

アメリカ在住日本人, 日系人児童へのプレイセラピー(遊戯療法) の実施とその効果の実証的検討研究

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Effectiveness of Child-Centered Play Therapy with Japanese Children in the United States

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本研究は child-centered プレイセラピーがアメリカに在住する, 日本, 日系児童の精神衛生の向上を促進するための, 文化に適応した介入的・予防的アプローチであるかどうかを検討したものである。近年の実証学的に検討された児童への心理的アプローチの奨励と, 同一民族, 人種間における違いを座視しない異文化領域における研究の助成が脚光下にある中, 本研究は質的分析と個人分析という2つの研究方法を導入した。child-centered プレイセラピーの効果は, 保護者が記入した Child Behavioral Checklist と, Parent Stress Index における得点の変化を基準に測定した。計10名の子どもがデータが統計処理に使用された。統計の結果, 統計的有意差は得られなかったが, 測定対象となった6つの項目いずれもプレイセラピーが実施されてから集められたデータ得点に Large から Medium サイズのエフェクトサイズが見出された。また個人分析からは質問紙の得点の変化に影響したと思われる環境的, 発達のそして文化的要因についての情報が得られた。

【キーワード】 プレイセラピー・日本人児童・異文化間カウンセリング

This study explored the use of child-centered play therapy (CCPT) as a culturally responsive intervention and a prevention treatment for the psychosocial well-being of Japanese children in the U.S. This study was composed of quantitative research design and individual analysis. Single-group repeated measures ANOVA was utilized for the group analysis and linear regression was employed for individual analysis in addition to qualitative data obtained through parent feedback and the researcher's observation of play therapy sessions. The participating children received a total of eight CCPT sessions. The impact of CCPT was measured by the Child Behavioral Checklist and the Parenting Stress Index. Data was obtained from a total of the four assessment points, and the data from 10 children were utilized for the statistical analysis. The results of the analysis did not reveal any statistical significance. However, large and medium

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effect sizes were obtained on all the six subscales during the treatment period. Individual analysis provided further information on possible environmental, developmental, and cultural factors that are considered influential issues on the change of individual scores.

【Key Words】 Play Therapy, Japanese children, Multicultural counseling

INTRODUCTION

Cultural diversity in the United States has rapidly become more evident, and an ever-increasing variety of colors accurately describes the diversity that now exists. By 2050, research has assumed that the White majority will be a minority exceeded by the total number of all the minority groups (Meacham, 2000) and that minority children will outnumber the population of Caucasian children in the United States by the year 2025 (Dana, 1998).

Despite this trend, the U.S. Department of Health and Human Services (1999) has indicated that the U.S. mental health system is not well equipped to satisfy the needs of racial and ethnic minority groups. Accordingly, scholars have begun to heed the call for mental health research aimed at describing, understanding, and remedying disproportionate access to mental health care services for racial and ethnic minorities. National interest in the mental health needs of minority groups in the United States has increased over the past few decades' as a result, research on multicultural issues and competence has been consistently conducted (Sue & Sue, 1999). However, failure to exploit the results of those studies to advance the underutilization of mental health services among minority group indicates some faults in adapting traditional methods of research to explore cultural concerns. The American Psychological Association (APA, 2003) advocated the importance of conducting culture-centered and ethnic psychological research, listing some limitations inherent in multicultural research. Among the limitations is the presumption that all people of color are similar, and large within-group differences are ignored despite of the great within-group heterogeneity of all the major racial and ethnic groups in the United States (APA, 2003).

The Asian-American population is one of the fastest growing minority groups in the United States, and has high heterogeneity within this group itself (Kerl, 1999). According to the U.S. Bureau of the Census (2000), 11.9 million people (4.2%) out of the U.S. population identified themselves as Asian, defined as Asian only, or Asian and at least one other race. The Japanese, one of the 11 identified Asian groups, comprise 7.8% of the total Asian population in the U.S. (U.S. Bureau of Census, 2000). Even within the Japanese, there is diverse heterogeneity because of the specific immigration history and also due in part to the fact that their interracial marriage rates are the highest of all Asian Americans (Le, n/d), resulting in an increased number of biracial or multiethnic Japanese children. The "model minority" myth is often applied to the Japanese in the

United States, indicating that they are considered relatively successful and problem-free because of their high socioeconomic and educational status (Sue & Sue, 1999). However, existing research reports various psychosocial issues, including acculturation, language, and interpersonal difficulties among Japanese children in the United States. In addition to the understated attention to the mental health issues in Japanese children in the United States, a stigma attached to mental health services and a lack of mental health care providers with Japanese ethnic backgrounds are major obstacles for Japanese parents who seek professional psychological support for their children. Improving the accessibility to mental health services for Japanese children in the United States may include employing the expertise of trained therapists who have an understanding of the Japanese culture, can speak their language, and have the ability to provide a developmentally appropriate intervention such as play therapy.

For almost 100 years, play therapy has been recognized and practiced as a therapeutic alternative for children. Play is the “native language” of children and an innate and universal communication system with which children communicate in a direct or symbolic way (Landreth, 2002). The significant role of play in children’s development is even recognized in the United Nations’ “Declaration of the Rights of the Child,” in which the importance of play is accorded equally to nutrition, housing, education, and health care (Kim, 2002).

According to Landreth, Homeyer, Glover, and Sweeney (1998), empirical evidence supports play therapy as an effective intervention in treating a variety of issues in children. Ray, Bratton, Rhine, and Jones (2001) and also in Bratton, Ray, Rhine, and Jones (2005) conducted the largest meta-analysis of play therapy outcome studies, including 93 studies dating from 1942 to 2000. The result of the meta-analysis revealed a treatment effect size 0.80 standard deviation, indicating the strong effectiveness of play therapy. Although the meta-analysis includes studies presenting a wide array of children’s issues, only 5 out of 93 studies treated minority children. Ray et al. specifically noted a lack of ethnic diversity in populations studied and called for increased research on play therapy with culturally diverse children.

Play therapy has been accepted, acknowledged, and utilized as a main mental health intervention for children in various settings in Japan for over the past 5 decades (Akuta, 1999; Hironaka, 2002; Yoshida & Itoh, 1997). However, empirical research studies that identify play therapy as an appropriate treatment methodology for Japanese children are scarce, and the effectiveness of play therapy is reported predominantly in case study layout. Abe and Maeda (1981) postulated that lack of consistency in the theoretical approaches in play therapy in Japan may have been hindering researchers from adopting scientific methodologies to examine the effectiveness of play therapy.

A major mission of multicultural research in play therapy is to provide cross-cultural information so that play therapists can build their sensitivity, acquire knowledge, responsibility

and develop active competence (Gil, 2005). Along with this mission is the examination of the validity of play therapy that was established and developed in predominantly Western cultures. Moreover, because of the universal nature of play as a communication medium for children, there is a presumption that this practice has universal application to any ethnicities, overlooking the possibility of inherent cultural bias in this practice. Although existing studies support play therapy as an effective treatment modality for minority children (Baggerly, & Parker, 2005; Cosico-Berge, 2002; Garza & Bratton, 2005; Shen, 1999), reevaluation of traditional play therapy and consideration for modifications are both critical in providing more culture-centered play therapy for minority children.

Purpose of the Study

The purpose of this study was to examine the effectiveness of child-centered play therapy (CCPT) with Japanese children in the United States. The changes in the parent and child relationship as well as child behaviors as observed by their parents were investigated as a group to assess the impact of CCPT. In addition, the process of play therapy with each individual child was explored to identify within-group differences.

Diversity within Japanese in the U.S. due to a variety of immigrant backgrounds is one of the obstacles facing researchers in their attempts to conduct group experimental design methodology, which requires control for variables to reduce the threat to internal validities. In order to respond to the need for evidence-based treatment for this population as well as the need to conduct multicultural research without ignoring the within-group differences, this study was composed of two research methodologies: quantitative research design and case-study analysis. The intent of this study was to provide preliminary results regarding the effectiveness of CCPT as a culturally responsive intervention and prevention modality for Japanese children in the United States to expand the repertoire of culturally centered care for this underserved population.

METHODOLOGY AND PROCEDURES

This study employed a single-group repeated measures analysis of variance (ANOVA) design to examine the effectiveness of child-centered play therapy (CCPT) with Japanese children referred for Externalizing and Internalizing behaviors and parental stress related to the parent-child relationship. In addition, linear regression was employed to examine individual child participants' changing patterns of behavior as observed by parents throughout the period of study. In this study, CCPT was defined based on the definition by Landreth (2002). In this study, the Externalizing Behaviors and the Internalizing Behaviors subscales of the Child Behavior

Checklist (CBCL) operationally defined externalizing and internalizing behaviors. Externalizing behaviors refer to behaviors that express inner conflict or internal problems outwardly. Internalizing behaviors refer to behaviors that are symptomatic of an attempt to cope with internal conflicts as an inward expression of experience, such as being withdrawn or depressed. Parental stress in this study was defined by the Total score and two domains of the Parenting Stress Index (PSI): the Parent Domain and the Child Domain. The Parent Domain measures stress related to a parent's functioning. The Child Domain assesses the child's characteristics that contribute to stress in the parent-child system.

Instruments

The Parental Stress Index (PSI) (Abidin, 1995) and the Child Behavior Checklist (Achenbach & Rescorla, 2000a, 2000b) were utilized in this study. Notwithstanding the existence of Japanese versions of both the PSI and CBCL instruments, the decision to utilize the English versions was made for this study for the following reasons: (a) The Japanese version of the PSI has not been tested for its validity and reliability utilizing Japanese subjects; (b) the newest Japanese translated version of CBCL is the 1991 version for children aged 4 -18, whereas the most current English version is 2001. Although the reliability and validity of the 1991 Japanese version of the CBCL (JCBCL) was tested (Itani, Kanbayashi, & Nakata, 2001), the assessment was conducted on old data; (c) About half of the participants in this study were biracial children having one Japanese parent and one non-Asian parent whose native language was English. Most of the families in the study have been living in the United States for more than five years, and the parents have enough command of English to read and understand the questionnaires.

Participant Selection

The volunteer research participants were recruited from The Japanese School of Dallas. Participants were recruited from the kindergarten through third grades, and ages ranged from 4 to 9 years. In order to be eligible to participate, the children must have met the following criteria: (a) parent or guardian consent was obtained, (b) parent agreed for child to participate in eight 30-minute sessions of culturally responsive child-centered play therapy, (c) child's main language was either English or Japanese, (d) parents must be literate in English, (e) child was not currently receiving any form of psychotherapy, (f) child was between 4 and 9 years old, and (g) child attended The Japanese School of Dallas once a week in addition to weekly local school. A total of 16 children originally participated in the research. However, of 16 children, a total of 10 participated in all eight sessions, and their parents completed all the assessments required.

Therefore, data from those 10 children were utilized for analysis. Table 1 presents demographic information on the participants in the study.

Table 1. *Demographic Information for Child Participants*

Gender	
Male	3
Female	7
Ethnic Groups	
Japanese	6
Japanese American	4
Grade	
Kindergarten	4
First	1
Second	3
Third	2
Average Age	6.7
Average Length of	
U.S residency	5.15

Collection of Data

The parents of the child participants in this study completed the PSI and the CBCL at four different points; baseline (4 weeks prior to the first child-centered play therapy (CCPT) session); pretest assessment point (following 4 weeks of no treatment prior to CCPT); the second assessment point (following 4 sessions over 4 weeks of CCPT); and the third assessment point (following 8 sessions over 8 weeks of CCPT). Any change between data obtained at baseline and at pretest was utilized as a baseline. The baseline measures the natural frequency of subjects' targeted behaviors before the introduction of the experimental variable. This design allowed the researcher to avoid some threats to internal validity such as history, maturation, statistical regression, and experimental mortality; hence, the outcome of the study may be attributed to treatment effects. Baseline measurements help to establish high internal validity.

Qualitative data regarding child participants' behaviors were obtained through three methods: parent consultation, child background information forms, and play therapy session summary

forms. Parent consultations were held at the initial meeting and at the end of the 8 week play therapy treatment.

Description of Treatment

During the treatment phase of the study, Japanese children whose parents signed the consent form received 30 minutes of child-centered play therapy (CCPT) once a week for 8 weeks based. Landreth (2002) defines child-centered play therapy as a dynamic interpersonal relationship between a child and a play therapist who provides selected play materials and facilitates the development of a safe relationship for the child to fully express and explore self through play. Modifications and adaptations were made in order to create a culturally responsive play therapy environment including playroom/toys, the therapist, and the play therapy structure. Play therapy was conducted in a class room at a school equipped with portable play therapy materials and also at private practice offices in the participants' neighborhoods in Texas depending on a participant's schedule.

RESULTS

Single-group repeated measures ANOVA was performed on the Internalizing Problems, the Externalizing Problems, and the Total Problems in the Child Behavior Checklist (CBCL), and the Child Domain, the Parent Domain and the Total Stress Domain in Parenting Stress Index (PSI). Two separate ANOVAs were conducted for each syndrome scale of CBCL and PSI. The first ANOVA examined differences between the baseline and the pretest. The second ANOVA examined differences between the pretest, assessment point 2 and assessment point 3. The alpha .05 level of statistical significance was used as a criterion. Because the study is under-powered due to the small sample size, the partial eta squared was computed for each analysis of six subscales to determine the practical significance. The guidelines for an eta squared proposed by Cohen (1988) were utilized to interpret the data. Suggested values of eta squared were following; 0.01 = small, 0.06=medium, and 0.14= large (Cohen, 1988).

In addition to the group analysis, individual analyses were conducted on individual participants' Child Behavior Checklist (CBCL) Total Scores, utilizing linear regression. Linear regression describes the growth patterns of individuals (Ware, 2006), in this case, the relationship between four assessment points and a dependent variable. Additional qualitative data generated from the researcher's observations of play therapy sessions as well as parents' feedback were also examined in this study.

Table 2. Repeated Measures ANOVA on Internalizing Problems on the CBCL from the baseline to

the pretest

Source	<i>SS</i>	<i>df</i>	<i>MS</i>	<i>F</i>	<i>p</i>	Partial Eta Squared
Individuals	2235	9	248.33			
Time	24.2	1	24.2	1.02	0.34	0.1
Error	213.8	9	23.76			
Total	2473	19				

**Computed using p = .05*

Table 3. Repeated Measures ANOVA on Externalizing Problems on the CBCL from the baseline to the pretest

Source	<i>SS</i>	<i>df</i>	<i>MS</i>	<i>F</i>	<i>p</i>	Partial Eta Squared
Individuals	2180.8	9	242.31			
Time	96.8	1	96.8	3.43	0.09	0.28
Error	254.2	9	28.24			
Total	2531.8	19				

**Computed using p = .05*

Table 4. Repeated Measures ANOVA on Total Problems on the CBCL from the baseline to the pretest

Source	<i>SS</i>	<i>df</i>	<i>MS</i>	<i>F</i>	<i>p</i>	Partial Eta Squared
Individuals	1579.8	9	175.53			
Time	72.2	1	72.2	2.53	0.15	0.22
Error	256.8	9	28.53			
Total	1908.8	19				

**Computed using p = .05*

Table 5. Repeated measures ANOVA on Child Domain on the PSI from the baseline to the pretest

Source	<i>SS</i>	<i>df</i>	<i>MS</i>	<i>F</i>	<i>p</i>	Partial Eta Squared
Individuals	786.94	7	112.42			
Time	7.56	1	7.56	0.18	0.68	0.03
Error	290.94	7	41.56			
Total	1085.44	15				

**Computed using p = .05*

Table 6. Repeated measures ANOVA on Parent Domain on the PSI from the baseline to the

pretest

Source	<i>SS</i>	<i>df</i>	<i>MS</i>	<i>F</i>	<i>p</i>	Partial Eta Squared
Individuals	1446.94	7	206.56			
Time	10.56	1	10.56	0.28	0.61	0.04
Error	259.94	7	37.13			
Total	1717.44	15				

*Computed using $p = .05$

Table 7. Repeated measures ANOVA on Total Stress on the PSI from the baseline to the pretest

Source	<i>SS</i>	<i>df</i>	<i>MS</i>	<i>F</i>	<i>p</i>	Partial Eta Squared
Individuals	2965.75	7	423.68			
Time	0.25	1	0.25	0.05	0.95	0.001
Error	347.75	7	49.68			
Total	3313.75	15				

*Computed using $p = .05$

Table 3 to Table 7 are the results of the ANOVA between the baseline and the pretest for Internalizing, Externalizing and Total Problems scores of CBCL and the Child, Parent, and the Total Stress domain scores of the PSI. Any change that occurred during this time period is not regarded as a result of the treatment. As the tables show, for all the six subscales, *F* ratio was not statistically significant at the .05 level, indicating that there was no statistically significant change during the no treatment period (from the baseline to the pretest). However, the partial eta squared was determined as medium for Internalizing Problems subscale of CBCL ($\eta^2=0.1$), as large for Externalizing Problems subscale ($\eta^2=0.28$), and for Total Problems subscale ($\eta^2=0.28$) of CBCL based on the Cohen's guideline (1988). The partial eta squared was determined as small for Child Domain subscale ($\eta^2=0.03$), Parent Domain subscale ($\eta^2=0.04$), and the Total Stress subscale ($\eta^2=0.001$) of PSI.

Table 8. Repeated Measures ANOVA on Internalizing Problems on the CBCL from the pretest to the third assessment

Source	<i>SS</i>	<i>df</i>	<i>MS</i>	<i>F</i>	<i>p</i>	Partial Eta Squared
Individuals	2106.03	9	234			
Time	55.4	2	27.7	0.66	0.53	0.07
Error	753.27	18	41.85			
Total	2914.7	29				

*Computed using $p = .05$

Table 9. Repeated Measures ANOVA on Externalizing Problems on the CBCL from the pretest to

the third assessment

Source	SS	df	MS	F	p	Partial Eta Squared
Individuals	2428	9	269.76			
Time	49.4	2	24.7	2.04	0.16	0.19
Error	217.93	18	12.11			
Total	2695.33	29				

*Computed using $p=.05$

Table 10. Repeated Measures ANOVA on Total Problems on the CBCL from the pretest to the third assessment point

Source	SS	df	MS	F	p	Partial Eta Squared
Individuals	1986.83	9	220.76			
Time	30.87	2	15.43	1.04	0.38	0.1
Error	268.45	18	14.92			
Total	2286.15	29				

*Computed using $p=.05$

Table 11. Repeated measures ANOVA on Child Domain on the PSI from the pretest to the third assessment point

Source	SS	df	MS	F	p	Partial Eta Squared
Individuals	1566.5	7	223.79			
Time	204.08	2	102.04	2.3	0.14	0.25
Error	621.25	14	44.38			
Total	2391.83	23				

*Computed using $p=.05$

Table 12. Repeated Measures ANOVA on Parent Domain on the PSI from the pretest to the third assessment point

Source	SS	df	MS	F	p	Partial Eta Squared
Individuals	2122.29	7	303.19			
Time	59.08	2	29.54	0.39	0.69	0.06
Error	1073.58	14	76.69			
Total	3254.95	23				

*Computed using $p=.05$

Table 13. Repeated measures ANOVA on Total Stress on the PSI from the pretest to the third assessment point

Source	<i>SS</i>	<i>df</i>	<i>MS</i>	<i>F</i>	<i>p</i>	Partial Eta Squared
Individuals	4259.63	7	608.52			
Time	414.75	2	207.36	1.49	0.26	0.18
Error	1943.25	14	138.8			
Total	6617.63	23				

**Computed using $p=.05$*

Table 8 to Table 13 are the results of the ANOVA between the pretest and to the third assessment point time for Internalizing, Externalizing and Total Problems scores of CBCL and the Child, Parent, and the Total Stress domain scores of the PSI. Any changes reflected in the scores that occurred during this period of time can be attributed as a result of the treatment. As the tables show, for all the six subscales, *F* ratio was not statistically significant at the .05 level, indicating that there was no statistically significant change during the treatment period (from the pretest to the third assessment point). However, the partial eta squared was determined as large for Externalizing behaviors subscale of CBCL ($\eta^2=0.19$), Child Domain subscale ($\eta^2=0.25$), and Total Stress Domain subscale ($\eta^2=0.18$) for the PSI, as medium for Internalizing Problems subscale ($\eta^2=0.07$), Total Problems subscale ($\eta^2=0.10$) of CBCL, and Parent Domain subscale ($\eta^2=0.06$) of PSI. None of the scores on the six aforementioned subscales achieved statistical significance. However, this study carried 10 children for data analysis of CBCL scores and 8 for PSI scores; it is likely that the study is under-powered due to small sample size. This seems a logical explanation for the fact that statistical significance was not obtained (Armstrong & Henson, 2004). However, the large and medium effect sizes obtained in this study indicate a considerable impact of CCPT on Japanese children in this study.

Most of the individual linear regression data on the Total Problems scale of the CBCL followed a common pattern of decline between the baseline and the pretest assessment point, followed by elevation between the pretest and second assessment points, then a decrease to scores below the scores from last third assessment point . The average slope of a score curve across the four assessment points is -0.24. The small average drop rate may be attributed to the fact that 9 out of 10 individuals' scores on the Total Problems scale of the CBCL fell within the normal range throughout the assessment points.

DISCUSSION

Child Behavior Checklist (CBCL)

A similar pattern of the estimated marginal means across the four measurement points was repeated in the Internalizing Problems, Externalizing Problems, and Total Problems scores on the CBCL. In general, from the baseline to the pretest assessment point, the scores decreased. However, from the pretest to the second point, the scores increased, and then scores dropped again at the last third assessment point.

The decrease in the participants' CBCL scores from the baseline to the pretest assessment point led the researcher to postulate that the decline in scores during this period may reflect alleviated concerns on the part of the child participants' parents. Although no CCPT treatment was provided for the children during this period of time, the researcher frequently contacted their parents through phone calls and e-mails to arrange play therapy sessions (e.g., the location of the office, time to provide the service). In addition, during this phase, parents were instructed to read to their children a storybook on play therapy provided by the researcher to prepare them for their initial play therapy session. This assignment for the parents may have increased their interaction with their children as well as provided a topic to share. As Agatsuma (2003) reported, Japanese parents in the United States tend to experience difficulty communicating with English-speaking mental health and educational professionals, and it is often a struggle for them to obtain sufficient information to support their children. It is possible that some parents involved in this study experienced a degree of relief or hope as a result of their frequent contacts with the therapist; this sense of relief may have increased the parents' tolerance of their children's behavioral problems. As an alternative explanation, the parents' sense of relief or hope may have affected their children in positive ways, resulting in decreased behavioral problems.

The pattern of score changes between the pretest and the third assessment point illustrates a common process of play therapy. Moustakas (1955) observed and analyzed the process of play therapy in young children, identifying several stages in the therapeutic process, which indicate a retreat of a child's behaviors before any positive change occur. The pattern of child participants' behavior changes in this study (based on CBCL scores) also coincided with the results of a study by Ray (in review). She reported that upon completion of 3 to 7 sessions of play therapy, parent-child relationship likely deteriorated due to child behaviors; however, significant beneficial effects began at 11 sessions. Meta-analysis of 93 research studies on the effectiveness of play therapy conducted by Bratton et al. (2005) also concluded that 35 to 40 sessions tend to have a peak effect.

Parenting Stress Index (PSI)

There were no statistically significant changes in parents' PSI scores in the Child Domain, the

Parent Domain, or the Total Stress Domain. However, results of a partial eta squared did reveal large effect sizes in the Child Domain and the Total Stress Domain, and a medium effect size in the Parent Domain. During this period, the score of the Child Domain increased whereas the Parent Domain decreased; however, the scores in all three subscales of the CBCL exhibited a declining trend during the same time. This result led the researcher to speculate that positive change in child behavior may have encouraged the parents in their parenting skills, resulting in the reduction of stress regarding their perceived ability to be a parent. As another postulated explanation, the parents' decision to participate in this research may have brought some increased feelings of pride that they were making an effort to seek a beneficial service for their children. The contradictory result that the Child Domain score in the PSI increased while all three subscales on the CBCL decreased may indicate that the Japanese parents in this study may have rated higher scores on the items on the PSI that do not infer the child's behavioral problems. In fact, more parents obtained scores in the clinical range on the Reinforces Parent and the Acceptability scales that do not necessarily inquire into a child's behavior. For instance, some of the questions in the Acceptability scale on the PSI are "My child doesn't seem to learn as quickly as most children," and "In some areas, my child seems to have forgotten past learnings and has gone back to doing things characteristic of younger children." Considering the reports from the existing literature that Japanese and Japanese American parents hold higher educational expectations for their children than do European American parents (Shibusawa, 2001), those questions may have been contributed to higher scores by the Japanese parents. As a result, the parents may have reported higher stress on the Child Domain despite the fact that they perceived an improvement in the child's behavior

From the pretest to the second assessment point, the scores decreased, followed by an increase in the scores at the third assessment point but remaining below the scores of the baseline. It can be postulated that the decrease in scores between the pretest and second assessment points is an indication of parents' sense of relief or hope related to their children having begun the CCPT treatment. However, CCPT is designed to provide therapeutic intervention for children, not for parents. Therefore, it is not surprising that the decrease in the scores on the Parent Domain did not have a sustained effect. Most of the local schools that the children in the study attended began the summer break between the second and the last third assessment point. Therefore, the parents were spending more time together with their children and, as a result, the parents may have been feeling more challenged in their parental roles at this period of time, resulting in higher stress. This is an additional explanation for the escalation of the score from the second assessment point to the last third assessment point on the Parent Domain of the PSI.

Cote and Bornstein (2001) conducted a study of parenting cognitions among immigrant groups, and stated that parenting cognitions are believed to acculturate exceptionally gradually, if at all.

They also reported that Japanese mothers are significantly more likely to attribute their lack of success in parenting to their own efforts and that they rated themselves as being less satisfied with their parenting than those in other immigrant groups. One Japanese parent in the study reported to this researcher that the values and priorities that she inherited from her parents often seemed not to apply to her son because he is a “biracial child.” Additionally, Kazui, Muto, and Sonoda (1996) reported that Japanese mothers who have no involvement in social activities outside of their family tend to develop stronger feelings of anxiety and stress related to parenting. A mother in the study mentioned that it is difficult to enjoy engaging in social interactions with the other mothers at her child’s local school due to the limitations of her English language skills; however, she also feels anxious with mothers at the Japanese School of Dallas because the local Japanese community is so small that rumors and gossip circulate quickly within the community. It is notable that the Parent Domain scores were elevated above the Child Domain scores in this study; it can be postulated that this finding is due to Japanese mothers’ struggle to adapt their traditional parenting style to their biracial children. Another possible explanation is that the children in the study have acculturated to the United States faster than their mothers have. Yet another possible explanation is that Japanese mothers tend to personalize their unsuccessful experiences in parenting. Finally, lack of opportunity for social interactions may have contributed to the Japanese mothers’ elevated Parent Domain scores on the PSI.

Researcher’s Subjective Observations of a Play Therapy Session

In the first play therapy session, some of the children appeared to be perplexed when they first experienced the nondirective structure of the time. When they encountered the unfamiliar experience of freedom in the playroom at the initial session, the children frequently requested to bring their friends or siblings to the playroom. Although a puzzled feeling was observed in some children at the beginning of the treatment, none of them expressed strong discomfort or anxiety; that is, no children cried or requested to leave the playroom. The most frequent concepts that are cited as cultural differences between the United States and Japan are the concepts of individualism and collectivism (Azuma, 2001). The Japanese are often described as a nation that places priority on group interests over personal interests, on attending to and fitting in with others, and on the importance of harmonious interdependence with others (Markus & Kitayama, 1991). Considering the group-oriented cultural value among the Japanese, it seems that group play therapy may be utilized to help Japanese children familiarize themselves with the permissive play therapy environment as a prior step to individual play therapy.

The parents of the child participants in this study seemed to be motivated to participate in the research for one of two reasons: that is, to prevent future child behavior problems or to intervene in existing child behavior problems. In play therapy, the children whose parents seemed motivated to participate based on a desire to prevent child behavior problems appeared to engage

in higher levels of mastery play, whereas the children whose parents had been motivated to participate in order to intervene in current child behavior problems seemed to absorb themselves into fantasy and imaginative play.

The majority of child participants exhibited interest in the Japanese toys added to the playroom. It appeared that the Japanese toys often evoked family stories. For instance, a child who found Japanese juggling balls (*Otedama*) talked about her grandmother who is skilled at playing with the toy; the child expressed her feeling of sadness as she talked about how she missed her grandmother who lives in Japan. A female child created animals with Origami and decided to give them to her American friends because “they like those because they do not know how to do Origami!”

The Japanese toys included in this study were traditional and classic toys. When some children brought a paper balloon (*Kamifusen*) with them from the playroom, their parents expressed excitement to see a familiar toy from their childhood; the toys seemed to evoke nostalgic feelings in the parents. Some of the parents started tossing the balloon with their children in the waiting room. Existing literature on play therapy in a multicultural setting highlights the importance of the playroom environment, including modifications and the addition of culturally responsive toys (Chang, Ritter, & Hays, 2005; Garza & Bratton, 2005; Gil, & Drewes, 2005). It was observed in this study that culturally specific toys can address some of the unique experiences of culturally diverse children. Identity issues were also observed in one session. For instance, A 7-year-old female complained that she has to write in English when she makes something for her father and in Japanese when she makes something for her mother.

In order to fill the gap between research and the practice of counseling, a case report is presented. Although valid inferences cannot be drawn, anecdotal reports provide a glimpse of the impact of CCPT on individual Japanese children in the United States.

A 9-year-old Japanese American female, Akiko (a pseudonym).

At the initial meeting with the researcher, the mother reported that several months prior Akiko started frequently reporting somatic and panic symptoms and refusing to go to school in the morning. The mother also reported that Akiko became obsessed with trivial things, and her frustration was expressed through sobbing. Akiko became hypervigilant with others' moods and feelings and said that she felt sad if everybody was not smiling.

The mother mentioned that she “knew” the cause of Akiko's change. She remorsefully confessed that she had been imposing extremely high expectations on Akiko to live as a biracial child. The mother reported that she had been trying to accept Akiko as she was, and, as a result, she was experiencing some improvement in Akiko's behaviors. However, the mother expressed her concerns over Akiko's occasional intense emotional reactions and some regressed behaviors.

In play therapy, Akiko seemed excited but restricted at the beginning of the therapy process.

During this period of time, she mostly engaged in mastery play, using art and craft materials. She often drew “a smiley face.” In the middle phase of therapy, her play became more athletic, and she tried something that her “brothers do.” Interestingly, when she was attracted to a specific toy but not feeling comfortable enough to try it, she used a flashlight and manipulated the light to pretend that the light was playing with the toy. Toward the end of the session, Akiko’s play became more symbolic, and she either engaged in role play or she used a doll family to play out scenes.

At the feedback session, the mother reported significant improvement in Akiko’s behaviors; she reported that she had observed fewer emotional outbursts and somatic symptoms. However, the mother reported that Akiko started denying being part Japanese and that she became hesitant about coming to The Japanese School in Dallas.

This child’s Externalizing, Internalizing, and Total Problems scores on the CBCL at the last third assessment point were all lower than the scores obtained at the three previous assessment points. On the PSI, the scores on the Demandingness and Mood subscales in the Child Domain were in the clinical range across the four assessment points. However, the scores of those subscales at last third assessment point were lower than at the baseline point.

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