Eastern Illinois University
The Keep

Masters Theses | Student Theses & Publications

1-1-1993

The Effects Of Therapeutic, Play Activities On Three To Five Year-Old Children'S Prosocial Behavior In A Normative Setting

Heather M. Tyson
Eastern Illinois University

This research is a product of the graduate program in Home Economics at Eastern Illinois University. Find out more about the program.

Recommended Citation
Tyson, Heather M., "The Effects Of Therapeutic, Play Activities On Three To Five Year-Old Children'S Prosocial Behavior In A Normative Setting" (1993). *Masters Theses*. 455.
http://thekeep.eiu.edu/theses/455

This Thesis is brought to you for free and open access by the Student Theses & Publications at The Keep. It has been accepted for inclusion in Masters Theses by an authorized administrator of The Keep. For more information, please contact tabruns@eiu.edu.

LB
1861
.C57x
F3
1993
T9
copy 2

THE EFFECTS OF THERAPEUTIC PLAY ACTIVITIES ON THREE TO FIVE-YEAR OLD CHILDREN'S PROSOCIAL BEHAVIOR IN A NORMATIVE SETTING

TYSON

THESIS REPRODUCTION CERTIFICATE

TO: Graduate Degree Candidates who have written formal theses.

SUBJECT: Permission to reproduce theses.

The University Library is receiving a number of requests from other institutions asking permission to reproduce dissertations for inclusion in their library holdings. Although no copyright laws are involved, we feel that professional courtesy demands that permission be obtained from the author before we allow theses to be copied.

Please sign one of the following statements:

Booth Library of Eastern Illinois University has my permission to lend my thesis to a reputable college or university for the purpose of copying it for inclusion in that institution's library or research holdings.

11-17-93 ____________________ [signature] ____________________

Date Author

I respectfully request Booth Library of Eastern Illinois University not allow my thesis be reproduced because ______________________________

____

____

____________________ ____________________

Date Author

m

THE EFFECTS OF THERAPEUTIC PLAY ACTIVITIES ON THREE TO FIVE-

YEAR OLD CHILDREN'S PROSOCIAL BEHAVIOR IN A NORMATIVE SETTING

(TITLE)

BY

Heather M. Tyson

THESIS

SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
FOR THE DEGREE OF

Master of Science

IN THE GRADUATE SCHOOL, EASTERN ILLINOIS UNIVERSITY
CHARLESTON, ILLINOIS

1993

YEAR

I HEREBY RECOMMEND THIS THESIS BE ACCEPTED AS FULFILLING
THIS PART OF THE GRADUATE DEGREE CITED ABOVE

October 22, 1993	D. Jayne Ozier
October 22, 1993	James Slavik
DATE	ADVISER
October 22, 1993	Lucy A. Campanis
November 18, 1993	Joyce Crouse
DATE	DEPARTMENT HEAD

THESIS REPRODUCTION CERTIFICATE

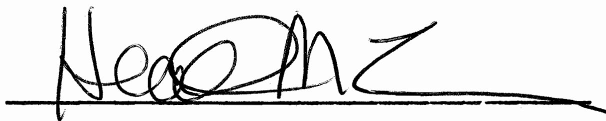
TO: Graduate Degree Candidates who have written formal theses.

SUBJECT: Permission to reproduce theses.

The University Library is receiving a number of requests from other institutions asking permission to reproduce dissertations for inclusion in their library holdings. Although no copyright laws are involved, we feel that professional courtesy demands that permission be obtained from the author before we allow theses to be copied.

Please sign one of the following statements:

Booth Library of Eastern Illinois University has my permission to lend my thesis to a reputable college or university for the purpose of copying it for inclusion in that institution's library or research holdings.

11-17-93 

Date Author

I respectfully request Booth Library of Eastern Illinois University not allow my thesis be reproduced because ______________________________

____

____

______________________ ______________________

Date Author

m

THE EFFECTS OF THERAPEUTIC PLAY ACTIVITIES ON THREE TO FIVE-YEAR OLD CHILDREN'S PROSOCIAL BEHAVIOR IN A NORMATIVE SETTING

by

Heather M. Tyson

Eastern Illinois University

December, 1993

Abstract

This study examined the effects of therapeutic play activities on three to five-year old children's prosocial behavior. The sample was taken from a child development laboratory located at an east central Illinois university. Play therapy has been very successful with children in many social service settings. However, prior to this study, little research conducted using therapeutic play in a normative setting. Two objectives guided this study. The first one was to determine if therapeutic play activities were effective in a normative setting. The second objective was to determine if prosocial behaviors would increase following the therapeutic play activities.

The researcher developed and administered an open-ended questionnaire to the parents of 24 children before and after the play therapy activities were implemented. This Prosocial Behaviors Inventory was coded to determine the mean level of prosocial behavior in which each child was operating. Results from a paired samples t-test suggested that levels of prosocial behavior did not increase at a statistically significant level due to the therapeutic play activities. However, the children's prosocial behavior did increase suggesting that with continued exposure to the therapeutic play activities the change might have been significant.

Acknowledgements

The writer would like to express her appreciation for the people who helped her complete this study:

The graduate committee members, Dr. Campanis, Dr. Ozier, and Dr. Slavik, for their input and encouragement;

Ms. Darice Delap, whose insight and encouragement helped make my assistantship an educational and enjoyable experience;

My goddaughter, Lexi, who made me laugh through every stress filled moment of this experience;

My friends, Maleah, Barb, Luci, and Jane, whose patience and understanding provided me with the support needed to finish this study;

The Rail Staff for assissting me in covering the days I needed off and encouraging me to finish quickly:

My family, Mike, Rhonda, Todd, Gen, Matthew, Karen and April whose continuous praise and love keeps me going.

TABLE OF CONTENTS

Page

ABSTRACT 2

ACKNOWLEDGEMENTS 3

LIST OF TABLES 5

CHAPTER

I. INTRODUCTION 6

Research Hypothesis 7
Objectives 7
Rationale 7

II. REVIEW OF LITERATURE 10

Introduction 10
Historical Background 11
Perspectives of Play Therapy 12
Play Therapy Tools 20
Prosocial Behavior 22
Conclusion 23

III. METHODOLOGY 24

Subjects 24
Research Design 24
Dependent and Independent Variables 24
Data Collection Instruments 25
Procedure for Implementation 27
Data Analysis 30

IV. RESULTS, DISCUSSION, LIMITATIONS 31

Discussion 37
Limitations 38

V. CONCLUSIONS AND RECOMMENDATIONS 40

APPENDIX 43

BIBLIOGRAPHY 49

List of Tables

Table Page

1. Prosocial Behaviors Inventory Pre-Test and Post-Test Scores and Means........ 33

2. Ranges and Means of PBI Pre-test and Post-Test Scores...................... 34

3. Comparison of Mean Scores by Children's Age and Sex........................... 36

4. Comparison of Mean Scores by Number of Siblings.............................. 36

Chapter I

INTRODUCTION

Play therapy was defined by Axline (1947) as an "opportunity which is given to the child to ´play out´ his/her feelings and problems" (p.9). This type of therapy is compared to that of an adults seeking help from counselors. Adults talk out their problems whereas children play them out (Carter, 1987).

Play therapy allows counselors to enter the active world of children (Barlow, Strother & Landreth, 1985). It also provides children with a safe, unstructured environment in which they are free to explore their feelings (Carmichael, 1991). It was first implemented in the 1930s as a supplement to pediatric and psychiatric evaluation, diagnosis and treatment (Conn, 1989). Most practitioners use play therapy techniques so that they can interpret children´s activity and deduce what children are struggling with in their world.

Previous research has focused on the use of play therapy to solve " problems." It is usually implemented by practitioners when children are brought in by parents or recommended by teachers or physicians (Axline, 1947). There has been little, if any, research done on the use of play therapy in a normative

setting. Prosocial behavior involves the display of empathy, sharing and altruism (Carlo, Knight, Eisenburg & Rothman, 1991; Grimley, Zucker, Fakouri & Thompson, 1991; Kim & Stevens, 1987; Lennon & Eisenburg, 1987). The enhancement of prosocial behavior in preschoolers through therapeutic play activities has not been examined to date. The purpose of this study was to determine if the implementation of therapeutic play activities increases the level of prosocial behavior exhibited by preschoolers.

Research Hypothesis

There will be a significant increase in the level of prosocial behavior displayed by preschoolers following the implementation of therapeutic play activities.

Objectives

Two objectives guided this study. First, the study examined whether or not therapeutic play activities could be effective in a normative setting. The second objective was to determine if prosocial behavior increased after the therapeutic play activities were implemented.

Rationale

Prosocial behavior is desired in children and adults alike (Kim & Stevens, 1987). These behaviors

include characteristics such as empathy, altruism, sharing and moral sensitivity (Carlo et al., 1991; Grimley et al., 1991; Lennon & Eisenberg, 1987). The development of these characteristics is essential for children's competence (Kim & Stevens, 1987).

The current level of prosocial behavior exhibited by children has been the focus of research. Several measurement and categorization techniques have been developed by researchers (Carlo et al., 1991; Grimley et al., 1991; Kim & Stevens, 1987; Lennon & Eisenburg, 1987). Little research has been done on ways to enhance the use of prosocial behavior in preschool children.

More specifically, research has yet to investigate the use of therapeutic play to increase levels of prosocial behavior. Play therapy has, in the past, been used only in those situations where a problem needed a solution. Parents, as well as practitioners and educators, need to be aware of the benefits of therapeutic play in normative settings. Therefore, it would be beneficial to determine the effectiveness of therapeutic play activities in a normative setting. This study focused on the use of therapeutic play with children three to five years of age in a child development laboratory setting. Data were collected by observation of the children and a questionnaire

distributed to parents. Levels of prosocial behaviors were determined by use of an open-ended statement questionnaire distributed to parents prior to the implementation of therapeutic play activities. Changes in levels observed by the parents were determined by data collected on the same questionnaire following the therapeutic play activities.

Chapter II

REVIEW OF LITERATURE

Introduction

Play is one way of working on developmental problems and exploring possible solutions (Baumeister & Senders, 1988). A universal definition of what play is has not been determined yet. Smith, Takhuar, Gore and Vollstedt (1985) define play as involving five critera; intrinsic motivation, positive affect, nonliterality, means/ends and flexibility. The first criterion, intrinsic motivation, is based on the idea that play is done for its own sake and not brought about by basic bodily needs or by external rules or social demands. Behaviors that show positive affect are those that are pleasurable or enjoyable to children. Play that is not carried out seriously, but has an "as if" or pretend quality demonstrates nonliterality. Children who are more interested in performance of the behavior itself than in the actual outcomes of the behavior are engaged in the means/ends aspect of play. The final criterion for defining play is the flexibility aspect. Children's play shows variation in form and content. Play is children's natural medium of self expression (Axline, 1947; Barlow et al., 1985; Brooks & Benjamin,

1989). According to Bruner (1986), play provides a courage all of its own in the therapeutic setting because children feel free to express themselves without reserve. Play therapy provides counselors with the opportunity to enter the children's world (Axline, 1947). Several perspectives, including historical background, of play therapy are described in the following paragraphs. Playroom materials are outlined. Prosocial behavior involves those behaviors that entail emphatic responses, sharing and altruism (Carlo et al, 1991; Grimely et al., 1991; Lennon & Eisenburg, 1987). Prosocial behavior is further defined and conclusions are summarized.

Historical Background

Conn (1988) cited several other authors and discussed their reliance upon Freudian theory for their interpretations. As early as 1913, Hug-Helmuth began interpreting the play of children. There was a heavy reliance on Freudian theory in the interpretations (Conn, 1988). Two examples of the interpretations are that shooting a gun denoted a wish to kill one's father and running from the room represented a death wish. Later in 1937, Melanie Klein wrote that every form of play activity represented the processes of masturbatory fantasies. Klein also depicted the acts of reading and writing as violent attacks upon the mother's body and

the father's penis.

In the 1930s, the emphasis was on children in the play situation and their behavior in relation to therapists (Conn, 1988; Landreth, 1987b). The play interview was developed in which children were given the opportunity to express their feelings, fears or problems through the use of various dolls (Conn, 1988). This was not meant to replace pediatric and psychiatric examination and treatment, only to supplement it. The play interview was described as highly motivated and purposeful. These practitioners set the stage for the modern play therapist of today.

Perspectives of Play Therapy

Non-directive play therapy was developed by Virginia Axline in 1947. Axline's approach was non-directive in that children were allowed to take responsibility for directing the session (Axline, 1947; Schaefer, 1988; Landreth, 1987b). Self- awareness and self- direction are the goals of this type of play therapy (Schaefer, 1988). Schaefer (1988) later termed non-directive therapy as the relationship approach.

Axline (1947) emphasized the importance of the personality theory upon which non-directive play therapy is based. She believed a powerful force exists within every individual that strives continuously for complete self-realization. This growth force drives

people to achieve maturity, independence and self direction. If individuals have permission to be themselves with complete acceptance, then they have a good "growing ground" (Axline, 1947). Someone who had an insufficient growing ground might become maladjusted and need treatment to achieve the goals set by the growth impulse.

Axline (1947) outlined eight basic principles to guide the nondirective therapist. The first one involved the development of rapport with children. This should be established as soon as possible. Mitchum (1987) stated that it is the adult's role to establish trust and that it takes patience and firmness. The second is very simple, but very important. It is the therapist's responsibility to accept each child exactly as is, without question. Next, therapists should establish a feeling of permissiveness within the relationship. This is necessary so that children will feel free to express themselves without restraint. Therapists should always be alert to the feeling of their patients and be able to reflect those back to children. This allows children to gain some insight into their behavior. When using interpretations, therapists must be careful not to go beyond the symbols children are using. The fifth principle involves respect. Therapists must

respect children's abilities to solve their own problems when given the opportunity to do so. Children are encouraged to make decisions on their own and therapists should listen attentively. A climate of acceptance, faith and trust is developed when the therapist allows children to lead the way (Barlow et al., 1985). The sixth principle dictates that therapists do not attempt to direct children's activities in any way (Axline, 1947). Therapy is a gradual process and should be recognized as such by therapists. There is no attempt made by therapists to hurry therapy along, as stated in the seventh principle. The final principle involves limitations. Therapists should only set those limitations that are necessary to anchor the sessions in reality.

Four phases were identified during nondirective play therapy (Schaefer, 1988). First, children's negative emotions are expressed (Axline, 1947; Schaefer, 1988). Then, children begin to accept these negative emotions. Positive feelings are expressed in the third stage. The final stage involves the separation of the negative and positive emotions and the ability to express them more realistically.

Most practitioners rely heavily on this approach for reference and example. It is the most widely accepted form of play therapy. It is also the one that

is most often cited in the literature.

Kottman and Warlick (1990) developed Adlerian play therapy by integrating Adlerian concepts and techniques with those of play therapy. Adlerian play therapy has four primary aims. They are as follows: to establish and maintain an egalitarian relationship; to investigate the life-style of clients; to interpret the life-style in a way that encourages client insights and to reorient and re-educate clients. These goals are said to help therapists conceptualize and understand the children and to help them understand themselves.

This therapeutic technique works best with children between the ages of four and nine. This is because they are young enough to prefer play as their primary means of communication and old enough to understand basic verbal language. As children become involved in this type of therapy, they will begin to catch themselves at self-defeating behaviors and begin to be more aware of possible alternatives. They realize that they have control over their own thoughts, attitudes and feelings. Self confidence is the result of the development of coping successfully with life and its stresses.

The psychoanalytical approach was briefly outlined at the beginning of this review. This approach emphasizes the use of therapists' interpretations of

children's play activities to gain insight into the children's world (Schaefer, 1988). Analysis of the transference relationship allows therapists to help children achieve insight into their unconscious conflicts (Landreth, 1987b; Schaefer, 1988). This is obviously based on Freud's theories. Klein used this type of therapy liberally (Conn, 1989). Anna Freud noted that this type of treatment is not suitable for all types of children (Schaefer, 1988). She felt that play did not always represent something.

The next approach has been called both the structured approach and release therapy as Levy utilized it (Landreth, 1987b; Schaefer, 1988). A few definite toys are selected that would help children work through their troubles (Schaefer, 1988). The selection was based upon the case history of each child. There are three forms of release therapy. The first is the simple release of instinctual drives by encouraging children to throw objects around the play room, burst a balloon or nurse from a bottle. The second is the release of feeling in a standardized situation. The standardized situation is one with which children are familiar and in which they will feel comfortable. This can include sitting at a table, on a couch or playing with dolls on the floor. The last type of release therapy is the release of feelings by

recreating a stressful situation. Therapists take children back to the point of trauma, such as abuse, so that they can recreate and release their feelings. Repetition of the situations introduced in therapy is involved in all aspects of release therapy.

Schaefer (1988) outlines three signs that therapists should look for to indicate the success of release therapy. They are as follows: the direct manipulation of dolls; absorption so deep that they are oblivious to their surroundings; and the acting out of primary impulses rather than holding back out of defensiveness. Release therapy is highly specific and usually involves some free play time, too.

Several practitioners have recognized the need for filial therapy techniques. Guerney (1991) outlined three reasons for inclusion of parents in therapy. They are the following: parents are the most influential people in their children's lives; parents, in the past, have resented their exclusion; and the new knowledge, skills and status that parents achieve as primary change agents enables them to function adequately outside of the play therapy session. Bishop (1988) summarized a play therapy session in which a father and son interact and solve their problems during the third session. If the father had not been included in the session, results would have been longer in

coming.

Nystul (1987) developed a parent-centered model of therapy. His research concurs with Guerney's (1991) and states the importance of parents' involvement in therapy. This model emphasizes the idea that parents can play an active role in their children's therapy (Nystul, 1987). Hodapp and Goldfield (1983) developed a program of mother-infant interactions to facilitate therapy with delayed children. These games included four distinctive features; mutual involvement, repetition, alternate turn taking and nonliteracy. Each of these characteristics is vital to the development of infants. Using these games not only helps the parents effectively interact with their children, it allows some of their guilt and anger to dissipate. These games show children in an active and personable light.

Barlow, Strother and Landreth (1986) believed that consulting with parents in conjunction with each child's play therapy sessions could facilitate communication in the home. Without revealing any confidential activities from the therapy sessions, therapists can provide parents with insights that will strengthen their relationship with their child.

The group play therapy experience has all of the same characteristics as individual play therapy with

one additional element; the reality of each child's world in relation to the other children (Axline, 1947). Therapeutic activities should be gauged so that children develop trust and acceptance with the others in the group (Mitchum, 1987). In group sessions, children must consider the thoughts and feelings of the other children in the group (Axline, 1947). Group play therapy allows children to help each other assume responsibility for interpersonal relationships (Barlow et al., 1986). The group therapy experience also allows counselors to see how children interact with their peers.

Symbols are synonymous with toys in the play therapy sessions. Children can have trouble expressing themselves through words; symbols allow them the opportunity to show what they are feeling inside (Sikelianos, 1986). Symbols are arbitrary and cannot be separated from the person (Vinturella & James, 1987). Types of symbols range from using a block as a telephone to repeatedly using the metaphor of broken plumbing when making reference to catheters. Storytelling can lead counselors to the problematic area by listening for the symbols in the stories (Stiles & Kottman, 1990). Symbols can represent feelings of aggression, fear, loneliness, rejection and even death (Sikelianos, 1986; Ainsa, 1981; Landreth,

1987a).

Children in hospitals are faced with an alien environment and unknown treatments for whatever their ailment is at the time. Practitioners need to realize that children should be treated differently than adults (Harvey, 1984). Treatment should encompass physiological needs as well as psychological ones (Wishon & Brown, 1991). Play therapy techniques can be implemented so that children will not fear the unknown and avoid feeling as if they have no control over their world.

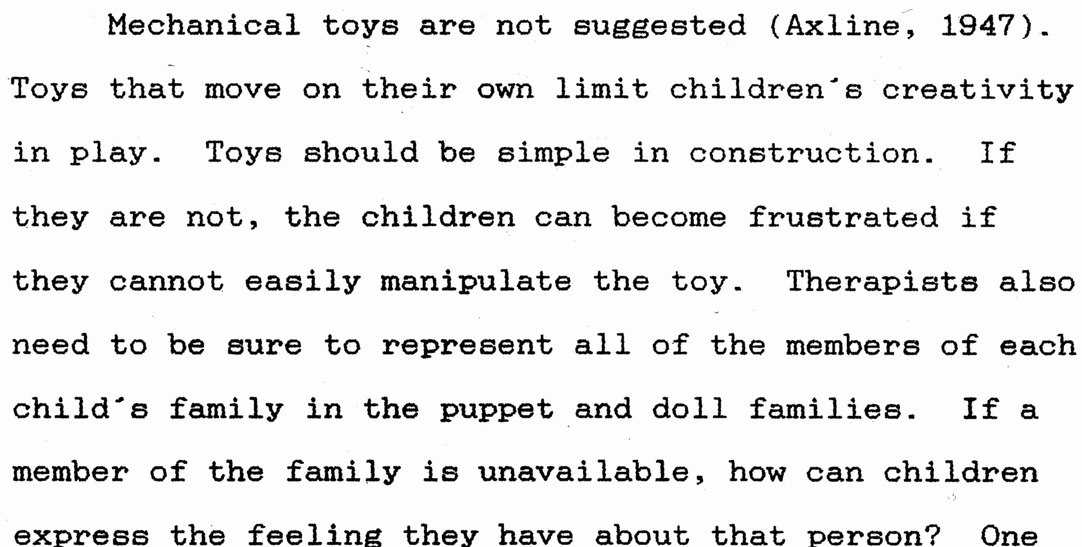
Play Therapy Tools

A separate room is desirable for the play therapist who works in an office setting (Axline, 1947). It is desirable, but not mandatory. An unused corner could be sufficient, if the right materials are available. A suitcase can be a successful storage place for the traveling therapist. The tools a play therapist uses for therapy seem obvious; toys. What kinds of toys? How are they useful? What types of toys should be avoided? These are the questions that will be addressed.

A complete list of the toys utilized by the differing types of play therapists would be endless. Some of the materials that have been used with varying degrees of success were provided by Axline (1947).

Here is an edited version of that list. A doll family, a doll house with furniture and play house materials, a nursing bottle, toy soldiers, army equipment, toy animals, didee doll, large rag dolls, puppets, a puppet screen, crayons, clay, finger paints, easel, paint, sand, water, toy guns, peg pounding board and a sandbox large enough to accommodate the doll house are just some of the materials used.

The toys that are listed above provide children with the opportunity to choose the medium of play that they need to express themselves. If children are not provided with the proper materials and the space to experiment with them, they will not feel free to show how they feel (Axline, 1947). If children are exposed to these materials and have the freedom to explore with them, they will eventually express themselves without reserve.



Mechanical toys are not suggested (Axline, 1947). Toys that move on their own limit children's creativity in play. Toys should be simple in construction. If they are not, the children can become frustrated if they cannot easily manipulate the toy. Therapists also need to be sure to represent all of the members of each child's family in the puppet and doll families. If a member of the family is unavailable, how can children express the feeling they have about that person? One

other thing therapists should provide is a coverall for the children's clothing. This will allow the children the freedom to experiment with messy play without fear.

Prosocial Behavior

Prosocial behaviors are those that show empathy, altruism, sharing, good mood and moral sensitivity (Carlo et al., 1991; Grimley et al., 1991; Kim & Stevens, 1987; Lennon & Eisenburg, 1987). Carlo et al. (1991) contend that children read facial cues and then respond with emphatic and altruistic tactics. The older children become, the easier it is for them to read the facial cues and the faster they respond (Carlo et al., 1991).

Kim and Stevens (1987) stated that children who exhibit prosocial behaviors have parents who exhibit prosocial behaviors. Children are also more likely to share with the children who are most popular and attractive in their peer groups. If the other people around children are in a bad mood, the level of prosocial activity declines. This is a result of the eventual loss of the children's good mood.

Grimley et al. (1991) contend that prosocial activity should not be classified as a behavior, but as an orientation. This "prosocial orientation" is a positive and pervasive way of thinking. People who have developed a true prosocial orientation exhibit

these behaviors at all times, not just when they might gain something from them.

Lennon and Eisenburg (1987) pointed out that the indexes used to measure prosocial behaviors were often based on assisting an unknown and unseen person. Laboratory settings were also the norms for testing prosocial behaviors. The need for more research is clear.

Conclusion

The testing of prosocial behavior in a normative setting was recommended by Lennon and Eisenburg (1987). Therapeutic play techniques have never been tested in a normative setting. There seems to be a research void outside of laboratories and offices in these areas. This study might provide some new information for practitioners in these areas.

Chapter III

METHODOLOGY

Selection and Description of Subjects

The purposive sample consisted of 24 children, ages three to five years, and one parent of each child. The 11 female and 13 male children were participants in the child development laboratory of an east central Illinois university. The children whose parents returned both distributions of the Prosocial Behaviors Inventory were included in the final analyses of the data. The subjects were predominately caucasian and middle-class, living in two-parent families. Race and family background were not addressed in this study.

Research Design

A one-group quasi-experimental design was used. A pre-test/post-test format was selected for measurement of existing levels of prosocial behavior. A comparison was made of factors such as age, gender, and number of siblings which were obtained through child development laboratory data. Levels of prosocial behavior were measured through the Prosocial Behaviors Inventory to determine the degree of therapeutic play influence.

Dependent and Independent Variables

The independent variable in the study was the

introduction of the therapeutic play activities. The therapeutic play activities implemented were directive in nature. Dolls and writing utensils were the main tools used in the activities. Situations relevant to the children's lives were depicted by use of the three stories detailed in Appendix A. The children were given the opportunity to develop their own endings to two stories and in the last story they were able to play with the dolls as well.

The dependent variable was the measurement of the exhibition of prosocial behaviors. A questionnaire was the main measurement tool. The null hypothesis stated that there will be no significant increase in the level of prosocial behavior after the introduction of therapeutic play.

Description of Data Collection Instrument

The descriptive data were collected through The Prosocial Behaviors Inventory (PBI) and the informational files at the child development laboratory. The PBI was developed, pilot tested and administered by the researcher. This questionnaire determined the existing levels of prosocial behavior exhibited by each child.

The PBI depicted 19 social situations in an open-ended question format. These questions depicted the probable beginnings of several play situations and

asked the parents to describe their own child's most typical behavior. The PBI consisted of a variety of social situations based on the researcher's observations of children's play. Examples of these situations are as follows: When your child wants something and is unable to have it, she/he...; Your child observes another child's rights being violated and she/he...; In situations where your child must take turns or wait for a certain amount of time, he/she.... The complete PBI is located in Appendix B.

The PBI was pilot-tested by the researcher with parents whose children were not enrolled in the child development laboratory. Revisions were made on those questions that needed clarification for the respondents. One question was deleted from the PBI due to a zero response rate. Content validity of the PBI was determined through research literature and the extensive input of early childhood educators.

The researcher developed a coding system for the PBI. The scores on the PBI ranged from zero to three. A zero was given if the questions remained unanswered or if the answer given was non-applicable. The number one was assigned to those social situations in which little or no prosocial behavior was exhibited. If a prosocial orientation was apparent, the number two was assigned. For those situations that clearly

demonstrated a strong prosocial orientation, the number three was given. The maximum possible score for the 19 items was 57 with a maximum mean score of three. This would indicate that the child was operating at the highest level of prosocial behavior. The researcher based the categorization of the prosocial behaviors, such as empathy and sharing, on the research literature (Kim & Stevens, 1987). All of the coding was done and recorded by the researcher.

Procedure for Implementation

The researcher administered the PBI before and after the implementation of the therpeutic play activities. Prior to the distribution of the PBI, consent for participation was established through the files at the child development laboratory.

Administration of pre-test. The PBI was administered to the parents on two separate occasions. The pre-test was administered prior to the initiation of the therapeutic play activities. Parents were given the PBI with a letter of explanation attached (see Appendix C). One week was allotted for the completion and return of the PBI, but due to a very low response rate, this time frame was extended by four days. Fifteen parents returned the pre-test of the PBI, indicating a 63% response rate. After the pre-test had been coded, the first set of therapeutic play

activities was implemented.

Therapeutic play activities. The researcher, who had received training in a graduate level play therapy practicum, began the therapeutic play activities. The first play activity was with the children in six separate groups of four children. The researcher divided the children according to age and the observed temperament of the children. Some changes were made due to absenteeism and reluctance to participate. All of the children were asked to participate in the therapeutic play activities during their free-play or self-selected play time. This time period was forty minutes long. A carpeted portion of the child development laboratory was sectioned off with furniture to limit the interference from the non-participating children.

The first therapeutic play activity involved stories describing three separate social situations (see Appendix A). Four dolls were used to depict each of these stories. The first story was told completely by the researcher who handled all movements by the dolls. In this completely directive story, the researcher described a social situation in which conflict occurred around the sand table. The conflict was resolved by the use of prosocial behaviors. The same story was told to each of the six groups.

The second story described by the researcher involved conflict on the playground. Suggestions for possible solutions were asked for from the children. The researcher and the children discussed these responses and then the researcher acted out the one that involved the highest level of prosocial orientation.

The researcher began the third and final story and then the children were asked to take one of the dolls and to resolve the conflict. The children, for the most part, followed the examples of the former stories and completed the story situation with prosocial resolutions.

The second therapeutic play activity required a cooperative effort. The researcher once again selected six groups of four children. The children were placed in different groups than in the first activity in order to vary group dynamics. The children were asked to work together in designing a play yard. They were told that they should each draw a different piece of play equipment that they wanted in the play yard. Each of the therapeutic play experiences lasted about ten minutes. Some groups took a little longer due to questions and/or discussion. All therpapeutic play activities were completed by Friday.

<u>Administration of Post-test</u>. The post-test of the

PBI was administered the Monday following the final play activity. Twenty post-tests were returned indicating an 83% response rate, a higher return rate than the pre-test. However, the researcher was only able to use those twelve respondents who completed and returned both administrations of the PBI. There were six male and six female subjects included in the final number. The age range for the male subjects was as follows: four three-year old boys; one four-year old boy and one five year old boy. The range of ages was greater for the female subjects. There were three three-year old girls; one four-year old and two five-year old girls.

Data Analysis

The researcher recorded the scores of each of the children on the pre- and post-test copies of the PBI. The scores were totaled and a mean score was calculated. The researcher compared the levels of the prosocial behavior on the pre-test and post-test to determine the level of change. A significance level of .05 was predetermined and a paired samples t-test was then used to determine the level of significance in the data.

Chapter IV

RESULTS, DISCUSSION, LIMITATIONS

The purpose of this study was to determine if therapeutic play activities would increase the levels of prosocial behavior displayed in three to five year old children. The null hypothesis stated that there would be no significant increase in the levels of prosocial behavior after the introduction of therapeutic play. The data for this study were collected through the Prosocial Behaviors Inventory (PBI) and data files. Children's prosocial behavior level was obtained through coding parents' answers on the PBI. All PBI questionnaires were administered in a pre-test, post-test format to parents. The independent variable introduced in this study was the therapeutic play activities. These were implemented with the children in the child development laboratory. The parents given the PBI were instructed to return it to the child development laboratory. Although twenty-four parents received the PBI, only twelve of the respondents returned both the pre-test and post-test versions. Data from only 50% of those children enrolled in the laboratory were collected, although all twenty-four of the children participated in the

therapeutic play activities.

Responses to both the pre-test and post-test of the PBI were coded by the researcher. The pre-test cumulative scores ranged from 22 to 48; with the post-test scores ranging from 22 to 49. The mean score on the PBI for each of the children was calculated and recorded. The pre-test means ranged from 1.157 to 2.526; with the post-test scores ranging from 1.157 to 2.578. This score reflected the approximate level of prosocial behavior exhibited by each child at that time. Table 1 illustrates the pre-test and the post-test cumulative scores and mean scores of the twelve children.

A comparison of the mean scores illustrated in Table 1 shows that there was very little difference between the pre-test and post-test behaviors of most children. There were, however, four children, subjects 6, 9, 11, and 12, whose scores were four to nine points higher on the post-test of the PBI. The highest level of change in scores was from a 29 on the pre-test to 38 on the post-test. This illustrates that there were some behavior changes in these children after the introduction of the therapeutic play activities.

Table 1

Prosocial Behaviors Inventory

Pre-Test and Post-Test Scores and Means

	Pre-Test		Post-Test	
Subject	Score	Mean	Score	Mean
1	40	2.105	41	2.157
2	30	1.578	30	1.578
3	48	2.526	49	2.578
4	22	1.157	22	1.157
5	37	1.947	37	1.947
6	37	1.947	41	2.157
7	34	1.789	34	1.789
8	39	2.052	39	2.052
9	29	1.526	38	2.000
10	34	1.789	34	1.789
11	38	2.000	44	2.315
12	25	1.315	31	1.631

The following table illustrates the cumulative mean scores for the 12 subjects. The maximum and minimum scores as well as the means on the pre-test and the post-test are presented (see Table 2).

Table 2

Ranges and Means of PBI Pre-Test and Post-Test Scores

	Pre-Test	Post-Test
Minimum	1.157	1.157
Maximum	2.526	2.578
Mean	1.811	1.903

N= 12.

The researcher used a paired samples t-test to determine if the null hypothesis was rejected. There were a total of twelve observations used for the research study. The statistical level of significance used to analyze the data was .05. The overall mean for both the pre-test and post-test was significantly lower than the 2.179 score needed to indicate significant results. There were, however, some scores that did meet or exceed the t-score (2.179). The comparison of the pre-test and post-test scores show significant change in fewer than half of the children. When testing for the mean for all the subjects, the calculated t was not significant. Therefore, the

researcher failed to reject the null hypothesis.

The data were also analyzed according to the age and sex of each child in relation to the mean score (see Table 3). The number of siblings was also examined in relation to the mean score (see Table 4).

The mean score of children the post-test of the PBI were slightly higher than the scores on the pre-test. This indicates some positive change in prosocial behavior. Only one group, the five year old female children scored higher than the t-score (2.179) on both the pre-test and the post-test distributions of the PBI. The pre-test mean was 2.236 and the post-test mean was 2.262. The score increased .026 points on the post-test. The mean score for the four year old children on the pre-test was a 2.026 and 2.157 on the post-test. This score indicates a .131 point increase on the post-test. The three year old children showed a .113 increase on the post-test of the PBI. The mean score for three year old children on the pre-test was a 1.631 and the post-test score was a 1.744. Although these scores fail to support a significant change in behavior, they do illustrate that change occurred. The highest increase was in the four-year old age group.

Table 3

Comparison of Mean Scores by Children's Age and Sex

	Pre-Test					Post-Test		
Age	M	n	F	n	Group	M	F	Group
3	1.631	(4)	1.631	(3)	1.631	1.709	1.789	1.744
4	1.947	(1)	2.105	(1)	2.026	2.157	2.157	2.157
5	1.789	(1)	2.236	(2)	2.087	1.789	2.262	2.263
G*	1.710		1.912		1.810	1.798	2.008	1.902

Note. n=12, G*=Group.

Table 4

Comparison of the Mean Scores by Number of Siblings

Number of siblings	n	Pre-Test	Post-Test
0	2	1.420	1.815
1	4	1.828	1.907
2	5	1.957	2.020
3	1	1.789	1.789

A comparison of the pre-test and post-test means indicates that the children with zero siblings had the highest level of change in behavior. The single children scored a 1.420 on the pre-test and a 1.815 on the post-test. The children with only one sibling scored a 1.828 on the pre-test and a 1.907 on the post-test. The children with two siblings showed a .063 point increase in prosocial behaviors after the introduction of the therapeutic play activities. The pre-test mean for the child with three siblings stayed at 1.789 both distributions of the PBI. As the number of siblings decreased the levels of behavior change increased.

Discussion

The first objective of this study examined whether or not therapeutic play activities could be effective in a normative setting. The researcher designed the activities in line with some of the everyday activities that the children would have experienced. This was to insure that the children did not react to changes in routine and/or environment. During the implementation of the therapeutic play activities the children did not seem concerned about any changes in setting.

The second objective of the study examined whether prosocial behavior levels would increase after the implementation of therapeutic play activities. The

changes in the behaviors of some of the children indicate that the therapeutic play activities did have some effect. The children whose prosocial behavior level increased did benefit from the therapeutic play activities. Half of the children involved in the study illustrated this increase on the post-test of the PBI. The children whose score rose over four points on the post-test of the PBI indicated a strong change in the levels of behavior.

Overall, there was not a significant change in the prosocial behaviors of the children involved in the study. The researcher failed to reject the null hypothesis. There was, however, an indication of a slight level of success in this study. The mean scores outlined in tables three and four illustrate that the highest level of change occurred in the children with zero siblings. The significant change in this group might be atributed to the absence of group interactions in the home. The results indicated that changes occured and illustates the need for continued research.

Limitations

The limitations in this study had an affect on the overall outcome. The first limitation was the time constraints put on the implementation of the therapeutic play activities. If time had allowed, the activities would have been implemented several times to

each group of children instead of just once. The researcher believed that the changes in levels of prosocial behavior would have increased significantly after several sessions with the children. Another time constraint was the use of a "group session." The therapeutic play activities would have been more effective if there had been time for one-on-one sessions. The small sample in this study also limited the ability the generalize the findings. Although only half of the parents completed both tests, the response rate on the post-test of the PBI was 83%. These limititations suggest a need for additional research with a larger sample size and a longer treatment period.

Chapter V

CONCLUSIONS AND RECOMMENDATIONS

Therapeutic play can be beneficial to children in a normative setting. The results of this study, although not statistically significant, do suggest that the use of therapeutic play activities influences the behaviors of children. The researcher found that the activities did have a slight effect on the level of prosocial behaviors in children. This change in behavior could be a result of the use of play to send a message. Play is a child's natural medium of expression. If child care professionals want to have effective communication with children, using play is an important tool to utilize.

Parents and teachers alike can use therapeutic play to communicate with children. The use of play alone to influence the behaviors of children is an effective educational tool. Demonstrations of prosocial behaviors when playing with children would encourage them to exhibit these behaviors (Baumeister & Senders, 1988; Kim & Stevens, 1987). Messages through play are better understood by children and can be very effective. The researcher observed some of the children in the child development laboratory

duplicating the play activities in the laboratory. The older children followed some of the recommended strategies from the therapeutic play activities. The enhancement of behaviors, prosocial and others, can be influenced through play activities (Landreth, 1987).

The implications for further research into the use of therapeutic play as a means of increasing levels of prosocial behaviors are limitless. Testing the use of therapeutic play at the preschool and elementary education level is important. At which age do therapeutic play activities fail to influence behavior? Testing parents' and teachers' knowledge of which play activities are prosocial in nature and increase prosocial behaviors should also be included. This study needs to be replicated with a larger number of subjects and more time spent implementing therapeutic play activities.

Communication with children is essential in all societies. At some point, adults need to become proficient at speaking the language of childhood. This language is play (Axline, 1981). The most important part of therapeutic play for all adults; child care providers, teachers, parents and child care specialists, to master is the complete integration of Axline's (1988) eight basic principles into everyday interactions with children. These principles should be

the reference that all adults rely upon when interacting with children. A child needs acceptance and a sense of control at all times, not just in counseling. Children will not grow if adults do not respect their abilities and give them the opportunity to try new things.

APPENDICES

Appendix A

Story One-

Sam, Billie, Morgan and Chris were all playing at the sand table. Sam and Chris decided that they wanted the same toy. Chris had been playing with the toy for a long time and Sam wanted to take a turn. At first, Chris did not want to let the toy go. Then Sam reminded Chris how long he'd been using the toy. Sam also asked if he could please take his turn because friends share toys. Chris decided Sam could have the toy for a turn and then Morgan and Billie could take a turn too. This made everyone at the table happy. Sharing with people and talking out things is the way to solve problems.

Story Two-

This time our friends are playing on the playground. Everyone was excited about going outside to ride a bike. When Sam, Chris, Morgan and Billie get outside, there are only two bikes left. What should they do?

Story Three-

This time the friends are inside and they all want to paint on the easel.

Appendix B

Prosocial Behaviors Inventory

In the following situations, please describe your child's usual or most typical reaction or behavior:

When your child and another young child are playing together and they decide they want the same item (toy, paper, pencil, book, Crayon), he/she ...

If a group of three to four children are playing together and one of the children, other than your own, is moved to tears (fell down, wants something, misplaced something), your child ...

When anger erupts (yelling, fighting) among your children, your three to five year old ...

When your child wants something (toys, snack, extra privileges) and is unable to have it, she/he ...

When your child becomes frustrated with an activity (game, toy), he/she ...

When your child becomes frustrated with an adult (parent, care giver, teacher), she/he ...

Appendix B--continued

When your child becomes frustrated with another child (took toy, won't listen, won't play a certain way), he/she ...

In situations where your child must take turns or wait for a certain amount of time (playing games, cooking, waiting in line), she/he ...

When your child is being reprimanded for his/her own safety, he/she ...

When you are trying to explain something to your child that he/she doesn't want to hear (can't do something, bedtime, bathtime), she/he ...

When two playmates of your child begin to fight (yell, punch), your child ...

When your child interacts with an infant, he/she ...

In situations where your child and her/his siblings are playing together and another child wants to join, your three to five year old ...

Appendix B--continued

In situations where you are involved with (an)other child(ren), who are not related, your child ...

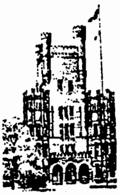
If another child gives your child advice (suggestions, criticism), she/he ...

When anger erupts with your child and his/her playmates, your three to five year old ...

If your child takes an object (toy, book) away from another child and an adult asks her/him to return it, he/she ...

Your child observes another child's rights being violated and she/he ...

The first time your child came into contact with a small animal (kitten, puppy, rabbit), she/he ...



EASTERN ILLINOIS UNIVERSITY
CHARLESTON, ILLINOIS 61920

College of Applied Sciences
School of Home Economics
(217) 581-6076

Appendix C

March 31, 1993

Dear Parent(s):

Play is a child's natural medium of expression. I plan to implement some activities in the School of Home Economics Child Development Laboratory that will utilize play as our primary form of communication. The focus of the activities will be on problem solving within a group structure. I hope that these activities will be a valuable learning experience for your children.

In partial fulfillment of my graduate studies I have developed a questionnaire to measure the influence of the play activities implemented in the lab. This questionnaire will be submitted to you on two separate occasions. It will only take a few minutes of your time to complete. This is the first administration. The play activities have not begun at this time. The second distrubution will occur approximately two weeks following final implementation of the play experiences.

In order to obtain an accurate measurement of the effects of the play activities, your participation is invaluable. The questionnaire is composed of several open ended statements. Please relate the responses of your three to five year old on as many of the questions as you can recall. I have provided some examples within the statements to give you some idea's about what situations I am asking about. There is no reason to limit yourself by those suggestions. They are included merely as possible references.

Please complete the attached questionnaire and return it to the School of Home Economics Child Development Laboratory by April 6, 1993. All of the responses will be kept confidential. If you have any questions, please contact me at the Child Development Laboratory (581-6043).

Thank you,

Heather M. Tyson
Graduate Assistant

James Slavik, Ph.D.
Faculty Advisor

References

Ainsa, T. (1981). Teaching the terminally ill child. _Education_, _101_(4), 397-401.

Axline, V.M. (1947). _Play therapy._ New York: Ballantine Books Inc.

Barlow, K., Strother, J. & Landreth, G. (1985). Child-centered play therapy: Nancy from baldness to curls. _The School Counselor_, _26_, 347-356.

Barlow, K., Strother, J. & Landreth, G. (1986). Sibling group play therapy: An effective alternative with an elective mute child. _The School Counselor_, _27_, 45-51.

Baumeister, R.F. & Senders, P.S. (1988). Identity development and the role structure of children's games. _The Journal of Genetic Psychology_, _150_ (1), 19-37.

Bishop, J.K. (1988). Even nothing can be complex. _Early Childhood Development and Care_, _39_, 77-88.

Brooks, A.R. & Benjamin, B.J. (1989). The use of structured role play therapy in the remediation of grammatical deficits in language delayed children: Three case studies. _Journal of Childhood Communication Disorders_, _12_(2), 171-186.

Bruner, J. (1986). Play thought and language. _Prospects_

Quarterly review of education, 16(1), 77-83.

Carlo, G., Knight, G.P., Eisenberg, N. & Rothman, K.J. (1991). Cognitive processes and prosocial behaviors among children: The role of affective attributions and reconciliations. Developmental Psychology, 27(3), 456-461.

Carmichael, K. (1991). Play therapy: Role in reading improvement. Reading Improvement, 28, 273-276.

Carter, S. (1987). Use of puppets to treat traumatic grief: A case study. Elementary School Guidance and Counseling, 21(3), 210-215.

Conn, J. (1989). Play interview therapy: Its history, theory and practice- A fifty year retrospective account. Child Psychiatry and Human Development, 20, 3-13.

Grimley, L.K., Zucker, K.B., Fakouri, M.E. & Thompson, M.W. (1991). Developing a prosocial orientation in children: A proactive prescription for perestroika. School Psychology Review, 20(3). 401-407.

Guerney, L. (1991). Parents as partners in treating behavior problems in early childhood settings. Topics in Early Childhood Special Education, 11 (2), 74-90.

Harvey, S. (1984). Training the hospital play specialist. Early Childhood Development and Care,

17, 277-290.

Hodapp, R.M. & Goldfield, E.B. (1983). The use of mother infant games as therapy with delayed children. Early Childhood Development and Care, 13, 17-39.

Kim, Y.O. & Stevens, J. (1987). The socialization of prosocial behavior in children. Childhood Education, 63(3), 200-202

Kottman, T. & Warlick, J. (1990). Adlerian play therapy. Journal of Humanistic Education and Development, 28, 125-132.

Landreth, G.L. (1987). Lessons for living from a dying child. Journal of Counseling and Development, 6, 100.

Landreth, G.L. (1987). Play therapy: Facilitative use of child's play in elementary school counseling. Elementary School Guidance and Counseling, 21(5), 253-261.

Lennon, R. & Eisenberg, N. (1987). Emotional displays associated with preschoolers' prosocial behavior. Child Development, 58, 992-1000.

Milos, M.E. & Reiss, S. (1982). The effects of three play conditions on separation anxiety in young children. Journal of Consulting and Clinical Psychology, 50(3), 389-395.

Mitchum, N.T. (1987). Developmental play therapy: A

treatment approach for child victims of sexual molestation. Journal of Counseling and Development, 65, 320.

Nicol, A.R., Smith, J., Kay, B., Hall, D., Barlow, J. & Williams, B. (1988). A focused casework approach to the treatment of child abuse: A controlled comparison. Journal of Child Psychology and Psychiatry and Allied Disciplines, 20, 703-711.

Nystul, M. (1987). Strategies for parent centered counseling of the young. The Creative Child and Adult Quarterly, 12(2), 103-110.

Pellegrini, A.D. (1985). The relations between symbolic play and literate behavior: A review and critique of the empirical literature. Review of Educational Research, 55(1), 107-121.

Schaefer, C. (1985). Play therapy. Early Childhood Development and Care, 19, 95-108.

Sikelianos, M. (1986). A disturbed child's use of persisting graphic symbols in the course of long term play therapy. The American Journal of Art Therapy, 25, 53-65.

Smith, P.K., Takhuar, M., Gore, N. & Vollstedt, R. (1985). Play in young children: Problems of definition, categorization and measurement. Early Childhood Development and Care, 19, 25-41.

Stiles, K. & Kottman, T. (1990). Mutual storytelling:

An intervention for depressed and suicidal children. _The School Counselor_, _37_, 337-342.

Vinturella, L. & James, R. (1987). Sand play: A therapeutic medium with children. _Elementary School Guidance and Counseling_, _21_(3), 229-331.

Wishon, P.M. & Brown, M.H. (1991). Play and the young hospitalized patient. _Early Childhood Development and Care_, _72_, 39-46.