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# Adaptation of the Child - Parent Relationship Therapy Model for Use With Senior Citizen Volunteers in School Settings: A Pilot Study

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# **Adaptation of the Child–Parent Relationship Therapy Model for Use With Senior Citizen Volunteers in School Settings: A Pilot Study**

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*This study provides a proposal for crucial volunteer services to fill the gap for overburdened school counselors when parents are unable to engage in Child–Parent Relationship Therapy (CPRT), a highly effective intervention for childhood problems. CPRT has been successfully adapted for use with individuals other than the child’s parents. The researcher in this pilot study adapted CPRT for use with senior citizen volunteers who often possess untapped abilities and talents. Seniors received several weeks of training, and then met with children for 1/2 hour supervised, video-taped play sessions for several weeks. Childhood adjustment problems were assessed before and after the intervention using the Child Behavior Checklist (CBCL) and Teacher Report Form (TRF). Seniors’ responses were measured before and after with the Older Adult Self-Report and qualitative interviews. Although no significant differences were noted on pre versus posttest measures for the children (CBCL and TRF), anecdotal reports suggest potential effec-*

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*tiveness of this volunteer intervention for school counselors to utilize. In addition, senior citizens reported their own benefits from working with the children. Suggestions for future research in this area are offered.*

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**Keywords:** school-based play therapy, Child–Parent Relationship Therapy, senior citizens as therapeutic agents, senior volunteers, play therapy

In today's society, children face many challenges. Currently, more than one in five children struggle with a mental health disorder to the extent that it impairs their functioning (Merikangas et al., 2010; National Institute of Mental Health, 2013). With the shortage of mental health professionals working in elementary schools, these numbers are most likely lower than the actual number of students who could be diagnosed with a mental disorder. Therefore, student needs are not being identified, much less met. Furthermore, those students who don't meet the criteria for a diagnosable mental disorder may still have a variety of mental health needs that need proper attention and care in order to increase the likelihood of optimal development and performance in the early years of school. According to Merikangas et al. (2010), the number of youth suffering from a mental disorder is higher than those suffering from the most common physical disorders including asthma and diabetes, which underscores the importance of prevention and early intervention for at-risk children. In addition, mental disorders manifest early in life, with anxiety disorders presenting before age 6 and behavior disorders before age 11 (Merikangas et al., 2010).

There is certainly a need for effective treatment to help students with mental health issues. Out of all the children who need mental health services, 80% do not receive treatment (Mash & Dozois, 2003). If mental health problems are left untreated, they are more difficult to treat later and can lead to more complex mental illnesses. Untreated mental illness can lead to unstable employment and juvenile justice system involvement, among many other problems (Mash & Dozois, 2003).

The American School Counselor Association has recommended a ratio of one counselor to every 250 students. Unfortunately, this is more of an ideal than a reality. In the United States, the ratio of counselors to students is closer to 1:472 and in the state of Illinois 1:672 (U.S. Department of Education, 2009). Clearly, there are not enough counselors to provide services to students that need it most. A typical school counselor is expected to help students achieve academic success at school, which entails duties beyond traditional mental health services. With these other duties taking precedence, counselors have little time left to address social and emotional concerns of their students that directly and indirectly affect their academic progress. Taking these limitations to the counselor's availability into consideration, the need for alternative ways of helping students becomes apparent. School personnel are left to grapple with the problem of significant student problems with few resources. Volunteers may be one way to fill the need for services without increasing costs.

## **CHILD–PARENT RELATIONSHIP THERAPY**

Child–Parent Relationship Therapy (CPRT) is used by trained play therapists to teach parents to be therapeutic agents with their children through didactic instruction, demonstrations of play sessions, required video-taped home play sessions, and group

supervision. Parents are taught child-centered play therapy principles and skills, including reflective listening, recognizing and responding to children's feelings, therapeutic limit setting, building children's self-esteem, and encouraging internal locus of control. Parents are taught to create a supportive, accepting therapeutic environment that facilitates a child's personal growth and acts as a catalyst for change in the child (Landreth & Bratton, 2006). CPRT differs from other parent-child therapies because the goal is not problem solving but rather relationship building that will lead to cooperative problem solving. There are several other factors included in CPRT that make it distinctive. For instance, the sessions are led by the child; the adult is there to encourage and reflect rather than direct and question. The parent or caregiver is trained to accept the child's behavior rather than correct it—with a few exceptions. Within sessions, communication is play based, that is the child communicates their feelings, wishes, and wants through play rather than verbal conversation. Finally, the play within the session is symbolic of actual events or emotions (Landreth & Bratton, 2006). As the parent learns to create an atmosphere of unconditional acceptance, they begin to see the world through the child's eyes and are then free to communicate empathy. The parent sends the messages: "I am here. I hear you. I care. I understand" (Landreth & Bratton, 2006). In return, the child learns to identify and express feelings appropriately, to control impulses, to recognize choices, to solve problems, to make responsible decisions, and to trust themselves (Landreth & Bratton, 2006). CPRT is led by a trained therapist through 1 1/2 to 2 hour group training sessions that last for 10 weeks. Parents are then asked to bring in taped play sessions with their child to receive feedback and supervision from the group. Finally, parents use a specific set of toys during these special play times.

Strong empirical support exists for the use of CPRT to successfully address children's social, emotional, and behavioral problems. In a well-known study by Bratton, Ray, Rhine, and Jones (2005), the researchers concluded that CPRT had an effect size of 1.25, making it one of the most effective forms of treatment in the child psychotherapy field. CPRT has been associated with decreases in internalizing and externalizing behavior problems, and facilitation of academic success (Landreth & Bratton, 2006). In addition, children participating in CPRT sessions have demonstrated less anxiety and depression, and showed greater adaptability, leadership, and social skills (Post, McCallister, Shelly, Hess, & Flowers, 2004). Similar studies have noted statistically significant changes in overall reduction of child behavior problems and increases in parental acceptance and empathy, along with decreases in parental stress (Ceballos & Bratton, 2010; Kale & Landreth, 1999; Smith & Landreth, 2004; Tew, Landreth, Joiner, & Solt, 2002).

## ADAPTATIONS OF CPRT WITH OTHER POPULATIONS

Recently, CPRT has been adapted for use with adults other than parents. In one study, Morrison and Bratton (2010) sought to determine the effectiveness of Child-Teacher Relationship Training (CTRT), a version of CPRT. The study consisted of 24 teachers and aides and 52 children who were randomly assigned to two groups. In the first group, participants were trained in CTRT through two phases. During Phase 1, teachers were trained to incorporate CTRT with individual students. In Phase 2, the

experimental group incorporated CTRT into the entire classroom. Those participants not in the experimental group were put into an active control group where they were trained in Conscious Discipline—a training program to help teachers and aides respond to children in more positive ways. Teachers were also asked to fill out the Teacher Report Form (Achenbach & Rescorla, 2001) at pretest, midpoint, and posttest. Results indicated a clinically significant decrease in both Externalizing Problems and Internalizing Problems for those students receiving CTRT. The participating schools also reported fewer office referrals for students participating in CTRT. Further, with teachers and aides trained in CTRT, mental health professionals have more time to dedicate to the more severe issues on their caseloads.

Draper, White, O'Shaughnessy, Flynt, and Jones (2001) conducted a study to investigate the effects of training kindergarten teachers, kindergarten paraprofessionals, and first grade teachers using kinder training. Based on observation and the Behavior Assessment Scale for Children (BASC) Teacher Rating Scale, Draper et al. (2001) found that the children in the study had a decrease in negative behaviors and an increase in adaptive behaviors. It is also important to note that the literacy skills of the children increased in all participants even though all of the children differed in levels of literacy and abilities or difficulties in various subjects.

In a study where teachers in 2-, 3-, and 4 year-old classrooms were trained in a 10 week filial therapy method, Post, McCallister, Shelly, Hess, and Flowers (2004) found that children who were deemed at risk possessed fewer cognitive, social, and emotional school-readiness skills. After administering the BASC, the Assessment of Child-Centered Play Therapy Skills, and the Measurement of Empathy in Adult-Child Interaction (MEACI) in a pre- and posttest study, the researchers found that teachers who went through the kinder training sessions showed improved ability to use play therapy skills and demonstrate empathy toward children. In addition, the children participating in kinder training decreased their internalizing behavior problems and improved their adaptive coping skills. A year after the study concluded, Hess, Post, and Flowers (2005) interviewed the teachers who had participated in the kinder training. The teachers reported successful continued use of play therapy and empathy skills in the classroom setting.

Jones, Rhine, and Bratton (2002) utilized a filial therapy model to work with high school students who participated in play therapy sessions with prekindergarten and kindergarten aged children. The children took part in an average of 20 play therapy sessions each. Before and after the study, the high school students were assessed by using the MEACI and the children's parents were given the CBCL, and the children's teachers were given the Early Childhood Behavior Scale (Jones et al., 2002). Researchers found statistically significant decreases in the total behavioral problems in the experimental group. This included a decrease in withdrawal, depression, and anxiety. The study also found that the high school students who were involved in filial therapy training had increased empathic play behaviors along with increased ability to communicate acceptance (Jones et al., 2002).

## USE OF PARAPROFESSIONALS

Use of paraprofessionals in mental health and education is not a new development. Paraprofessional services blossomed in the 1960s as the transition from

deinstitutionalization of many clients took place in favor of least restrictive environments. At the same time, there was a scarcity of professionals to work with such clients, providing a catalyst for use of paraprofessional services that also had the potential to have a positive effect on the “helper” (Walter & Petr, 2006). Although the evaluation of such services from students, parents, teachers, and administration is overwhelmingly positive (Marks, Schrader, & Levine, 1999), studies provide mixed results regarding effectiveness (Walter & Petr, 2006). Paraprofessionals can be defined as individuals who do not have formal training from universities nor a degree in the field in which they are working (Walter & Petr, 2006). Therefore, concern exists about paraprofessionals practicing within the scope of their expertise and the nature and role of their supportive services. Additionally, paraprofessionals who identify with their clients may unintentionally experience an “identity limbo” between professional and consumer roles, according to Kalafat and Boroto (1977).

Although paraprofessionals do not provide therapy, they can provide valuable services. Steps can be taken to address potential problems. After proper screening for mental health problems, clear roles must be defined, including specific goals and objectives within the paraprofessional’s scope of expertise. Training and orientation are of utmost importance, especially before beginning services to ensure a good grasp of essential skills. In addition, confidentiality and professional boundaries must be covered and continually assessed. Close supervision is a necessity for quality assurance of services, ongoing evaluation of progress, and potential need for professional referrals. Ultimate responsibility for services must reside with a trained professional, in the case of CSRT, a trained therapist.

## SENIOR CITIZENS POTENTIAL CONTRIBUTION

The average life span has increased almost 50% since the 1900s. With this extended longevity, typical retirement for older adults lasts an average of 14 years. Characteristics of today’s senior citizens can be marked by increases in overall physical and mental well-being (Pillemer, Wagenet, Goldman, Bushway, & Meador, 2010; Rozario, 2007). Additionally, many of today’s current senior citizens are better educated and have more free time than previous generations (Harper & Levin, 2005).

Due to the “Baby Boomer” generation, retired individuals now outnumber the 46 million students attending elementary and secondary schools (Fischer & Schaffer, 1993). During older adulthood, seniors may strive to make significant contributions to society. Keeping active and involved within their communities provide these individuals with a sense of meaning, purpose, and satisfaction. The benefits seniors gain from volunteer service are well documented. Volunteering is associated with better perceived health, higher physical functioning, improved psychological well-being, increased longevity, positive affect, social connectedness, and purpose in life (Greenfield & Marks, 2004; Luoh & Herzog, 2002; Pillemer et al., 2010).

Likewise, a senior citizen’s involvement in a school can have a tremendous impact on the overall well-being of a student. These volunteers are capable of providing individualized attention for students who struggle not only academically, but emotionally. Retired individuals who volunteer within the school setting also

generate greater appreciation from the students for the wisdom and knowledge that they can provide. Students may acknowledge that there are others within society that care for their well-being. These acts of kindness in turn generate a greater sense of self-efficacy and self-worth among the students. In a study by [Cooledge and Wurster \(1985\)](#), older adults were paired up with students for tutoring purposes. The students' scores on achievement tests were compared with other students within the same classroom. Students who were tutored by senior citizens scored significantly higher than those who did not receive assistance. Foster grandparents differ from volunteers in that they are typically provided a stipend for their services; however, their contributions to special needs children are numerous, with nearly three quarters of their time logged in education programs of some sort providing mentoring and tutoring with positive results ([Peacock & O'Quin, 2006](#)).

The relationship between students and older adult volunteers appears to be a reciprocal one in which both benefit from the relationship and individualized attention ([Peacock & O'Quin, 2006](#)). In this study, older adult volunteers learn play therapy skills to work with students struggling with emotional or behavioral issues whose caregivers are unable to engage in CPRT. Like CPRT, Child–Senior Relationship Training (CSRT) utilizes a one-on-one relationship to help the child discover his or her own abilities and work through their emotional struggles. The older adults likewise gain a sense of fulfillment and purpose, knowing that they have helped a child through unique challenges. CSRT shares many similarities with CPRT and CTRT. All groups are trained by an experienced play therapist in a group setting. Specific toys in a tote bag playroom are utilized in 30-min play sessions to facilitate developmentally appropriate communication. All groups learn child-centered play therapy skills and build a transformative relationship that is believed to have therapeutic properties, although it is not considered to be traditional therapy per se. All sessions are videotaped and play sessions are closely supervised. [Table 1](#) lists differences.

## METHOD

### Participants

Participants were comprised of two groups: Senior citizen volunteers (age 55 and up) and elementary aged children (Grades 1–3). Participants were recruited from a local elementary school and the local Life Span Center Retired Senior Volunteer Program. Senior volunteers were recruited by the director of the program, choosing from over 450 listed volunteers. Seniors were selected with the

**Table 1.** Comparison of Differences Among CPRT, CTRT, and CSRT Groups

Groups	CPRT	CTRT	CSRT
Relationship	Already established	Somewhat established	Not established
Use of skills outside session	Generalization assumed	Encouraged to generalize	No contact outside session
Materials and motivational material	Geared toward parents	Geared to teachers	Geared to senior citizens
Where sessions take place	Home	School/classroom	School



following stipulations in mind: (a) age 55 and older in good physical and mental health, having never been convicted of a felony; (b) have never been formally accused or convicted of a child-related crime of any kind including physical abuse, sexual abuse, emotional abuse, or neglect; (c) have the ability to be playful and enjoy the company of a child; and (d) are open to feedback from others. Senior volunteers were also required to undergo a criminal background check.

Four senior citizen volunteers agreed to participate in the pilot study. Of the four volunteers, three were self-identified as Caucasian, and one as Filipino. All four seniors were women with a range in ages of 60 years old to 74 years old (mean age = 69 years old). These four seniors were paired with four elementary aged children ranging from 7 years old to 9 years old (mean age = 8 years old). Of these four children, three were males and one was female. All four children were identified by their parents and teachers as Caucasian.

The school's counselor was asked to choose children who were functioning in the borderline clinical range in terms of internalizing and externalizing behavior problems as measured by the CBCL and/or TRF (i.e., not currently suffering from a psychological disorder or currently receiving psychological counseling). However, due to the nature of informed consent and the school personnel's responsibility for selecting appropriate participants, CBCL and TRF scores were not collected until the children were already enrolled as participants. Although the school staff (school counselor and principal) believed all the children to be functioning in the borderline range, in fact, they were not. Parents/guardians were contacted by a member of the research team to determine if they were interested in participating in the pilot study. Children met with the research team where an age appropriate informed consent was read and explained to each child to determine child assent for the project.

## Measures

The Teacher Report Form (TRF; [Achenbach & Rescorla, 2001](#)) was chosen to measure teacher report of child behavior problems due to its well-established validity and reliability, as well as the Child Behavior Checklist (CBCL; [Achenbach & Rescorla, 2001](#)). Both the CBCL and TRF have three domain scales: Internalizing, Externalizing, and Total Problem scales. Scores below 65 are considered to be in the normal range. Clinical range is  $> 70$  with a Borderline range of 65–69. The Older Adult Self Report ([Achenbach, Newhouse, & Rescorla, 2004](#)) was chosen to screen for overall potential problems for senior volunteers and measure any changes from the beginning to the end of the study. Researchers monitored senior empathy with the Measurement of Empathy in Adult–Child Interactions (MEACI) only for quality assurance, as the researchers felt it necessary to provide training to the senior volunteers before allowing contact with the children for safety/confidentiality reasons. Therefore, a formal pretest–posttest comparison was not possible. The MEACI was adapted by [Bratton \(1994\)](#) from a scale developed by [Stover, Guerney, and O'Connell \(1971\)](#) to operationally define empathy as related to parent–child interactions. Lastly, qualitative senior interviews were utilized.

## Procedure

In this pilot study, the researchers followed the 10-week CPRT format. Because the senior–child relationship was not an already intact one, two group meetings were added at the beginning and end of the study for seniors and children to interact (i.e., kick off and a goodbye party) for a total of 12 weeks. Seniors received 3 weeks of training and supervision at the university prior to beginning their first play session. Each group training session lasted 1 1/2 hours and was recorded for quality assurance. Volunteers also videotaped each of their seven 1/2 hour play sessions with the children and brought them to group sessions for supervision and feedback.

Senior volunteers conducted weekly 1/2 hour play sessions at the school with one assigned child either directly before or after the weekly group training session. This format was determined at the request of the seniors who preferred to have training and play sessions on the same day to keep the rest of the week open for other activities. At the beginning of the study, seniors met with the primary researcher to ask questions about the pilot study and select play times. The kick-off party including seniors, children, and the research team was then scheduled with the children to explain the study and facilitate relationship building. Seniors met the child they were paired with and were given potential questions they could choose to ask their target child to get to know them. All children at the kick-off chose to participate in the study.

Adaptations of the CPRT model developed by Landreth and Bratton (2006) included consideration of time of year and subsequent driving conditions, larger type print of materials, and scheduling of sessions to allow for travel and physician's appointments. Additionally, researchers adjusted segments of the curriculum by removing parent–child specific information and adding a brief review of child development to facilitate accurate understanding of child communication in play sessions and what to expect from an elementary school-aged child. Adjustments were also made in personalization of examples to fit a newly developing relationship between adult and child versus an already intact one. In addition, a trained graduate assistant graciously agreed to standby as play sessions were conducted to answer any questions on-site and to provide live assistance at play sessions including setting up and taking down the toys, as well as burning DVDs on-site for supervision purposes. Lastly, motivational material was specifically geared toward increasing the seniors' motivation.

## RESULTS

This pilot study followed a pretest–posttest design. Childhood adjustment problems were assessed before and after the intervention with the CBCL and the TRF. Seniors' responses to the intervention were measured both before the intervention and after by utilizing the OASR, as well as by brief qualitative interviews.

Descriptive and inferential statistics for the present study are presented in Table 2. A paired-samples *t* test was conducted to examine differences between the pre- and postintervention scores on the CBCL and TRF for the child participants

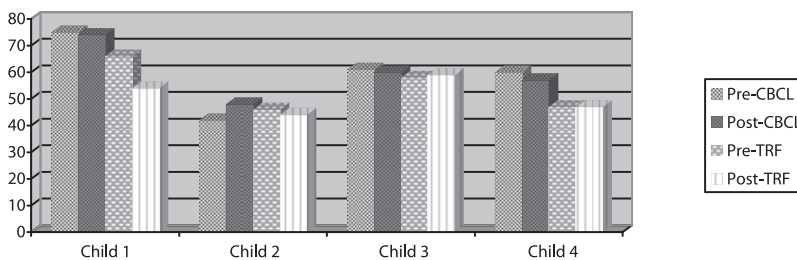
**Table 2.** Mean T-Score Differences For Pre- and Postintervention Total Scores of the Child Behavior Checklist (CBCL), Teacher Report Form (TRF), and Older Adult Self Report Form (OASR)

Group	Mean/ <i>sd</i> (pretest)	Mean/ <i>sd</i> (posttest)	<i>t</i> -value (pre-post)	<i>df</i>	Alpha
Child CBCL	59.5/13.5	59.8/10.8	-.127	3	.91
Child TRF	54.3/9.5	51.0/6.8	1.09	3	.36
Senior OASR	37.5/4.5	35.7/5.6	2.33	3	.11

and the OASR for senior volunteers. There were no statistically significant differences noted between the preintervention and postintervention. Total mean scores on the CBCL,  $t(3) = -.127$ , the TRF,  $t(3) = 1.09$ , or the OASR,  $t(3) = 2.33$ . Due to the very low sample size, total scores are provided for each child participant on both the pre- and posttest CBCL and TRF instruments in Figure 1.

Seniors' qualitative interviews were gathered individually following the completion of the study and were approximately 45 min to 1 hour in length. Each interview was recorded then transcribed following the standards of phenomenological qualitative research (Creswell, 1998). Two researchers met to describe their own experience with the phenomenon and discuss potential biases. One researcher was part of the study and one was not directly involved with the participants in order to reduce bias. Each researcher separately reviewed statements in the interviews, listing significant themes, with those statements then being grouped into units. Following independent coding, researchers met again to compare themes collected. When discrepancies occurred, the researchers consulted the transcriptions for clarification. Researchers then compared and contrasted personal and participant perceptions, looking at the data from multiple angles to provide an exhaustive description of the phenomenon. Then, an overall description was constructed by each independent researcher and then by meeting together. These descriptions were constructed for each participant and then as an overall senior volunteer group.

The interviews with senior volunteers revealed several themes. First, the volunteers all noted improved communication skills as a benefit of participation. These skills, according to the seniors, extended beyond the study for use with friends, spouses, grandchildren, and others. Overall, each participant felt they were better listeners and noted an improvement in their communication effectiveness with others. One participant noted prior to the CSRT training, she struggled to connect with her students she had at a part-time job. She reported the reflective listening

**Figure 1.** Pre- and posttest CBCL and TRF total scores for each child.

skills she learned helped her to finally connect with her students, resulting in the best teaching evaluations she had received. Another volunteer noted how others responded to her improved communication skills by describing a situation unrelated to the study where someone overheard her utilizing general CSRT skills while tutoring a second grader (not a participant of the study). She stated “we usually meet out in the hall, cause that’s about the only place, but there was a parent who sits in the same area and just yesterday she says ‘I hope you don’t mind, but I’ve been eavesdropping on what you’ve been saying’ and she said, ‘You are so gentle and kind and a good listener with the kids.’ And I said well, that’s partly due to my CSRT training!”

Each volunteer stressed overall positive experiences with the program and discussed the importance of satisfaction related to lifelong learning and a sense of fulfillment and purpose. One participant commented “It was a learning experience. Not only with the children, but in the group was quite a learning experience, I thought. I’ve been very impressed with that.” Another noted “I think that we became a close knit little group of volunteers and getting to know each other. And you know getting to share about our experiences and then to learn something new . . . I’m always anxious to learn new things.” A different participant noted her pride in her accomplishments “. . . that I can do this. That I had learned some skills and can put them into practice. Yea, it was a good ego boost for me.” The last volunteer noted “One of the advantages probably is that you learn something from the student or from the child as well as you are trying to help her. And I also found out that I can use that for my students as well in the university. I tried on two or three students of mine and it worked! So, I said, ‘ooh (laughing) this is a good thing to learn!’ So, I was open to anything then because I know, since I know I can use it for my own students . . . but if I can change somebody, even just one, that for me is an achievement.”

All the volunteers reported feelings of significance regarding helping someone else. One participant put it this way “I feel good about it, ‘cause I felt like he, this was good for him. He began including others and I was hopeful that it carried over, not just in the playroom but that it would carry over so that he did include others more.” Another stated “you know I think he counts me as a friend, and that was important.” Also noted was the group’s belief in the power of play. One participant stated “It really (play) reflects what’s going through their brain. Their inner brain and their heart . . . Now that I’m at the end of it, I think it really made a difference for him.” Another stated “I think it gave them a sense of belonging even though it was just you in there with them, they felt like we belonged to each other during that time.” Another noted “It’s such a wonderful program for the kids and it’s so important, especially for the aggressive boys, that they have an outlet like that.” Benefits of the group were noted several times by members with group cohesion being very frequently mentioned. One woman responded the following way when asked how she was impacted by the training “Because it was a small group, therefore I felt close to everyone.” Another stated “We were just so comfortable in our little group. And I’m sure that we’re all missing it today.” Another member of the group stated “I thought it was a very congenial group. And everybody had something to offer. And everyone seemed very interested in doing it from the very beginning . . .”

## DISCUSSION

The researchers in this pilot study sought to determine whether CPRT could be successfully adapted for use with senior citizen volunteers in the elementary school setting. The pretest–posttest design specifically addressed change in problem behaviors before and after the intervention. Although results were not statistically significant, anecdotal evidence provides some support for its effectiveness. For example, researchers noted positive shifts in the children’s play therapy themes and clinical indication of resolution of some adaptive behavior problems. For example, the school’s principal casually noted during a site visit that none of the children had been in the principal’s office for weeks. He indicated one child in particular was seen 2–3 times per week prior to the study. This same child began the study with aggressive behaviors rooted in perceived danger and lack of nurturing in the environment. After very few play sessions, the child drew the volunteer a picture of the two (senior and child), noting the senior being represented as a long necked brontosaurus, with the much smaller child (also a brontosaurus) nestled closely underneath its long neck. According to the child, he had purposefully clipped the edges of the picture to remind him of his favorite blanket that helped him feel safe.

Additionally, several methodological errors may have contributed to the lack of significant findings. First, because consideration was given regarding the potential for problematic winter weather, the study began the first week of school. Teacher Report Forms were completed before children began their play sessions (i.e., the first week of school). Because children have a tendency to engage in honeymooning in novel situations, behavior problems may not have been perceived by new teachers who were unfamiliar with the children’s histories. In fact, the Mean preintervention *T* scores for both the CBCL and the TRF fell below both the Clinical (> 70) and Borderline ranges (65–69). Although the principal and school counselor were both familiar with the children’s presenting problems, new teachers were not privy to this information. Second, the researchers experienced great difficulty getting the posttest measures back from parents. The primary researcher sent materials out several times and made several phone calls to remind parents in addition to sending the materials home with the child, resulting in getting the data back weeks after the study was completed in two cases. Although parents were asked to back date the data, obvious problems with accuracy exist in this situation.

There were many limitations with this pilot study including a very small sample size. Although the small number was chosen due to the unique adaptation of the model with a new population, this may have very well contributed to the lack of significant findings. Increasing the sample size and optimally adding a control or comparison group of some sort is recommended for future studies. In addition, the study was 12 weeks from beginning to end, resulting in seven play sessions. Because the relationship between seniors and children was not established prior to the beginning of the project, extending the training out to cover a longer period of time may result in more significant differences between pre- and posttest measures. Baggerly and Landreth (2001) also noted anecdotal support for their adaptation of CPRT utilizing fifth-grade students to work with kindergarten children referred for school adjustment difficulties, despite lack of statistically significant differences.

Results from the OASR given to senior volunteers suggested that the seniors began the study relatively problem free in regards to adjustment problems. Therefore, no significant differences were noted due to participation in the study. This was not necessarily a surprising finding as researchers worked to screen out any individuals with serious mental health issues; however, qualitative interviews revealed themes from the group related to overall life enhancement as a result of participation in the group. Similar to the findings of other studies (Newman, 1991), the participants positively benefited from volunteering. More specifically, the volunteers were positively impacted by working with the children themselves. During follow-up qualitative interviews, the seniors talked at length about how gratifying their play therapy experience had been and identified clear benefits for themselves, as well as for the child with whom they worked. Although the OASR may continue to be used to screen for mental health problems, selection of a new instrument that measures other factors such as well-being rather than adjustment may measure changes more effectively in future studies.

### **Recommendations**

Researchers learned many valuable lessons conducting this pilot study, some of which were quite unexpected. First, researchers noted how incredibly busy senior citizens were. Scheduling the sessions was a major obstacle and, therefore, play sessions and CSRT meetings were set for the same day to allow travel and meeting of other commitments for the busy seniors in this study. This should be anticipated by researchers looking to replicate this study and a concerted effort should be given to communicating benefits of being involved in long-term projects as many seniors felt uncomfortable committing to 10 weeks. Once the seniors met the children, their commitment was strengthened and, therefore, a kick-off party seems valuable for both child and senior participants. Although children in the Borderline clinical range were sought out, the group collectively did not actually fall in that range. This may be reflective of the measure not detecting perceived problems from the school staff or some problems with staff perceptions of the severity of children's social-emotional difficulties. Additionally, because the study took place at the beginning of the school year and the school counselor referred the children, teachers filling out the TRF may not have been familiar with the children's problems as many children tend to engage in "honeymooning" at the beginning of school. Researchers replicating this study will want to ensure child participant scores fall in the Borderline, or perhaps even clinical range, depending on the severity of symptoms. It is important to target children with sufficient symptomology while being careful not to overwhelm volunteers beyond their level of expertise. Beginning the study later in the year may also help researchers obtain accurate pretest CBCL and TRF scores. Lastly, adding parental incentives for returned data may eradicate the data collection problem researchers experienced.

Motivating parents is different from motivating senior volunteers. Each senior struggled in their own way to trust the CPRT process and worried she wasn't helping enough. The fact that seniors spend only 30 min a week with the child exacerbated that worry as parents and teachers spend considerably more time with



target children in related studies of the effectiveness of CPRT. More group time devoted to supervision of these aspects is, therefore, recommended. Utilizing the MEACI at pre- and postintervention is an important consideration for future researchers. On the one hand, it could provide a valuable measure of effectiveness. On the other hand, there are some ethical considerations to utilizing the MEACI as a true pretest. In other words, allowing seniors to play with children prior to any training carries with it some risks, although providing some training and then giving the MEACI doesn't provide a true baseline. Looking more closely at MEACI scores throughout the intervention may help future researchers measure change more effectively. In addition, motivational material was geared specifically toward the senior volunteer population and all noted this was an important piece of the training. In fact, at the end, the group requested copies of all stories, readings, and motivational material. Lastly, although formal data were not collected from the children, children provided positive feedback regarding their experiences with CSRT at the goodbye party. One child happily recited word for word the letter his senior had written him regarding his strengths. All the children commented on the fun they had playing and how they would miss their special playtimes. Teachers similarly shared how the children looked forward to the playtimes and counted on them each week, benefiting from the consistency they received. Qualitative information from child participants would provide additional data for researchers to consider in utilizing this model.

Utilizing paraprofessional senior volunteers, although helpful to overburdened school counselors, carries with it ethical considerations, especially in working with minor children. Beyond the basic safety requirements utilized in this pilot study, other items must be considered. Although preservice training is mandatory, ongoing training and supervision is also critical to ensuring each individual child's needs are being appropriately addressed. For some children, CSRT may uncover additional aspects to the presenting problem that may necessitate a referral to a professional provider. In the CSRT model, seniors are not delivering therapy. The idea is that the relationship between senior and child has the potential to be transformative and healing for many, but certainly not all children. Similarly, selection of children is crucial as senior paraprofessional volunteers would not be trained to manage homicidal or suicidal children for example. The CSRT model is proposed to be utilized by trained school counselors who can determine the appropriateness of referrals based on multiple sources of data including parents, teachers, aides, and school personnel. In conclusion, it is notable that these participants would not likely have been seen by the school counselor. Although seniors were not viewed as replacements for a school counselor, they were, in fact, able to provide services to a group that would not have received school services unless their condition worsened considerably.

## CONCLUSION

According to the American School Counseling Association, the four components of a School Counseling Program include: guidance curriculum, responsive services, individual planning, and system support. In typical elementary schools,

75% of a counselor's time is spent on guidance curriculum and responsive services. Responsive services address the immediate concern of the individual students. This leaves very little time for treating root causes of behavioral problems. Training senior volunteers benefits the senior population by providing new learning opportunities, as well as opportunities for continued generativity through a therapeutic relationship with a child. Similarly, children have the benefit of a relationship with a caring, empathic adult and the opportunity to learn to appropriately identify/express feelings, solve problems, practice impulse control, and make positive choices. Additionally, school personnel receive assistance in helping children with a myriad of problems despite cutbacks in funding. Due to the potential benefits for multiple stakeholders and anecdotal evidence for the positive effects on children and qualitative interview information from seniors, future research into adapting this model for use with senior citizen volunteers is warranted.

This pilot study investigated the effectiveness of Child–Senior Relationship Training in an elementary school setting. Although results were not statistically significant, methodological errors may have contributed to nonsignificant findings; however, anecdotal evidence including reports from teachers and school personnel suggest a significant value to the children and the school system itself. Future research should be focused on investigation of the effects of a longer intervention period due to the need to develop trust and rapport with an unknown individual (vs. a parent or teacher). In addition, a larger sample size with a control or comparison group is obviously preferable, as well as additional supervision checks for the senior citizens to ensure adequate comprehension of play therapy principles and effectiveness with delivery of the intervention.

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