard. Even adults struggle with putting their thoughts into words and reaching a resolution. Adults can speak out their feelings, but children have limited vocabulary and life experience, so the way they can “speak” thoroughly like an adult is through play (Cochran et al., 2022). When dealing with complicated thoughts, adults will think about a topic repeatedly, and this topic will give them anxiety, so they will stop thinking about it before reaching some type of thoughtful wisdom or psychological settlement. In therapy, a therapist will aid an adult with these thoughts and talk through the entire thought to reach a resolution (Cochran et al., 2022). This process is how child-centered play therapy works, but with play. CCPT focuses on the child’s needs and emotions. Children, like adults, are equally capable of coming to their own understanding of their thoughts through the help of a therapist, except instead of only words, they use play (Cochran et al., 2022). Children under eleven are especially limited in explaining their thoughts verbally, so play therapy can make sense of these complicated emotions (Landreth, 1993). If the same method of communicating was applied to children as it is adults, it would not allow children to fully explore their experiences.

Play is synonymous with children, as children across all cultures, races, ethnicities, ages, and poverty levels play. Play is so important for children--it is central to their cognitive growth (Bratton et al., 2009). In fact, play has been deemed a necessity for children in order to fit in the social world and develop a positive sense of self (Isenberg & Quisenberry, 2002). Children play to interact with peers and grow confidence in dealing with their environment and personal experiences (Landreth, 1993). Axline used play as a way for psychologists to aid children who need help working through their problems. She described play as the child’s “natural medium of

self-expression” where they can act out their feelings, trauma, thoughts, and any possible difficulties through (Cochran et al., 2022, p. 4).

Method of CCPT

So how does CCPT work? Instead of people, children will put all their “anxieties, fears, fantasies, and guilts to objects rather than people” (Landreth, 1993, p. 17). And the therapist who facilitates the child’s experience must do so in a very predictable, active, and steady way so that the child knows what to expect. The predictable, consistent nature of the therapist’s aid also then grants the child the ability to express themselves in a non-predictable way (Cochran et al., 2022). The child feels somewhat separate from what they are acting out because playing is seen to be in the fantasy realm, not reality, which is positive because then the child can be less overcome by their experiences (Landreth, 1993). Nancy Cochran explained in her book, *Child-Centered Play Therapy: A Practical Guide to Therapeutic Relationships with Children*, that the meaning of “nondirective” approach that makes CCPT what it is can be misleading at times (2022). CCPT is child-centered, but playroom toys are conscientiously chosen for a child, so that the playroom somewhat directs a child to self-express. The therapist does set goals, progress is made, and the therapist will be able to better understand of a child’s internal process via play (Cochran et al., 2022). A good way to understand CCPT would be that it is led by the child with adult facilitation through verbal and nonverbal skills. Nonverbal behaviors mean actions the therapist consciously does throughout the session, for example leaning forward and making their physical direction always towards the child throughout the session (Ray et al., 2009). Verbal skills mean the therapist focuses on the child’s experience with “empathetic acceptance, the child is freed up, and in a sense, ‘directed’ to attend to [their] inner experience, [their] thoughts, feelings, reactions to [their] outer world, and [their] choices” (Cochran et al., 2022, p. 5). Therapists match their

verbal response to not overly direct the session but instead facilitate with tracking, reflecting, and encouragement (Ray et al., 2009). The therapist does not specifically direct the child to better behavior, it comes from the sessions opening the child's inner want to mature. If a therapist did tell the child what they should do or act, it would disempower the child. The therapist needs to be deeply empathetical, have unconditional positive regard, and demonstrate genuineness for CCPT to work most effectively and empower the child-client (Cochran et al., 2022). If these criteria are met, the child plays and makes better sense of their possible trauma or emotions. It changes "what may be unmanageable in reality to manageable situations through symbolic representation, which provides children opportunities for learning to cope by engaging in self-directed exploration" (Landreth, 1993, p. 18). They are able to take control of their emotions instead of letting them take control of them, which is very helpful for children who have undergone traumatic experiences. Therapists or counselors follow eight principles that were originally outlined by Axline in 1947. Cochran et al. (2022) and Landreth (1993) have provided the list of the principles that are outlined here:

1. Establish conditions for rapport: a warm, caring relationship through which the child feels safe developing the relationship.
2. Accept the child completely and do not judge or diagnose, no liking or disliking, just accept the child. That way, the child can choose the best therapeutic path to bring change in their life.
3. Establish feeling of safety and permissiveness so the child can feel safe to totally express all their feelings.
4. Recognize and reflect feelings of the child so that the child can understand and get insight into their behavior.

5. Maintain respect for the child and believe in the child's ability to solve their own problems.
6. Let the child lead the way and not direct any play or conversation. Any infringement on these will hurt self-expression, the relationship, and the therapy length.
7. Remember that therapy cannot be hurried, it is a gradual process.
8. Use limitations wisely. There should not be too many limits that the child is not free to express themselves, but also use limits so that the child is connected to reality and responsibility.

In order for therapy to work most effectively, the mediator of play therapy must rely on these principles. These principles are followed by trained therapists and counselors, but other facilitators like parents have recently been trained more and more to use these skills. As more research has been done on the effects of child-centered therapy, evidence has piled up suggesting that child-centered approaches are very effective (Bratton et al., 2009). Because of this growing body of evidence of the positive effects of child-centered play therapy, schools have been making use of CCPT too, which is especially helpful for children who cannot afford a therapist.

CCPT in Schools

Child-centered play therapy has been shown to be very useful in schools. Already, psychological intervention at a young age can drastically alter a child's future. Increased stress levels at a young age have been associated with worsening academic performance, school dropout, and increased risk of developing further mental health problems (van Loon et al. 2020). In fact, the state of mental health issues for children has become so widespread that the need for mental health aid in the United States has been termed a health crisis (Committee on School

Health, 2004). Mental health treatment for issues can help mitigate levels of school violence, dropout rates, bullying, suicide and homicide rates, and high-risk behaviors (Committee on School Health, 2004). Schools are a great place for children to receive said mental health aid because they spend a huge portion of their awake hours at school. Schools also have already been increasing their focus on mental health services (Ray et al., 2015). Because of this correlation, schools have a perfect opportunity to capitalize on CCPT, and some have already yielded promising results. Next will be discussed just a few of the positive results of CCPT in school environments.

Examples of Utilizing CCPT in Schools

Blanco et al. (2012) conducted a follow up study to see the long-term impact of CCPT of 18 previously identified academically at-risk first graders from a previous study by Blanco in 2011. Their results found that the children who participated in 26 CCPT sessions showed significant “growth in academic achievement” (Blanco et al., 2012, p. 11). According to Cochran et al. (2022)’s perspective of the case, the students were labeled at risk by their school district and still achieved consistent, enhanced academic achievement after CCPT.

A quantitative single case research design by Montemayor (2014) analyzed 12 students in a south Texas elementary school from ages pre-kindergarten 3-4 and Kindergarten age, who received 45-minute CCPT sessions 12 times over six weeks. These students had been identified by the teacher as having behavioral issues in the classroom. After the twelve weeks, the students were scored using the Child-Behavior Checklist and Caregiver-Teacher Report Form, and the study showed that 71% of their scores showed a positive change in behavior, and 29% did not. Of adults that daily interacted with children, 90% of parents and 80% of teachers said the child’s

behavior saw improvement (Montemayor, 2014). These results further show the efficacy of CCPT in schools.

A meta-analysis done by Ray et al. (2015) reviewed CCPT as an effective intervention for elementary schools within 23 studies. The study found that child-centered play therapy was in fact “an effective response service in an overall comprehensive developmental guidance program” in elementary schools (Ray et al., 2015, p. 121). The children showed serious progress in improving their problematic behaviors or characteristics. Internalizing issues improved at a deviation of 0.21, externalizing issues at 0.34, total problems at 0.34, self-efficacy improved at 0.29, academic performance at 0.36, and solving other problems at 0.38 over peers who did not receive CCPT intervention (Ray et al., 2015). Internalizing issues includes problems involving the self, like how a child feels about themselves, withdrawal, anxiety, depression, and emotional issues (Nikstat & Riemann, 2020). These issues are more cognitive, while external issues manifest themselves as more problems in “social environment[s]” like aggression, impulsivity, deviance, and hyperactivity (Nikstat & Riemann, 2020, p. 1). In the case of children, internalizing issues can greatly affect other children’s learning in the classroom.

The importance of these studies in schools cannot be underestimated. All were of different designs and demonstrated evidence that CCPT has positive behavioral changes on children identified with behavioral issues. Because of the promising results in schools and the fact that many children attend elementary school, CCPT utilized in school settings would be highly effective. Bratton (2010) issued similar agreement that school location is a prime venue for changing a child’s future and behavior through CCPT. Several studies outlined later not only focus on elementary students as the ones above but focus on elementary-age children in poverty

environments. While children in low-income level areas receive less equitable educations at times, schools would be the most efficient place for children in poverty environments to receive CCPT, as there is not another setting to implement CCPT as easily as schools could.

Other Poverty-Identified Assistance Methods

Poverty is identified as a qualifier for federal assistance in schools in the United States. For example, one federal aid program in the U.S. is Head Start, which using poverty as an identifier to receive aid. Children in the program are put into learning environments that promote school readiness and excellency in language, literacy, and social and emotional development. Parents are also supported and work on being engaged as the child's role model and teacher ("Tennessee Head Start"). Head Start is the "largest early intervention and prevention program for at-risk low-income children," used to identify and help the identified children with their disruptive behaviors (Bratton et al., 2013, p. 29). In the federal school lunch program, the eligibility for free or reduced-price lunch in public schools is based on determined percentage below the federal poverty line (Yoshikawa et al., 2012). These types of programs use low-income as an identifier because poverty makes children more vulnerable to mental, emotional, and behavioral problems.

Negative Impacts of Poverty on Children

In the United States, poverty is the "state in which one lacks a usual or socially acceptable amount of money or material possessions to provide for his or her basic needs, which typically include food, water, sanitation, clothing, shelter, health care, and education" (Pascoe et al., 2016, p. 3). People in poverty cannot afford an acceptable number of comforts. Definitions of poverty

can also vary from place to place. Tucker (2022) defined two main types of poverty: absolute and relative. Absolute poverty is usually measured by lack of or quality of food, shelter, and other basic material needs, which many studies in the U.S. use as a definition of “poverty” (Yoshikawa et al., 2012). Relative poverty means being able to financially live in a way that is socially acceptable (Townsend, 1979, as cited in Tucker, 2022). Koball & Jiang (2018) separated poverty levels by low-income, encompassing near poor, poor, and deep poverty. Using any of these definitions, it is undeniable that poverty involves some level of inadequate meeting of basic needs, which can cause friction in other areas of life. Despite being a first world nation, poverty levels in the United States are drastically high, with children unevenly receiving the brunt of the issue.

Statistics on Childhood Poverty

Compared to similar nations, the United States’ poverty range was 20% in 2012, which is much higher than other developed nations like Norway, Germany, and Canada right to the north (Smeeding & Thévenot, 2016). The official federal poverty level (FPL) in 2022 for the U.S. was 11.5%, but that percentage only comes from looking at a small number of factors like pretax income, and it uses federal poverty threshold salaries that are inflation adjusted. Using the SPM, which considers income but also several other factors like taxes, noncash benefits, nondiscretionary expenses, and geographically adapted poverty thresholds to consider other things like costs for food, clothes, and bills, the poverty rate was 12.4% in 2022 (Shrider & Creamer, 2022). Looking just at children, 38% in America are low-income, and 17% were poor in 2019, which means there were more than 27 million children living in low-income families (Koball et al., 2021). The numbers have not drastically improved since then. From 2021 to 2022, the SPM child poverty rate doubled, which means there are many children still living in low-

income surroundings (Shrider & Creamer, 2022). These numbers are shocking because it means that children are unequally represented in poverty compared to the population; they only make up around 23% of the population but are 32% of all the population in poverty (Koball et al., 2021). Younger children too are unevenly represented because they are more likely than older children to live in poverty or near-poor environments (Pascoe et al., 2016). These American families that are near-poor live barely above the poverty threshold, and they experience similar risks of those below the poverty threshold (Yoshikawa et al., 2012). Included below are the FPL levels for 2023 and 2024 for the contiguous United States in Figure 1.

Figure 1

Federal Poverty Level (FPL)

Family size	2023 income numbers	2024 income numbers
For individuals	\$14,580	\$15,060
For a family of 2	\$19,720	\$20,440
For a family of 3	\$24,860	\$25,820
For a family of 4	\$30,000	\$31,200
For a family of 5	\$35,140	\$36,580
For a family of 6	\$40,280	\$41,960
For a family of 7	\$45,420	\$47,340
For a family of 8	\$50,560	\$52,720
For a family of 9+	Add \$5,140 for each extra person	Add \$5,380 for each extra person

HealthCare.Gov. (2024). Federal Poverty Level (FPL).

Effects of Childhood Poverty on Mental Health and Well-Being

Child poverty is an especially dismal topic because children are not yet able to hold jobs to yet break the cycle of poverty and are at the mercy of their caregivers. They can experience food insecurity, lack of housing or utilities, higher exposure to pollution, and dangerous neighborhoods, just to name a few (Pascoe et al., 2016). Along with the fact they cannot really change their socioeconomic status, many children in poverty endure terrible consequences because of their settings. These consequences go as far as to affect future physical health, language and cognitive development, academic achievement, and educational attainment (Yoshikawa et al., 2012). This paper will next examine the negative effects of poverty on children's mental health, school success, and well-being.

Children living in poverty status are also more at risk to experience adverse childhood events, or ACEs, which can be parental death, parental incarceration, experiencing or witnessing domestic or neighborhood violence, living with someone who is mentally ill, suicidal, or with a substance abuse problem, and being treated or judged unfairly due to their race/ethnicity (Powell & Davis, 2019). In fact, Parker et al. (2021) even defines childhood poverty as an ACE and source of trauma. So, childhood poverty can not only increase other adverse childhood events, but it is also one itself, just adding to the cycle of trauma. These ACEs can hurt a child's brain development, stress response, ability to use learning processes, or even change behavior, which can be very destructive to coping skills and lead to forming maladjusted behavior skills (Powell & Davis, 2019). Unfortunately, ACEs are of increasingly high occurrence, so their effect must be identified and mitigated early on in a child's life (Parker et al., 2021). Without early intervention, ACEs can affect a wide range of things, like behavior and even educational performance (Powell & Davis, 2019).

Other than having more experiences of adverse events that cause trauma than children not in at-risk poverty environments, poverty can cause even more negative effects on their future mental, emotional, and behavior, or M-E-B health (Yoshikawa et al., 2012). Poverty can have impairments on children in poverty's cognition and social-emotional growth (Evans & English, 2002). Many studies have shown a causal influence of absolute poverty having negative impacts on mental, emotional, and behavioral health development (Yoshikawa et al., 2012).

Psychological stress and trauma can have lasting repercussions on a child in the future as it hurts their M-E-B development. Poverty supports the growth of toxic stress, which hurts the body and aggravates the mind as there are many physiological and psychological costs to try and balance out this stress (Pascoe et al., 2016) When this toxic stress is frequent, which it usually is because a child in low socioeconomic settings do not easily leave poverty situations, it builds up and hurts the prefrontal cortex's ability to suppress the amygdala, which can lead to a decline in impulse control, leading to behavioral problems. Chronic stress can also harm relationship building, learning, behavior, and can increase maladaptive behaviors in the future (Pascoe et al., 2016). All in all, living in economically disadvantaged environments makes children more likely to experience adverse childhood experiences which can create trauma for them, as well as increasing chronic stress that can impede a child's future social and learning development.

Therefore, while not maybe seemingly influential at first, poverty is shown to extend its grip into every part of a child's life through social, emotional, physical, behavioral, and cognitive aspects (Tucker, 2022). These aspects then later affect a child's future. Reiss (2013) carried out a systematic review of 55 studies that showed that children living in low-income environments were two times as likely than children in higher economic statuses as likely to have mental health issues, especially under twelve years old. These mental health issues include negative behaviors

that can linger with them into adulthood, impeding their future with roadblocks (Post et al., 2019). Young children in poverty who have highly disruptive behavior face grim futures with their learning and relationships (Cochran & Cochran, 2017). In fact, “conduct problems present in ages 7–9 years were significantly associated with future higher rates of crime and substance dependence,” plus mental health problems such as depression and anxiety disorders, antisocial personality disorder, and suicide attempts and sexual/partner relationships like teen pregnancy and domestic violence (Fergusson et al., 2005, as cited in Cochran & Cochran, 2017, p. 60). Children in poverty are disproportionately affected by behavior and cognitive problems than those who are not, and because of their social status are not helped as much.

Effects of Childhood Poverty School Success

Children who are from impoverished settings are more likely to perform worse in school compared to those who are not, for example their literacy scores are worse (Smeeding & Thévenot, 2018). Living in poverty predicts deficits in children’s cognitive and academic abilities, including poor verbal skills, low IQ, grade repetition, and early school dropout (Brooks-Gunn and Duncan, 1997, as cited by Capella et al., 2008). Why is there such a lessened performance of children in poverty concentrated schools? There is evidence that public schools in poor communities struggle to realize their potential to advance more positive future outcomes for their students (Capella et al., 2008). Furthermore, children from low-income families experience more a negative school environment than those who are not. They more often have under-qualified teachers who do not expect as much from their students in performance, which can hurt outcomes (Weinstein, 2002, as cited by Capella et al., 2008). The funding of high-poverty schools can affect programs, school-materials, and overall opportunities for their

students. The difference in capable and accomplished teaching staff for poor students furthers the gap of education between them and those who attend schools in higher socioeconomic areas.

Education is especially important because performing well in educational endeavors is one of the strongest ways to break the cycle of poverty (Tucker, 2022).

Inequal Levels of Poverty Based on Race

It would be wrong not to acknowledge too the discrepancies between races for children in poverty. In America, poverty is also affected by the United States' history of systematic oppression and racism, which makes it harder to break the cycle of poverty (Lin & Harris, 2008, as cited in Tucker 2022). Among children under nine in 2016, the biggest group of children living in low-income families and poor children is Hispanics, next being Non-Hispanic Black, and then Non-Hispanic White. Based on population size, Black, Native American, and Hispanic children are all disproportionality low-income and poor (Koball & Jiang, 2018). There is a statistically significant relationship between the effects of CCPT and a child's ethnicity too, CCPT has shown more effects in bettering behavior in non-Caucasian children than Caucasian (Lin & Bratton, 2015). The real reason is not known, but one suggestion is that bilingual children possibly are not able to fully represent themselves in the world, but in play they do not need language to express their emotions. Lin & Bratton (2015) believe this statistic to mean that CCPT can be considered a "culturally responsive intervention" (p. 54). Marginalized children are often excluded from treatment and psychological help because of their ethnicity or poverty (Post et al., 2019).

Overall Conclusion of Childhood Poverty Effects

Overall, young children are more likely to live in impoverished environments (Koball et al., 2021). This fact, coupled with the evidence that poverty has direct harmful effects on early brain development, means intervention is necessary at a young age (Pascoe et al., 2016). Brain development and disruptive behaviors emerge from trauma and stress related to living in poverty environments. Without early intervention for the then developed disruptive behaviors, these children are more likely to further develop severe mental health issues later in life (Bratton et al., 2013). This paper argues that child-centered play therapy is an effective early intervention to interrupt impacts of poverty by older childhood and adolescence. CCPT has already been shown to help children in poverty with ACEs reach developmental needs because of its relational nature and use of toys (Parker et al., 2021). There are also numerous studies that all provide data that play therapy has been significantly effective for children in poverty environments in addressing behavior problems and educational achievement. On top of that, CCPT would yield the highest number of effective treatment if done in schools. Young children are most likely to have access to and receive mental health aid when these services are offered in schools (Blanco et al., 2019).

CCPT as an Early Intervention to Interrupt Impacts

This section aims to justify CCPT as an early intervention in schools to respond to and interrupt impacts of poverty for young children by older childhood and adolescence. It first looks at an early study from 2003 that analyzed homelessness and poverty together and the effects of CCPT for young children in these situations. Stemming from that discussion, several promising research studies are stated that analyze CCPT's mitigation outcomes on a well-defined set of consequences of poverty -- disruptive behaviors. Finally, the impacts of CCPT on school achievement for students in poverty environments is examined. The purpose of this portion of the paper is to show the growing, undeniable evidence of CCPT treatment for at-risk,

impoverished children, and CCPT treatment's positive responses on the cognitive, educational, and behavioral development planes when put into place early and in an accessible location.

CCPT's Impact on Self-Efficacy and Behavior

In 2003, Dr. Jennifer Baggerly published an article encouraging play therapists to utilize the child-centered play therapy approach for children who are homeless. This article is one of the earliest publications used in this paper besides Landreth's in 1993, and Baggerly's work is the oldest work in this paper that directly focuses on intertwining the CCPT discipline with children who are homeless. At the time of its publication, her work was one of the few addressing play therapies with impoverished children (Baggerly, 2003). Baggerly argued that play therapists have an ethical obligation and social responsibility to expand their methods and skills to support children from all socioeconomic backgrounds and offered the study with evidence of CCPT's positive impact for homeless children to help therapists in this regard. Baggerly argued that children living without a home are exposed to more stressful life events than those who are poor but not homeless. These adverse life events meant higher instances of anxiety, depression, behavioral problems, aggressive and disruptive behavior, shame, and lower self-esteem (Baggerly, 2003). Undergoing play therapy at school helped these children develop a sense of safety and relieved anxiety about transportation worries to their sessions. Now, not all children who are homeless are poor and vice versa, but in these scenarios, these children were implied to be homeless as an extension of poverty. The study analyzed 40 children's CCPT sessions over three years. The play therapists' goals were to establish a positive foundation of hope based in genuineness, faith, and healthy relationships so that they could convey that "hopefulness as faith and healthy relationships are available to children regardless of financial status" (Baggerly, 2003, p. 93). These CCPT sessions also stressed the non-directive approach of CCPT so that children

could begin releasing pent-up stories and feelings about their lives, either related to homelessness or other ACEs of poverty. CCPT treatment awarded positive results; these children were given a safe environment to work out trauma and build their confidence to handle future trauma-related situations, and in return they were able to build their self-esteem, self-actualization, and sense of love and belonging (Baggerly, 2003). Baggerly encouraged future professionals to look at how the bitter effects of poverty hurt children in multiple realms, and therapists have a duty to provide and call for action.

Similarly, play therapists have also been called to work on the serious matter of social discrimination that marginalized children in poverty receive (Post et al., 2019). Children in poverty environments can suffer from many other issues in their lives, especially in the realms of mental health and behavior because they are “excluded from the mainstream social, economic, cultural, and political life because of ethnicity or poverty” (Post et al, 2019, p. 88). These disruptive behavior problems in school for at-risk children were and are but are not limited to “aggression, noncompliance, destruction of property, attention problems, distractibility, and hyperactivity” (Bratton et al., 2013, p. 29). These externalizing actions are a big problem because they can damage their school attainment and personal relationships. They can also have impacts on children in their later years of life (Pascoe et al., 2016). When these problems are not mitigated early on, they can have disastrous outcomes in the future. Post et al. (2019) asserted that play therapists should consider the backgrounds of their students and pay attention to how different cultures, forms of oppression, and power dynamics can affect their therapist-patient relationship with the marginalized children they are working with. Marginalized children are at risk to develop aggressive behaviors that can damage their future potential.

In some diagnostic cases, aggressive behaviors are categorized into three groups of conduct disorder, oppositional defiant disorder, and attention deficit/hyperactivity disorder, although the “aggressive” category name can be misleading (Ray et al., 2009). Ray et al. (2009) sought to understand CCPT’s effects as an early responsive technique to aggressive, disruptive behaviors. They focused on argumentative behaviors, cruelty to others or animals, destruction, disobedience, fighting, screaming, throwing tantrums, demanding attention, teasing, and threatening others in their study (Ray et al., 2009, p. 167). It follows that aggressive behaviors at a young age can increase if not properly mitigated at a young age, and older children and young adults who have aggressive symptoms could have been helped if they had received some type of mental help treatment at a younger age. They also focused their study at a Title 1 school. Title 1 schools are considered “high-poverty contexts” as they are schools where 40% or more of their students come from low-income families (Tucker, 2022, p. 244). These environments with concentrations of poverty are not good for child behavioral, social, cognitive, and educational development (Cochran & Cochran, 2017). Because of the severity of the behavior problems with some of the children at school, the administration asked Ray et al. to help the identified children with aggressive tendencies, so there was no random assignment on who received treatment, there was instead a “wait-list” of children who did not undergo CCPT sessions during the study. The results once again found CCPT being effective at reducing maladaptive behaviors. Teachers reported a compelling decrease in aggressive behaviors, and even though parents could not see a big of a change, that is believed to be due to not a large enough “sample sizes and a similar enough pattern of effect sizes” for their reports (Ray et al., 2009, p. 172). As mentioned near the beginning of this paper, CCPT’s doctrine is based on letting the child fully express themselves in a monitored environment. This study demonstrates that the facilitation by a therapist and

allowance to safely act out their aggression helps the child work on acting out in more socially allowable ways and felt understood (Ray et al., 2009). This study is a crucial point that indicates that CCPT can help at-risk children, as this study was carried out at a Title 1 school, and the results showed a decrease in disruptive behaviors, something children in poverty environments can deal with more often than non-impooverished children.

Bratton et al. (2013) produced a study that investigated CCPT's effectiveness for 54 low-income preschool-age children that were professionally established to have disruptive behaviors in the classroom at clinical levels in the Southwest United States. Their teachers disclosed that they had conduct issues, aggression, defiance troubles, hyperactivity, impulsivity, and attention problems. These children were very young, only between three and four years old. All the 27 children who were in the experimental group underwent CCPT sessions at 30-minute intervals twice a week. Overall, the number of sessions they had were from 17-21 and were from qualified counselors who utilized both verbal and nonverbal cues in the sessions. From the experimental group, 21 children showed improvement in their severe behavior issues to normal behavior functioning. Even the six children who did not move into normal levels moved from "clinical levels of concerns...to the borderline range at posttest" (Bratton et al., 2013, p. 26). These results are significantly better than the control group where only five of the 27 had any improvement from meeting with a reading buddy for the same number of sessions and time as the CCPT group. Four of these children in the control group actually showed worse behavior.

Another critical study that establishes a pattern of the efficacy of CCPT for children in poverty environments is by Cochran & Cochran (2017). Students in this service project attended high-poverty schools that had free or cost-reduced lunches over 90% and were identified by principals because of their behavior. CCPT sessions were given to these referred students and

were rated by either their teacher or after-school director. These children were put through CCPT sessions for 20 minutes two times a week with around 18 sessions total (give or take a few students who had fewer, but all had a minimum of nine sessions). The results of the study showed that there was a statistically significant increase among the treatment group with self-efficacy, decrease in attention problems, and externalizing problems versus the control group. This research is very important because it helps establish a narrative for three things. First, this study directly found CCPT to be effective “for highly disruptive behavior in elementary school-age children... in high-poverty schools” (Cochran & Cochran, 2017, p. 67). Second, this study also shows how CCPT can possibly be a more effective service than social work help, parental programs, teacher assistance, mentoring, school counseling, and other disciplinary programs. This is because referred students “were not showing a decrease in highly disruptive behavior in spite of multiple other intervention facets,” and they were not undergoing any treatment outside of school (Cochran & Cochran, 2017, p. 61). Third, these findings utilized students or “beginner” play therapists, in fact 78% of the children were facilitated by these newer, younger administrators. and 59% were facilitated by those with a Master of Science in Counseling (MS) (Cochran & Cochran, 2017, p. 64). These therapists are not all doctorate holders, and high-poverty schools could utilize students at a much cheaper price. It also shows that counselors at school can carry out CCPT once they receive appropriate training.

Noticeably, all these studies have been conducted in school settings. That is because the school setting is the best location for these types of mitigating therapies. Professional psychological help is hard to afford and hard to seek out. In fact, some groups of children from ethnic minorities, who are disproportionately affected by poverty, are more accessible in schools because they are less likely to employ mental health services at the clinical level (Blanco & Ray,

2011, as cited in Post et al., 2019). Preventative measures, namely CCPT, can reach more children in poverty who need help if implemented in schools.

CCPT's Impact on School Performance

These next cited articles are no different in setting; all take place in school environments. While the other studies analyzed the benefits of positive behavior from CCPT, these studies focus on academic attainment, another notable realm that can be affected by childhood poverty and subsequent adverse childhood experiences. CCPT can aid educational endeavors because CCPT helps improve social and emotional learning, which is “the capacity to recognize and manage emotions, solve problems effectively, and establish positive relationships with others...which is essential for all students” (Zins & Elias, 2006). Massengale & Perryman’s (2021) results agree, and believe this research means that CCPT can have great effects on academics for children. It has also been suggested through research that exacting attention on academic interventions can boost children’s social and emotional functioning (Capella et al., 2008).

Blanco et al.’s 2019 research study focused on very young children, in Title 1 schools, and were identified as at-risk academically. Their study also questioned if CCPT could be a possible early mitigation service for bettering academic achievement, as these children were in kindergarten. Thirty-six children from three southwestern schools were a part of the study. Over a course of six weeks, the young students either received play therapy treatment 30 minutes two times a week or did not during the study’s course (but later were given the opportunity). A pre-study questionnaire was given to make sure there might not be too many other factors at home improving the child’s learning. Children who received CCPT times moved from the below

average YCAT Early Achievement Composite scores to average. They also improved on the General Information subscale and Writing Subscale (Blanco et al., 2019). One important finding this study found was that there are certain academic skills that are receptive to improvement after a short while, only 16 sessions. Other academic skills needed more long-term therapy, over 16 sessions, like reading, mathematics, and spoken language. However, the findings did show improvement, and the theory that CCPT can help academically at-risk youth is further backed (Blanco et al., 2019).

How long do these effects of play therapy last? Massengale & Perryman (2021) looked at this question in their recent longitudinal study looking at the effects of CCPT via Primary Project for academically “at-risk” elementary age children in the long-term. These 35 children were from the Perryman & Bowers (2018) study that identified second-graders in Title 1 schools who were at-risk for school failure. They were in second grade and received ten 30 minutes sessions spread out thorough one semester. Their academic performance and growth were measured by the Measure of Academic Progress (MAP) for their 3rd and 4th grade years. They found the academically identified at-risk children lowered the difference between non-at-risk students for reading levels. The students who were at-risk in first grade caught up to non-at-risk students in 2nd grade and both grew their reading scores the same for 3rd and 4th. At-risk children also lowered the gap in math scores to be no longer statistically significant. This research examined the impact of early intervention benefits for academic achievement over a long time, four years. These findings suggest that CCPT does have lasting, positive academic effect (Massengale & Perryman, 2021).

Older children too are still able to receive benefits from play therapy. Play therapy was found to aid 168 students in the 4th through 6th grade at high-poverty schools in maintaining

current levels of anxiety and sense of responsibility in academic endeavors versus those who did not receive treatment (Post, 1999). Some of these students received an average of four sessions, some only one, some 25. Their posttest measures were analyzed using analysis of variance (ANOVA). They did not improve overall, but did not decrease, unlike those in the control group who decreased in their handling of their academics and self-esteem (Post, 1999). Based on these results, it follows to infer that intervention must be done at younger levels to see higher levels of change. However, some students did not receive that many sessions, and possibly with more stable sessions would have performed better. Either way, CCPT did help these children not regress academically.

Finally, another very important aspect of academic achievement is student-teacher relationships, as the relationships facilitate the capacity to learn for the school year. Stress on the relationship is not good for child academic achievement. From three Title 1 elementary schools, 23 children participated in a study done by Muro et al. (2006). They ranged in age from 4-11 years old and went through 32 play therapy sessions, all done in the school. There was a 61% decrease for eight of the 13 children on the *Teacher Report Form* who were originally placed in the clinical/borderline range for behavior problems. Teacher stress levels changed too, from the beginning to the end of session span in this study (Post et al., 2019). Sadly, there was not a control group. Nevertheless, “the result that 23 child clients demonstrated a statistically significant change over three points of time for relationship stress and total behavioral problems suggests that the impact of play therapy occurred” (Muro et al., 2006).

Review of Effectiveness

This section reviewed many of the studies, research, and analysis done on the effectiveness of CCPT. To begin, Baggerly (2003) offered a perspective of the benefits of a CCPT approach when dealing with children who are homeless as a result of their poverty. Likewise, Post et al. (2019) reviewed research findings of the effectiveness of CCPT for marginalized children facing burdens associated with living in minority groups and/or low-income environments, stating that CCPT helps lower externalizing behaviors.

Getting into actual research study experiments, several highlighted the promising results of CCPT for behavior issues. Results from Bratton et al. (2013) concluded that CCPT helped children in the Head Start program improve behavioral issues. They cite their findings as evidence of the importance of early intervention methods for emotional and behavioral troubles for children at-risk because of their socioeconomic status. Ray et al. (2009) used students from Title 1 schools to help mitigate aggressive behavior for children, and their results offered CCPT as a hopeful therapy to help children work on controlling their aggressive behaviors. Cochran & Cochran (2017) aided children living in high-poverty concentration school settings to reduce externalizing and attention problems and improve self-efficacy. Results showed statistically significant effects in these three areas.

CCPT has also recently been shown to offer the possibility of improving academic achievement for young children in Title 1 schools. Blanco et al. (2019) produced study results that supported the use of CCPT for educational attainment for at-risk students. These students were all in kindergarten, so the results also support the use of CCPT for young children's academic improvement. Massengale & Perryman (2021) built upon research done with 2nd graders by Perryman & Bowers (2018) and used the children previously identified "at-risk" for school adjustment issues in a Title 1 school (p. 100). They used a longitudinal study design, with

only students who they could access data for all four years used. Their results showed growth of performance over four years from 1st to 4th grade for these previously identified at-risk students to catch up to and not fall behind non-at-risk students with aid from CCPT. Post (1999) analyzed the effects of CCPT for even older children in 4th, 5th, and 6th grades, and while no significant improvements were found, the children who received sessions did not decrease in their academic handlings unlike those in the control group. Another important aspect of educational attainment is teacher-child relationships. Results from the Muro et al. (2006) study advocate for the use of CCPT to ease stress on these relationships and bettering behavior problems.

While no definite conclusion can be drawn, the plethora of research suggesting the benefits of CCPT can be offered as evidence for its unmistakable, positive benefits on behaviors and education issues correlated with poverty settings. It is shown to be responsive to preschool-children's unique needs in the mental health field (Bratton, 2010). Research suggests that CCPT intervention is best utilized with younger populations, as they are in a crucial period of learning. CCPT "has the potential to interrupt the negative trajectory associated with disruptive behavior problems in early childhood, thereby preventing the development of more severe impairment across the child's life span" (Bratton et al., 2013, p. 39). In addition, CCPT has shown to benefit children's performance in their schooling if they are struggling, which is important because education is one of the best ways to escape poverty (Tucker, 2022). CCPT thus has the ability to counteract problems and change multiple future outcomes of a child's life.

Conclusion

With the benefits of child-centered play therapy increasingly shown, it is important to aim to include CCPT in schools. Schools are already an ideal location to reach families and children in a

poor community. Mental health services in schools for children in poverty environments are part of the “inherent” purpose of schools, to “support development and bridge home and neighborhood ecologies” (Capella et al., 2008). Public schools have a mission to serve their youth, so play therapists should call for CCPT to be set up in these establishments (Tucker, 2002). What is the problem then? Berkowitz (2005) examined the efficacy and prevalence of play therapy by interviewing 134 school psychologists. Less than half (40%) of them said they utilized play therapy in school because of training and administrative support, but many believed play therapy was effective. Bratton (2010) lists some of the possibilities for school counselors and mental-health workers. Suggestions include school counselors to name evidence for CCPT as “developmentally and culturally responsive,” educating their administrators about the need for CCPT, like the effects of poverty on children’s mental health and academic performance, and as currently there is a push to use only proven evidence-based treatment (EBT), using the proper research, like “systematic review[s] of the body of play therapy research conducted in school settings” that includes meta-analyses and “individual outcome research studies” to get state funding for counselors trained in CCPT (Bratton, 2010, p. 22).

There should also be collaborative efforts done by universities and local and state governments with high-poverty schools. In Post (1999), 12 graduate students acted as counselors after undergoing a graduate level “Introduction to Play Therapy” course. Cochran & Cochran (2017) used 15 graduate students, counselors, or therapists, and 78% of the children received play therapy from students or beginner therapists. These uses suggest successful play therapy is not only possible with clinical psychologists or people holding doctorates. There could be very successful collaboration through universities to work with governments to provide play therapy assistance in return for students receiving experience, scholarships, etc. These students

received significant real-world practice and the schools received mental health aid, all a win-win. Obviously, students need to go through proper training and background checks, but this idea could be a possible avenue for lessening the cost of play therapy for schools that cannot afford it. There is also a precedent for using federal programs in high-poverty schools. Primary Project, as described in Massengale & Perryman (2021), could be utilized in more of these schools. Primary Project is a preventative program that uses CCPT as a mitigation effort (Massengale & Perryman, 2021).

An important part of utilizing CCPT for impoverished children is making the effects of poverty known. With all the effects considered, poverty is detrimental to a young child's life. Play therapy has again and again evidenced its efficacy for children in high-poverty environments. Further studies and research would also help to push for CCPT as an effective treatment at improving a child's current life and future. Utilizing CCPT can help children escape negative outcomes and end the cycle of poverty. The children can then escape their low-income environments and provide less traumatic ones for their own children. With all considered, child-centered play therapy is a highly successful relief intervention for the trauma and subsequent symptoms of childhood poverty.

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