THE EFFECTS OF A PLAY THERAPY INTERVENTION

CONDUCTED BY TRAINED HIGH SCHOOL STUDENTS

ON THE BEHAVIOR OF MALADJUSTED YOUNG CHILDREN:

IMPLICATIONS FOR SCHOOL COUNSELORS

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This research study investigated the effectiveness of a child-centered play therapy intervention conducted by trained high school students on the behavior of preschool and kindergarten children with adjustment difficulties. Specifically, this research determined if play sessions conducted by high school students trained in child-centered play therapy skills and procedures facilitated change in the children's behaviors.

The experimental group children (N=14) each received 20 weekly individual play sessions from a high school student enrolled in a Peer Assistance and Leadership class. The high school students were randomly paired with a referred child. The high school students completed 7 one-hour training sessions in child-centered play therapy procedures and skills prior to beginning the weekly, supervised play sessions. The control group (N=12) received no treatment during the study. Pre and post data were collected from parents who completed the <u>Child Behavior Checklist (CBCL)</u> and teachers who completed the <u>Early Childhood Behavior Scale (ECBS)</u>.

Multivariate analyses of variance of gained scored revealed statistical significance in 2 of the 4 hypotheses. Specifically, the children in the experimental group showed significant decreases in internalizing behaviors ($p = .025$) and total behaviors ($p = .025$) on the <u>CBCL</u>. Although not in the statistically significant range, positive trends were noted in externalizing behaviors on the <u>CBCL</u> ($p = .07$) and total behaviors on the <u>ECBS</u> ($p = .056$).

All play sessions were conducted in the primary school that the children attended. The high school student facilitated play sessions helped to maximize the school counselor's time by meeting the needs of more students. Implications for school counselors are noted with suggestions for how to begin and maintain a similar program in schools. This study supports the use of child-centered play therapy by trained high school students as an effective intervention for helping young children with a variety of adjustment problems.

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CHAPTER 1

INTRODUCTION

In early childhood, children undergo significant emotional, cognitive and

physiological changes. Without the proper physical environment including adequate

nourishment, shelter, proper clothing, rest, medical care, and without proper

psychological care including love, acceptance and understanding, some children

experience difficulties, developmental delays, and a poor self-concept leading to feelings

of sadness and failure (Campanelle, 1971). When children begin school, these difficulties

may become more pronounced, manifesting in fear, frustration, and tension (Campanelle,

1971). Upon entering kindergarten, children often experience a decrease in self-esteem as

they begin to compare their own abilities, appearance, and behavior to that of their

classmates (Marsh, Smith, & Barnes, 1985). Approximately 1 in 5 children (20%)

experience behavioral, developmental, and emotional disorders (Mash & Wolfe, 1999).

With an estimated 32.6 million children enrolled in elementary schools and an additional

8.4 million in preschool and kindergarten (U.S. Census Bureau, 1999), the number of

children in school who could benefit from mental health services is, therefore, over 8

million. Left untreated, psychological problems can hinder learning readiness (Pianta,

1997) and can quickly lead to educational failings (Cowen, 1973; Margolin & Gordis,

2000). Children's emotional, physical, cognitive, and social well being is essential for

future success in school (Pianta, 1997).

Many children are dealing with issues of such intensity that they are unable to adjust to the many demands associated with school. They often seek an outlet through acting-out behaviors (Campanelle, 1971), which, in preschool children, are stable and sound predictors for problems in first grade (Heller, Baker, Henker, & Hinshaw, 1996). Withdrawal, anxiety, aggression, underachievement, truancy, absenteeism, school phobia, impulsiveness, significant learning problems, and behavioral problems are common in elementary school children.

Early, developmentally appropriate intervention for behavioral, emotional and social difficulties, gives children an optimal opportunity for school success. For appropriate intervention, the developmental needs of children entering preschool and kindergarten must be considered. Play is the child's natural form of expression (Axline, 1947; Ginott, 1961; Landreth, 1987, 1993) and is used by the child to express emotions, explore self, and investigate relationships (Campbell, 1993; Ginott, 1961; Landreth, 1991). Young children have not yet developed the cognitive ability to verbally express their feelings, reactions and perceptions of self, others and world (Piaget, 1954). They do, however, naturally express these perceptions, reactions and feelings through their play. Play can function symbolically to help children deal with direct and indirect experiences using concrete objects in a sensory-motor way. Play also facilitates children's development of expressive language, cognitive abilities, communication skills, decision-making skills, emotional understanding, and social skills, in addition to fostering exploration of interpersonal relationships, development of sexual identity,

experimentation with adult roles, and understanding of personal thoughts and feelings (Landreth, 1993).

Since the 1940s, play therapy has become increasingly more researched and more accepted by many child therapists as a developmentally appropriate intervention for young children. Child-centered play therapy is rooted in Carl Rogers' person-centered theory. Rogers (1961) believed that maladjustment arises from an incongruence between an individual's "real" self and the concept of self, which is formed through interactions with the environment. As individuals become more accepting of their "real" self, the gap between the self and experience shrinks, the individual grows toward greater self-acceptance, self-direction, self-trust, independence, creativity and other psychologically healthy behaviors. Growth can only occur through relationships with perceived accepting, empathic, sincere individuals (Rogers, 1951, 1961).

Similarly, child-centered play therapy stresses an interpersonal relationship between a child and a trained play therapist who selects play materials to provide that facilitate a safe relationship so the child can fully explore and express self (feelings, experiences, thoughts and behaviors) through play (Landreth, 1991). Via this relationship, the child is encouraged toward greater self-direction, self-confidence, self-reliance, creativity and trust in their own inner resources. Children are able to generalize their newly found knowledge from play therapy to environmental contacts outside the playroom (Jones, 2000). Play therapy procedures give children the opportunity to resolve adjustment difficulties that hinder social and emotional development and assist children

in getting the maximum benefit from learning experiences, helping them to increase their academic success (Axline, 1947; Campanelle, 1971; Quayle, 1991).

Because school counselors are in an immediate position to provide counseling services to children, Landreth (1987) recommended the use of play therapy by school counselors to meet a wide range of developmental needs. Even school counselors who have specialized in play therapy are often overwhelmed with additional duties and do not have enough time or resources available to help all of the students who have social, emotional and behavioral concerns. Therefore, the American School Counselor Association (ASCA) recommended that peer counseling programs be part of school guidance services (Myrick, Highland, & Sabella, 1995). Training peer helpers in child-centered play therapy skills and procedures through filial/family play therapy training is viable alternative for school counselors to better meet the needs of young children.

In the 1960's Bernard and Louise Guerney developed filial therapy to allow parents to create a therapeutic family system and enhance familial relationships. In the beginning, filial therapy utilized parents as psychotherapeutic agents to help their children overcome pre-existing problems and help prevent potential future problems through continued healthy parent-child interactions (Guerney & Guerney, 1989). Landreth revised and shortened the Guerney (1964) model to a ten week training course that teaches the concepts of filial therapy in a structured, but brief format. Through the years other modifications have been made so that filial therapy is now used to help not only parents, but also teachers and peer helpers in working with young children (Bavin-Hoffman & Landreth, 1996; Bratton & Landreth, 1995; Brown, 2000; Chau & Landreth, 1997; Foley,

1970; Glass, 1987; Glover, 1996; Guerney, 1976; Guerney & Flumen, 1970; Guerney & Stover, 1971; Kale & Landreth, 1999; Lebovitz, 1983; Landreth & Lobaugh, 1998; Oxman, 1973; Packer, 1990; Sywulak, 1977).

Peer facilitators have been successful in improving the behavior of students receiving help (Bowman & Myrick, 1987; Huey & Rank, 1984). Modifications to the filial training model to train fellow elementary students in play therapy have been helpful in facilitating behavioral and emotional growth in children's lives (Baggerly, 1999, Bowman & Myrick, 1987; McHale, 1983; Myrick, Highland, & Sabella, 1995). In her 1999 research, Baggerly extended the Landreth (1991) filial model to a peer helper program and trained fifth grade students in basic play therapy skills to work with kindergarten students. Yet, Baggerly (1999) experienced some difficulties in training fifth graders to implement basic play therapy skills and techniques. Baggerly (1999) believed that ten weeks was not enough time for the students to fully understand the concepts. Furthermore, fifth graders are in the concrete operations stage of development (Inhelder & Piaget, 1964), they lack the ability to think abstractly; therefore, Baggerly's (1999) fifth graders had difficulty creating spontaneous responses tailored to each specific situation. Peer helpers who are older and in formal operations developmental stage (Inhelder & Piaget, 1964) and who receive more training before working with a young child may overcome this limitation, and therefore, be better able to implement play therapy techniques.

While many studies have been conducted that show the effectiveness of play therapy in elementary schools (Bills, 1950a; Crow, 1990; Fall, 1999; Foley, 1970; Gould,

1980; Guerney & Flumen, 1970; Kranz, 1972; Pelham, 1972; Post, 1999; Quayle, 1991; Siegel, 1970) and have addressed the usefulness of play therapy in helping school children with adjustment difficulties (McGuire, 2000; Rennie, 2000), studies have not been conducted to ascertain the feasibility of training high school students in child-centered play therapy skills and techniques to work therapeutically with young children.

Statement of the Problem

The problem with which this investigation was concerned was that of determining the effectiveness of the application of child-centered play therapy procedures and skills by trained high school students in special play times as a method of intervention for young children with adjustment difficulties. Specifically, this study was designed to determine the improvement of children's behavior at home and school as a result of play sessions with trained high school students.

Review of Related Literature

The following review synthesizes theory and research in four areas: (a) history of play therapy; (b) play therapy with elementary school students; (c) history of filial therapy; (d) peer mentors and paraprofessionals.

<u>History of Play Therapy</u>

The beginnings of play as a therapeutic agent for children can be traced back to Sigmund Freud's (1955) advice to a father based on the son's play behaviors. Melanie Klein (1955) and Anna Freud (1965) respectively continued Freud's (1955) work by analyzing child play behaviors and developing a therapeutic alliance via play through which later interpretations were made.

Levy's (1938, 1939) release play therapy stressed the abreactive benefits of play over the interpretive aspects. Using this method, he presented a child with a structured play situation and toys specifically chosen to recreate a scene of a specific traumatic event. Through this reenactment, the child was allowed to release feelings of pain and anxiety heretofore associated with that event. Under the name "Structured Play Therapy" Hambidge (1955) extended Levy's (1938, 1939) work by more directly structuring events to recreate the anxiety producing situation, playing out the situation, then allowing free play to recover from the procedure.

Taft (1933) and Allen (1939) emphasized the curative power of the child and therapist's emotional relationship. They stressed seeing children as people with inner strength and the capacity to constructively alter their behavior. Otto Rank (1936) laid the philosophical basis for relationship play therapy by stressing the importance of the here and now therapist-client relationship and deemphasizing past history and the unconscious.

Virginia Axline (1947) successfully applied Rogers' (1951) person-centered therapy principles to children. Child-centered play therapy is based on the tenet that children's behavior is due to a striving for self-realization. Axline (1947) listed eight basic principles of play therapy that facilitate children's self actualizing potential (See Appendix A).

LeBlanc & Ritchie (1999) conducted a meta-analysis of outcome research that supported the effectiveness of play therapy. Landreth, Homeyer, Glover, and Sweeney (1996) compiled a comprehensive review of research and case studies that demonstrate

play therapy's effectiveness with a variety of children's problems including abuse and neglect, aggression, attachment, autism, chronic illness, emotional difficulties such as depression, grief, learning difficulties, low self concept, and traumatization. Additionally, Phillips and Landreth (1998) in a comprehensive national survey of play therapists found the following disorders amenable to play therapy: acting-out/impulse control, enuresis/encopresis, depression/withdrawal, phobias, physical/sexual abuse, and school adjustment/academic difficulties.

Play Therapy Research

In a quantitative study in a hospital setting over a period of four years with fifty-five children in the treatment group receiving seven consecutive days of individual play therapy and fifty-nine children in the control group receiving no treatment, Clatworthy (1981) found that children in the experimental group exhibited significantly lower levels of anxiety by the conclusion of the study than had the control group children. Hospital settings are only one place where play therapy has proven effective; elementary schools is another.

Perez (1987) compared group and individual play therapy to a control group to determine the most effective treatment modality for sexually abused children. There was no significant difference between individual and group play therapy. However, this study recognized advantages of group play therapy, such as helping to validate children's experiences by talking with other children who had been abused, reducing their sense of isolation, and experiencing relationships where abuse does not occur (Perez, 1987).

Play Therapy with Elementary School Students

In the 1960's, guidance and counseling programs were established in elementary

schools to make counseling available to all children (Landreth, 1991). Early in the

inception of play therapy in schools, Alexander (1964), Landreth (1972), Muro (1968),

Myrick and Holdin (1971), Nelson (1966), and Waterland (1970) reported success with

play therapy as a preventative tool. In addition to working with maladjusted children,

these techniques helped children with developmental needs. Indeed, play therapy in

elementary schools assists in children's intellectual, emotional, physical, and social

development and is a vital and integral part of the total educational process (Landreth,

1987, 1991). During play sessions, children receive the emotional outlet necessary to

achieve success in the classroom. The personal power, self acceptance, self control, self

discipline, and self understanding developed in play sessions help children accomplish

academic, developmental, social, and personal goals (Campanelle, 1971).

Bills (1950a, 1050b) studied child-centered play therapy skills and procedures

with both poorly adjusted (Bills, 1950a) and well-adjusted (Bills, 1950b), slow readers.

The eight experimental and eight comparison group children received six individual and

three group play therapy sessions over a six week time period. Compared to the control

group, the treatment group showed significant gains in reading ability.

Over the course of a year, Siegel (1970) conducted a study of forty-eight second to

fifth grade children with learning disabilities. Results indicated that children with learning

difficulties who received play therapy improved significantly in affective, cognitive,

environmental, and psychomotor dimensions. Furthermore, Pelham's (1972) research

showed play therapy to be an effective tool for learning readiness in socially immature kindergarten children.

Gould (1980) placed eighty-four elementary school children who had low self-image into one of three groups: experimental, receiving non-directive play therapy; placebo, participating in group discussion; and control, receiving no intervention. As compared to the other two groups, the children in the experimental group exhibited the strongest positive change. Quayle (1991) researched the effectiveness of play therapy for children with school adjustment problems such as acting out, learning difficulties, or moodiness. Fifty-four five to nine-year-old children were placed into a play therapy experimental group, a comparison tutoring group, or a control group that received no intervention. Results indicated that children in the experimental play therapy group exhibited more positive growth in such areas as assertive social skills, interactive participation, learning skills, peer social skills, self confidence, and task orientation than did the children in the other two groups.

Post (1999) studied the impact of child-centered play therapy on the self-esteem, locus of control, and anxiety level of at-risk fourth, fifth, and sixth grade children. Results indicated that, over the course of the school year, the children who received play therapy did not change; however, the students in the control group demonstrated decreases in self-esteem and locus of control. The findings indicate that a play therapy intervention may prevent children from developing a lower self-esteem and from minimizing their sense of responsibility for their successes and failures.

History of Filial Therapy

Several precursors to filial therapy can be traced back to the early 1900's. In 1909, Sigmund Freud (1955) began the use of training parents to be therapeutic agents for their children by instructing the father of a phobic 5-year-old boy in how to respond during play times with his son. Freud believed that the father's unique knowledge of the child, through which he was able to interpret the boy's remarks, was indispensable and that only the boy's father could have convinced the child to change so dramatically. Dorothy Baruch (1952) endorsed planned home play sessions to enhance parent-child relationships. Natalie Fuchs (1957) was one of the first people to utilize child-centered play therapy principles and skills for parent-child relationship enhancement. She noted that her daughter had emotional reactions associated with toilet-training and enlisted the encouragement and advice of her father, Carl Rogers. Fuchs (1957) achieved significant successful results by utilizing regularly scheduled play times that were based on procedures suggested in Axline's (1947) writings. Moustakas (1959) contributed one of the earliest descriptions of in-home special play sessions between parent and child.

> Play therapy in the home is essentially a relationship between a child and his mother or father through which the child discovers himself as an important person, sees that he is valued and loved, and recognizes his irreplaceable membership in the family. It is a way through which the child opens himself to emotional expression and in this process releases tensions and repressed feelings…He learns to count on regular meetings with the parent once or twice a week for one-hour periods in which he is the center of the experienced. A variety

of play materials are made available to him at this time…The parent…sits nearby

watching him closely and showing interest and regard…In the play therapy

relationship created in the home, the child finds that his parent really cares, wants

to understand, and accepts him as he is. (pp.275-277)

These early beginnings of in-home play sessions differed from filial therapy in that these

parents did not receive consistent weekly systematic training, direct supervision, or the

opportunity to communicate with their peers in a group therapy format about their

experiences (Landreth, 1991).

<u>Guerney Model</u>

Bernard Guerney, (1964) originally conceptualized filial therapy as a structured

treatment program for three to ten-year-old children with emotional problems. Filial

therapy uses a small group format to train parents in the basic principles, methodology,

and skills of client-centered play therapy. It is a structured program in which parent-child

play therapy type sessions are regularly scheduled at home and the parent, not a

professional therapist, is the therapeutic agent. Louise Guerney helped her husband early

on in the research, development, and training in filial therapy (Landreth, 1991). Filial

therapy originally promoted the emotional growth of children with emotional

disturbances and since has branched out to help children and families with various

relationship problems.

Filial therapy utilizes didactic group instruction from a professional with an

emphasis on play times and supervision. The play sessions seek to change the child's

perceptions or misperceptions of the parent's attitudes, behaviors, and feelings toward the

child; communicate feelings, needs, and thoughts that have previously been hidden from parents; and help the child gain a greater sense of confidence, self respect, and self worth. The tenets of filial therapy rely on the assumption that, upon learning the skills of child-centered play therapy, the parent will be more effective at improving the parent-child relationship than will a therapist performing the same function (Guerney, 1964).

VanFleet (1994) discussed three integral constructs to the practice and application of filial therapy. First, therapists must acknowledge the value of play in childhood, and recognize play as the principal avenue in understanding children's worlds. Second, therapists must trust that parents can learn filial therapy skills or the parent will probably never achieve understanding and mastery of the play time skills. Finally, filial therapists utilize an educational model rather than a biological or behavioral model in working with families. The three central goals of filial therapy identified by VanFleet (1994) include: (a) the elimination of presenting problems; (b) the development of positive interactions between parents and children; and (c) an improvement in families' communication, coping, and problem solving skills, thereby helping them handle future problems independently and successfully.

Stover and Guerney (1967) cite several advantages to using filial therapy training with parents. First, filial efficiently uses the therapist's time and effectively improves parental communication with children. If individual therapy is sought for the child, parents may feel guilt associated with resorting to professional help or fear and rivalry at the bond that develops between therapist and child. Training the parent to become an agent of change in the child's life reduces these potential problems. Additionally, through

filial training, parents develop more appropriate responses to a child's new behavior patterns.

Packer (1990) found that parents who received filial training believed themselves to have acquired skills that could effect positive changes in their children's behavior. As a result of filial therapy, the children reported being better able to manage their negative emotions and were more accepting of their fathers as authority figures in the presence of their mothers.

B. Guerney (1976) studied the effectiveness of filial therapy training as a treatment method for emotionally disturbed children. Results indicated that children in the treatment group significantly increased their social adjustment and maternal satisfaction, significantly decreased their emotional dysfunction and conflicts with parents, teachers, and peers, and significantly decreased the number of the children's symptoms. Degree or kind of child maladjustment, socioeconomic background, personality, and maternal attitude were variables not considered determinants.

Ginsberg (1976) investigated the efficacy of filial training with foster parents, single parent families, and socioeconomically varied families. Each group experienced positive results. Foster parents experienced reduced stress and an enhanced ability to build satisfying relationships with foster children.

Stover and Guerney (1967) provided filial therapy training to mothers and reported a significant increase reflective statement frequency and a decrease in directive statements. Other findings include positive changes in the parent-child relationship and the children's general emotional development. No control group was utilized in this

study. Oxman (1973) used Stover and Guerney's (1967) data as an experimental group and included a demographically matched volunteer control group. Statistical analysis revealed that the behavior of the children in the treatment group significantly improved.

Guerney and Stover (1971) employed filial therapy with fifty-one mothers and their children and found that a significant increase in the frequency of their reflection of feelings responses, allow children to be self-directed, and show involvement in their children's emotional behaviors and expressions. Clinical assessment instruments showed significant psychosocial adjustment and symptomatology improvement in all fifty-one children. The children, as a result of the play sessions, increased their interactions with their mothers, appropriately expressed feelings of aggression, learned more realistic sharing and conversing methods, decreased their dependence, and increased their leadership abilities.

L. Guerney (1975) conducted a follow-up of B. Guerney and Stover's (1971) research and significant longitudinal findings were revealed. Thirty-two mothers reported continued improvement, four reported regression, one reported deterioration. After the filial training, only one of the 42 children required additional treatment. Overall, the mothers positively evaluated the filial therapy training program. This follow up study underscores the effectiveness of filial therapy after a 3-year period.

Boll (1972) compared parents of educable mentally retarded children using three groups: parents trained in traditional filial therapy, parents given filial training in addition to instruction on reinforcement and extinction techniques, and a control group. Parents of

children in both treatment groups reported more of an increase socially acceptable behavior than did parents in the control group.

Sywulak (1977) controlled for potential differences between parents who seek professional treatment and those who do not by utilizing a design in which subjects acted as their own control group. Participants completed assessments instruments four months prior to training and two and four months after training commenced. Results revealed significant improvements in both child adjustment and parental acceptance. Additionally, withdrawn children evidenced faster changes than did aggressive children, fathers detected changes in adjustment later than did mothers, and parents exhibited the capacity and willingness to employ filial skills. Sensue (1981) conducted a follow-up to Sywulak's (1977) study and found even higher scores after the six-month of treatment and no significant losses after two to three years. During the follow-up, the children who had previously been diagnosed as maladjusted were as well adjusted as children in a control group who had never been diagnosed. In addition, both children and parents reported that the filial training helped create positive change within the family.

Wall (1979) compared the effects of three groups conducting play times: graduate therapist trainees; filial-trained parents directed and observed by therapist trainees; and untrained parents in the control group. Filial trained parents improved their empathic communication with their children. Children in both treatment groups improved their adjustment as a result of their expression of negative feelings and increased perception of negative attitudes in their families. Wall (1979) concluded that parent's acceptance of

children's negative feelings has a greater impact on the children than a therapist's acceptance has.

Lebovitz (1983) compared the effectiveness of three groups: a filial therapy training group, a group conducting supervised play sessions, and a control group. The children whose parents were in the filial training group were found to display a significant decrease in aggression, withdrawal, and dependence. The mothers in the filial treatment group significantly increased their communicated acceptance of their children's feelings and were more involved with, and allowed more self-direction in, their children's play sessions. Those mothers in the supervised play session group and the filial group reported that they became more accepting of their children and experienced a significant decrease in problem behaviors as compared to those in the control group.

Payton (1981) explored filial therapy effectiveness with parents, paraprofessionals, and a control group. As compared to the control group, filial trained parents reported significantly higher improvement scores in parenting attitude and children's behaviors. Results indicated that parents are more effective in affecting personality adjustment in their children than are paraprofessionals.

Kezur (1980) investigated mother-child communication patterns in children who received concurrent play therapy sessions and parent-child filial play sessions. Findings concluded that the mothers developed more effective communication patterns; the children who expressed anger with their therapists became more open to expressing anger with their mothers; mothers developed increased insight into their communication; the mothers who developed personal insights changed in a positive direction; the mothers

recognized that they were better able to meet their children's needs after they met their own needs; and as self esteem increased, positive change occurred in the mother-child relationships.

Landreth Model

Landreth (1991) revised and condensed Guerney's (1964) thirty plus weeks of training into a ten-week model that enhances parents' sensitivity to their children as they begin to create an accepting, understanding, and non-judgmental environment through which children explore new aspects of self and new ways to relate to parents. Training commences in a group of approximately 6 to 8 parents. Child-centered play therapy principles and skills are taught via audio-visual presentations, supervision, live demonstrations, discussions, and role-played situations. Much research has been conducted on both models of filial therapy.

Glass (1987) studied the effect of parents as therapeutic agents using Landreth's (1991) ten-week filial therapy training model and found a significant increase in parental acceptance of and unconditional love for their children. Parents reported a greater understanding of their children's play, a greater respect for their children's feelings, recognition for their children's need for autonomy, and a closer parent-child relationship. Both parents and children experienced increases in self-esteem and a significant decrease in parent-child conflict. Control group parents showed no significant change. Using the ten-week filial therapy training model with single parents, Bratton and Landreth (1995), using Landreth's (1991) ten-week filial therapy model with single parents, found significance on each hypothesis including increases in parental empathy and acceptance

and decreases in parenting related stress and children's behavior problems. As compared to mothers in the control group, experimental group mothers developed healthier parenting skills the emotional support the filial training sessions provided.

Kale and Landreth (1999) studied Landreth's (1991) ten-week filial training model with parents of children experiencing learning difficulties. Compared to the control group, the treatment group significantly increased their parental acceptance and significantly decreased their parenting stress. Parents in the filial group reported benefiting from the group format through which they met other parents with similar struggles with having children with learning disabilities. Significant change was not found in control group parents.

Tew (1997) investigated the efficacy of Landreth's (1991) ten-week filial therapy training model with parents of chronically ill children. As compared to parents in the control group, parents with filial therapy training had a significantly increased level of parental acceptance, and significantly decreased levels of parenting stress, perceived problematic behaviors, and emotional disturbance. Parent-child relationships were strengthened and enhanced. Glazer-Waldman (1991), also using Landreth's (1991) ten-week filial model, studied parents of chronically ill children. Results indicate that parents developed a greater, although not significant, awareness, sensitivity, and understanding of their children. Parents also reported positive changes in themselves and in their children, as well as better parent-child relationships due to the training.

Costas and Landreth (1999) researched the efficacy of the Landreth (1991) ten-week filial therapy model as an intervention for children who had been sexually abused

and their non-offending parents. Fourteen parents were in the experimental group and received filial training; twelve parents comprised the control group. As compared to the control group, parents in the experimental group significantly increased their level of empathy and acceptance toward their children and reduced parental stress.

Glover (1996) used Landreth's (1991) ten-week filial training model to study Native Americans parents on Montana's Flathead Reservation and found that, after their training, the experimental group significantly increased their level of empathic interactions with their children and decreased their parental stress. In turn, the children in the treatment group significantly increased the level of acceptable and desirable play behaviors with their parents. Positive trends were noted in parental acceptance and children's self-concept.

Using the ten-week model of filial therapy, Chau and Landreth (1997) studied Landreth's (1991) ten session filial model with immigrant Chinese parents and children in the United States. The results of this study indicated positive trends in increased levels of empathy and parental acceptance, and decreased parental stress within the experimental parent's group as compared to the control group parents. Yuen (1997) used the Landreth (1991) ten-week filial therapy training model with immigrant Chinese parents in Canada. Parents who received the training significantly increased parental empathy and acceptance of the children and significantly decreased their parental stress and perceived problematic behaviors in their children.

Landreth and Lobaugh (1998), using Landreth's (1991) ten-week model, studied the effectiveness of filial therapy with incarcerated fathers as a means of reducing

parental stress, increasing parental acceptance of and appreciation for the child, and improving the self-concept of the child. The experimental group showed a significant increase in several areas: unconditional love, recognition of children's need for autonomy, and improvement in child self-concept. In addition, parental stress and perceived problematic child behaviors decreased significantly in the experimental group. The control group demonstrated no significant improvement. Harris and Landreth (1997) studied the Landreth (1991) ten session training model with incarcerated mothers and found similar results. After ten bi-weekly sessions, the experimental group's level of empathic interactions with and acceptance toward their children increased significantly. The children in the experimental group significantly reduced their problematic behaviors. A positive trend in unconditional love was noted. Harris found no significant change in the control group.

Lahti (1993), in her ethnographic study, examined and described several advantages to utilizing the ten-week model. The didactic and group counseling formats provided a supportive atmosphere conducive to personal exploration. As parents assumed the therapeutic role, parental anxiety and stress diminished, and parents felt more empowered and self-aware in their ability to view their parent-child relationship more realistically and apply parenting skills more effectively. Parents reported decreased marital and parent-child friction as they increased and enhanced communication. Children accepted more responsibility for their actions, exhibited less withdrawn and aggressive behavior, and felt happier.

Bavin-Hoffman, Jennings, and Landreth (1996) conducted a longitudinal of the effects of Landreth's (1991) ten session filial training model. Participants included 20 married couples who participated in the ten-week filial training model from 1991-1994. The couples reported improved parent-child communication, interpersonal communication, and child behavior. Additional findings indicated increased confidence in parenting, parental unity, understanding of child's play, and parental acceptance.

Tyndall-Lind (1999) compared the effectiveness of individual play therapy and sibling group play therapy for child witnesses of domestic abuse. Results indicated that sibling group therapy was effective in improving the self-concept and decreasing total problem behaviors. Sibling group play therapy was also reported to be more effective than individual play therapy in reducing somatic complaints, aggression, and withdrawal with child witnesses of domestic abuse.

Peer Mentors and Paraprofessionals

Counselors have not been the only ones to work therapeutically with elementary school aged children, other students, teachers, and paraprofessionals have as well. The American School Counselor Association (ASCA) recommended twenty years ago that peer counseling programs be part of school guidance services (Myrick, Highland, & Sabella, 1995). Guerney and Flumen (1970) trained teachers in basic child-centered play therapy skills to use during special play times with their elementary school students. Teachers successfully helped the children decrease emotional difficulties and withdrawn behaviors. The children in the experimental group experienced a greater number of contacts with peers and their teachers than did the children in the control group.

Kranz (1972), using Axline's (1947) model, trained teachers as "clinical assistants" via a ten-week theoretical orientation course in play therapy. The teachers then engaged in special play times with children. Results indicated that teachers gained a greater understanding of the emotional world of children and a greater awareness of the influence emotional factors have in the educational environment. The children experienced substantial reduction in defiant behaviors, educational anxiety, and relationship problems.

Foley (1970), using the Guerney (1964) model, trained forty teacher trainees to work therapeutically with boys referred to a child guidance center. The treatment conditions consisted of either twelve play therapy sessions with either a trained therapist or a teacher trainee (experimental groups) or teacher trainees who were "friendly" (placebo group). Results, as reported by the boys' parents, indicated that the children in the experimental group working with therapists experienced a significantly greater amount of positive change than the other groups. The teacher trainee play group experienced the next greatest change over the placebo and control groups.

Brown (2000), using Landreth's (1991) model trained eighteen teachers-in-training the basic play therapy skills the semester before they began their student teaching assignment. As compared to the twenty trainees in the control group, experimental group trainees significantly increased their knowledge of and skills in play therapy, empathic behavior, communicating acceptance, and allowing a child self-direction, and decreased their belief in corporal punishment.

Stollak (1969) utilized Guerney's (1964) filial therapy model in training college students to conduct play times with children. Twenty college students received ten weeks of training prior to conducting special play times with children referred through a campus clinic. Results indicate that the undergraduate students significantly improved their reflections of content and feelings. Although no control group was used in this study, Stollak (1969) concluded that college students using child-centered play techniques are an untapped resource in treating children.

Reinherz (1969) trained college students to develop therapeutically valuable relationships with emotionally disturbed children in a state mental hospital. These relationships provided stable role models, an outside influence, and a normalizing relationship through which the children's acquired skills could be tested. Results of psychological testing indicated positive growth in the children as a result of the interactions with the college students.

Bowman & Myrick (1987) matched disruptive second and third grade students with fifth grade peer helpers and the results indicated a significant increase in the younger children's appropriate classroom behavior. McHale (1983) matched elementary school children with autism with schoolmates and found that after ten weeks of play sessions, the autistic children exhibited increased social interactions. Based on this research, Buse, Coke, Rubin, and Fletcher (1988) looked at the effects of play sessions on elementary school children who had severe behavioral disorders and another disability (mental retardation, communication disorder, or a physical disability). First, second, and third grade students facilitated daily play sessions for ten weeks, and the children with

disabilities increased their positive social interactions. When the children with the behavioral disorders were paired with the same partner and when the playmates took part in activities that the identified child took interest in, the positive behavioral change was even more pronounced.

Brake & Gerler (1994) demonstrated elementary school peer helper program benefits to students who received help and students who gave help. Fourth and fifth grade students identified as discipline problems developed group cohesiveness, learned skills and attitudes for helping kindergarten children, and read or played games with kindergarten children through a program called "Discovery." Kindergarten teachers reported that it was an important experience for the young children, who all enjoyed and looked forward to the play time.

Myrick, Highland, & Sabella (1995) surveyed 138 students who had received assistance from peer helpers at seven elementary and two middle schools and reported that students who received help enjoyed their peer helper and looked forward to seeing their friend. Their results showed no statistical difference between the elementary and middle school children's responses, indicating that peer helping relationships are valuable to children of many ages.

Baggerly (1999) investigated the effectiveness of child-centered play therapy procedures administered by fifth graders to kindergarten children who had adjustment difficulties. The fifteen children in the experimental group received ten weekly twenty minute play sessions and the fourteen control group children received no treatment. Results indicated that children in the control group demonstrated a marginally significant

decrease in "somatic complaints," with positive trends in self concept, total behavior problems, delinquent behavior, demandingness, and externalizing behavior problems. Teachers reported increases in the treatment group children's creativity, positive relationships, self acceptance, self confidence, self control, and self esteem and decreases in aggression and withdrawn behavior.

Peer helper programs have many benefits. After young children watch empathetic behavior, they are much more likely to demonstrate it themselves (Yarrow, Scott & Waxler, 1973). Students who provide peer help and mentoring increase their own emotional development. Finally, peer helper program foster a sense of community within schools (Foster-Harrison, 1995).

Internalizing and Externalizing Behaviors

Internalizing behaviors, such as anxiety, depression, social withdrawal, or somatic complaints, are internally manifested problems. Externalizing behaviors, such as aggressive behavior, antisocial behavior, hyperactivity, impulsivity, and inattentiveness, are outwardly manifested problems.

Externalizing behaviors are much easier to observe in children and, consequently, are more common reasons for referrals; however, the internalizing behaviors tend to become the more serious problems in children. For example, social attachments are necessary for avoiding many emotional difficulties, health problems, and personality disturbances in adulthood (Bowlby, 1977). Socially detached children are more likely to develop heart disease, hypertension, and mental illness (Thomas & Duszynski, 1974).

Internalizing behaviors in young children are concerning because of the developmental pathway, a behavioral continuum where successive problematic behaviors become more severe. Researchers suggest that extreme dependency of young children on their mothers, having few playmates, poor social skills, and maternal depression are pathways to internalizing behavior problems that may develop between ages two and six years of age (Merrell, 1996; Zahn-Waxler, 1987). Other contributors to the internalizing pathway include identified insecure attachment (Miller, Boyer, & Rodelitz, 1990) and loss of an object or learned helplessness early in childhood (Cantwell, 1990). Internalizing problems are less stable over time; therefore, internalizing pathways are more discrete than externalizing pathways of conduct disorder problems (Quay & Werry, 1986).

A developmental pathway of externalizing behavior of conduct disorder begins with noncompliance in the toddler years, progresses to impulsivity in preschoolers, manifests as aggression and oppositional-defiance in the primary school years, and then becomes a full blown conduct disorder by middle childhood (Merrell, 1996). Of the preschoolers classified with externalizing behavior problems, 94% were still classified as having borderline or pervasive symptoms in first grade (Heller, Baker, Henker, & Hinshaw, 1996). Early intervention, including play therapy and filial therapy, for children with externalizing behaviors is essential to preventing the solidification of negative behavior patterns. Intervention must address underlying causes and promote positive behavior strategies (Heller, Baker, Henker, & Hinshaw, 1996).

CHAPTER 2

METHODS AND PROCEDURES

A pretest-post test control group design was utilized to measure the adjustment of

identified preschool and kindergarten children who received twenty-minute structured

play sessions for an average of twenty weeks over seven months during the 1999-2000

school year. Play sessions were facilitated by high school juniors and seniors in a Peer

Assistance and Leadership (P.A.L.s) class who were trained in child-centered play

therapy skills and procedures. Preschool and kindergarten students who met the specified

criteria were randomly assigned to a control group that received no treatment during the

study or an experimental group that received weekly play sessions with a P.A.L. student.

After the completion of this research play sessions were provided by this researcher for

all of the control group children except one whose parent declined the play sessions for

her child.

Definitions of Terms

Academic progress refers to successful in learning without significant

modifications in instruction, materials, or testing. Learning difficulties are considered

behavioral. For the purposes of this study, problems with academic progress is the score

on the Academic Progress subscale of the Early Childhood Behavior Scale (McCarney,

1994).

Adjustment difficulties are any problems that prevent children from adjusting to

home, school, or classroom situations and learning environments. Children with

adjustment difficulties may have anxious, depressed, inattentive, shy, or withdrawn behavior or may be experiencing life changes such as parental divorce, a new sibling, or moving to a different home.

Aggression is the initiation of a hostile act against another. Often, it is an expression of anger, frustration, or inner turmoil. Aggression is behaviorally exhibited by an attempt to destroy objects or to harm another person. For the purpose of this study, aggression is the score on the Aggression subscale of the Child Behavior Checklist (Achenbach, 1991).

Attention problem is the tendency to be easily distracted and unable to concentrate more than momentarily. For the purpose of this study, attention problems is the score on the Attention Problem subscale of the Child Behavior Checklist (Achenbach, 1991).

Child-centered play therapy as defined by Landreth (1991) is

a dynamic interpersonal relationship between a child and a therapist trained in play therapy procedures who provides selected play materials and facilitates the development of a safe relationship for the child to fully express and explore self (feelings, thoughts, experiences, and behaviors) through the child's natural medium of communication, play. (p. 14)

Delinquent behavior includes the behaviors that are associated with the violation of legal or ethical standards, such as setting fires, lying, stealing, running away, and truancy. For the purpose of this study, delinquent behavior is the score on the Delinquent Behavior subscale of the Child Behavior Checklist (Achenbach, 1991).

Externalizing behaviors are outward manifestations of delinquent and aggressive conduct. For the purpose of this study, externalizing behavior is the Externalizing subscale score of the Child Behavior Checklist (Achenbach, 1991).

Filial therapy is the training, usually in a group format, of parents of young children to conduct weekly thirty-minute play sessions in a specific way with their own children in their own home (Guerney, 1964).

Internalizing behaviors are inward manifestations of emotional difficulties including anxiety, depression, somatic, complaints, and withdrawal. Emotions are directed inward after they are prevented from being expressed. For the purpose of this study, problems with internalizing behavior is the Internalizing subscale score of the Child Behavior Checklist (Achenbach, 1991).

Maladjustment includes difficulties that prevent children from adjustment to home, school, or classroom situations and learning environments. Children with adjustment difficulties may have anxious, depressed, inattentive, shy, or withdrawn behavior or may be experiencing life changes such as parental divorce, a new sibling, or moving to a different home.

Personal adjustment is a type of problem that represents certain behaviors in the educational environmental context such as stealing, attendance, predictability, sexual behavior, rule following, and cheating. This concept measures stability, responsibility, dependability, as well as more subtle indicators of emotional/behavioral problems such as a pervasive mood of dissatisfaction resulting from school-related or personal experiences.

For the purposes of this study, problems with personal adjustment is the score on the Personal Adjustment subscale of the Early Childhood Behavior Scale (McCarney, 1994).

Social problems are difficulties experienced in social situations. For the purpose of this study, social problems is the score on the Social Problems subscale of the Child Behavior Checklist (Achenbach, 1991).

Social relationship includes problematic behaviors ranging from the inability to make or maintain friendships to the acting out/aggressive behavior that interferes in daily interactions, problem solving, sharing, and resolving conflict. For the purposes of this study, problems with social relationship is the score on the Social Relationship subscale of the Early Childhood Behavior Scale (McCarney, 1994).

Somatic complaints are the physical symptoms of underlying emotional difficulties. For the purpose of this study, problems with somatic complaints is the score on the Somatic Complaint subscale of the Child Behavior Checklist (Achenbach, 1991).

Thought problems are low prevalence, general problems in patterns of thinking including having "strange ideas." For the purpose of this study, thought problems is the score on the Thought Problems subscale of the Child Behavior Checklist (Achenbach, 1991).

Total problems is the total number of problems indicated on the Internalizing and Externalizing subscales of the on the Child Behavior Checklist. For the purpose of this study, total problems is the score on the Total Problems scale of the Child Behavior Checklist (Achenbach, 1991).

Young children are children in preschool or kindergarten.

Hypotheses

To set the concrete measurements for this investigation, the following hypotheses were postulated:

1. As reported by parents, young children who receive play sessions will achieve a significantly lower mean total score on the <u>Child Behavior Checklist</u> at post testing, as compared to the pretest, than will the young children in the control group.

2. As reported by parents, young children who receive play sessions will achieve a significantly lower mean score on the Internalizing Behavior Problems scale of the <u>Child Behavior Checklist</u> at post testing, as compared to the pretest, than will the young children in the control group.

3. As reported by parents, young children who receive play sessions will achieve a significantly lower mean score on the Externalizing Behavior Problems scale of the <u>Child Behavior Checklist</u> at post testing, as compared to the pretest, than will the young children in the control group.

4. As reported by teachers, young children who receive play sessions will achieve a higher mean Total score on the <u>Early Childhood Behavior Scale (ECBS)</u> at post testing, as compared to the pretest, than will the young children in the control group.

Instruments

<u>Child Behavior Checklist</u>

Achenbach and Edelbrock (1986) developed the <u>Child Behavior Checklist</u>

<u>(CBCL)</u>. The 1991 profile was used in this study. It takes approximately twenty minutes

to complete and is comprised of 113 items for children two to sixteen years of age.

(Achenbach, 1991). Factor analysis revealed that the 113 items can be placed into the

following nine subscales: Withdrawn, Somatic Complaints, Anxious/Depressed, Social

Problems, Thought Problems, Attention Problems, Delinquent Behaviors, Aggressive

Behaviors, and Sex Problems (Achenbach, 1991). The Behavior Problem Scale can be

computed and Internalizing and Externalizing emerged as factors in a second-order factor

analysis of the Behavior Problem Scale. T-scores and percentiles can be computed for

each subscale and factor score.

Syndrome scales are derived from the principle components of the correlation

among items; therefore, internal consistency is built in. Cronbach's alpha represents the

mean of all correlations between each possible set of half the items that make up a scale.

Cronbach's alpha is .89 for Internalizing Behavior Problems and .93 for Externalizing

Behavior Problems in boys age 4 to 11. In girls of the same age, Cronbach's alpha is .90

for Internalizing and .93 for Externalizing Behavior Problems. Problem item inter-

interviewer reliability of item scores was found to be .959 by comparing scores of three

interviewers with 241matched triad sets of children.

Test-retest reliability and scaled score long-term stability were respectively

established at .89 and .70 for Internalizing and .93 and .86 for Externalizing Behavior

Problems. Children who have received mental health services significantly decreased

their problem scores and obtained lower long-term stability coefficients indicating that

the CBCL is sensitive to intervention effects with children.

Content validity is supported due to the items' ability to significantly discriminate

between demographically matched non-referred and referred children. Criterion-related

validity is supported by the fact that the CBCL's quantitative scale scores are able to

discriminate significantly between demographically matched non-referred and referred

children. Construct validity is supported through significant associations with analogous

scales on the Quay-Peterson Revised Behavior Problem Checklist (Quay & Peterson,

1983) and the Conners Parent Questionnaire (Conners, 1973).

Early Childhood Behavior Rating Scale

The Early Childhood Behavior Scale (ECBS) by McCarney (1994), was

developed to identify early childhood behaviors, in children ages two through six, that are

often associated with behaviorally disordered and emotionally disturbed children. The

Total Score was subcategorized into Academic Progress, Social Relationships, and

Personal Adjustment.

Test-Retest reliability was established at .88 for the Total score. On each subscale

the following levels were established: .88 for Academic Progress, .86 for Social

Relationships, and .91 for Personal Adjustment. Correlation coefficients range from .81

to .88 with a mean of .85, with inter-rater reliability established at .01 significance level.

Using the Kuder-Richardson 20 formula, internal consistency and reliability were

established, with reliability for each of the three subscales at or above the .90 level.

To ascertain construct validity, a factor analysis was performed and results yielded three factors, Academic Progress, Social Relationships, and Personal Adjustment. To establish criterion validity, the ECBS was compared to the CBCL. The comparison yielded coefficients beyond the .001 confidence level. The ECBS has strong diagnostic validity for identifying behaviorally disordered students, as do the three major factor areas of Academic Progress, Social Relationships, and Personal Adjustment.

Selection of Participants

Fliers announcing the beginning of the P.A.L.s program for children experiencing adjustment difficulties were sent home to all kindergarten and afternoon preschool students attending the Tenderfoot Primary School in the Sanger Independent School District. In addition, all teachers were given a form and instructions to identify children in their classrooms who met the selection criteria (See Appendix A). Parents of all identified children were contacted by phone. Parents who responded were contacted by the researcher and provided additional verbal and written information about the play sessions, the study, and how confidentiality would be maintained (See Appendix B).

Children who met the following criteria were included in the study: (a) the parent(s) or legal guardian must either be able to speak, read and write in English or must have someone who can help fill out all information, (b) the family must be planning to keep the child in Tenderfoot Primary School through May of 2000, (c) the child must not currently be in counseling, (d) the child must be able to speak English, (e) the parent or legal guardian must plan to complete all pretesting and post testing, (f) both the parent or legal guardian and the child must agree to the child's participation in a weekly twenty

minute play session with a trained high school student for the remainder of the school year, and (g) the parent or legal guardian must sign and return the consent for pretest and post test video taping. The University of North Texas Institutional Review Board for the Protection of Human Subjects reviewed and approved this research project.

Thirty completed packets were returned and those students were randomly assigned to either the experimental (N=16) or control group (N=14). The experimental group was comprised of sixteen children because the P.A.L. class contained sixteen high school students, each of whom needed to work with a young child as part of the class assignment. Out of the original thirty, four children moved prior to the end of school leaving the experimental group with N=14 and the control group with N=12. By the end of the project, the experimental group consisted of seven boys and seven girls while the control group consisted of eight boys and four girls. Participating children's ages ranged from four to six years old.

Table 1 presents the demographic data of the experimental and control groups.

Table 1

Demographic Data of Experimental and Control Group: Gender

	Males	Females	Total (n=26)
Experimental Group	7 (50%)	7 (50%)	14
Control Group	8 (66.7%)	4 (33.3%)	12

At the beginning of the study, the average age for experimental group members was 5.5, and the average age for control group members was 5.3. The greatest variance among the groups was that only one participant who finished the study was Mexican-American, and she was in the experimental group. The ethnicity of the remaining members was Caucasian. These demographics serve only to describe the experimental and control groups.

The high school students who worked with the young children included 6 males and 10 females who were selected as an intact group in the P.A.L. class. Young children were randomly assigned to high schools students for the school year. Out of the sixteen high school students, two females are Mexican-American. The rest of the high school students are Caucasian.

Table 2

Demographic Data of High School Students: Gender

Males	Females	Total (n=26)
6 (37.5%)	10 (62.5%)	16

Collection of the Data

Before play sessions began, completed packets containing the informed consent, Child Behavior Checklist, demographic data, and parenting presentation interest form (See Appendix B) were collected from parents. After parental informed consent was obtained, teachers filled out the Early Childhood Behavior Rating Scale on each child.

Three weeks prior to the end of the school year, post testing materials were distributed to experimental and control group parents and teachers. The control group children were then given the opportunity to participate in play sessions with a trained play therapist. All but one control group child, whose mother wished for him to not be involved, met twice a week for three weeks of play therapy with this researcher.

To ensure confidentiality of the information provided on questionnaires and videotapes this researcher assigned codes to each participant, with only the researchers having the master list of the participants' names. All confidential material remained in a locked file. Names of both high school students and preschool and elementary children will not be disclosed in any discussion or publication of this material. All parents of participants were made aware that confidentiality would be maintained.

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

This researcher and two other advanced doctoral students (Leslie Jones and Kim Hilpl) trained the high school students in basic play therapy skills and procedures by modifying the Landreth (1991) model for teaching filial therapy. Didactic lecture, discussion groups, experiential activities such as role-playing, videos of play sessions were utilized. Using didactic lectures and role-playing in training play therapy skills has been supported by two studies. Arnold (1976) showed that training utilizing microcounseling, "learning by doing" is effective for teaching graduate students the three essential play therapy skills of reflection of feeling statements, reflection of behavior statements, and limit setting. Linden and Stollak (1969) utilized didactic lectures and experiential approaches with undergraduate college students trained in play therapy skills

and procedures and found that the students taught by the didactic approach reflected

significantly more feelings and behavioral content and were less restricted and directive

than were students trained solely through the experiential approach.

A developmentally appropriate, adapted form of Landreth's (1991) 10-week filial

therapy training model for paraprofessionals was the basis for the child-centered play

therapy training for the high school students. Since none of the students had children of

their own or interacted with young children on a daily basis, the students benefited from a

longer time to practice and learn the skills and procedures of child-centered play therapy.

The training focused on basic child-centered play therapy principles of creating a safe and

accepting atmosphere, following the child's lead, reflecting feelings and behaviors,

enhancing self esteem, facilitating decision making, and setting therapeutic limits.

The researcher chose the child-centered play therapy approach for the participants

for two main reasons. First, research studies have demonstrated that students, parents and

paraprofessionals can effectively implement person-centered interpersonal

communication skills (Boll, 1972; Bratton & Landreth, 1995; Brown, 2000; Ginsberg,

1976; Guerney, 1975; Kezur, 1980; Lebovitz, 1983; Payton, 1981; Seidenberg, 1978;

Stollak, 1969; Sywulak, 1977). Second, high school students' developmental and

cognitive abilities are best suited to the child-centered approach because is does not

require interpretation or analysis as many other therapeutic approaches do.

Toy kits were provided for each play time (See Appendix C). The high school

students arrived at Tenderfoot at noon and began setting up their play kits in designated

empty rooms. Half of the play times were conducted from 12:10 p.m. to 12:30 p.m. and

the other half were from 12:35 p.m. to 12:55. High school students picked up and

returned the Tenderfoot children to their teachers. The researchers monitored all play

times. The high school students received supervision from at least one researcher during

the time they were not with their Tenderfoot child. For supervision purposes, two video

cameras were utilized to tape four out of sixteen sessions per day on a rotating basis.

Videotapes were locked in a cabinet and destroyed at the completion of this study.

Adapted Training Model

Training sessions lasted approximately two hours during the P.A.L. class meeting

time and were conducted by the researcher and two cohorts, all advanced doctoral

students. All sixteen high school students learned new concepts through didactic lectures,

role-playing in which participants alternated between being the kindergarten student or

the facilitator, discussion groups and video tapes of experienced play therapists. The

training session were implemented in three phases:

Phase One: Training

The high school students and facilitators met in their classroom at the high school

and introduced themselves. The basics of the project were explained. The students

discussed the differences in the authoritarian, authoritative, and permissive parenting

styles. Students took part in experiential activities utilizing and familiarizing themselves

with these styles of interaction.

The concept of following the child's lead was explained, discussed, and

demonstrated. Students learned about one-way and two-way communications styles and

learned the necessary skills for effective communication. Students explored why two-way

communication is beneficial when working with children. Students took part in experiential activities that showed the difference between one-way and two-way communication styles. One such activity included having the students pair up with one student explaining to the other what the irregular geometric design in front of them looked like, and the silent partner, based solely on their partner's explanation, tried to draw it. After they were finished, they compared pictures. Next, they began the same activity, but this time, the drawer was also allowed to talk and ask questions. Again, they compared pictures when finished. Each student had the opportunity to be the drawer and the communicator for both parts of the activity.

The facilitators reviewed the concept of following the child's lead and described play as the child's natural language and that a child's language is based on actions, not words. The four basic feelings, and the importance of recognizing and reflecting feelings, were taught and discussed (See Appendix C). Students learned that the purpose of recognizing and reflecting feelings is to help the person feel understood and to build the person's self-understanding. Worksheets and live demonstrations were utilized. This researcher sought a high school volunteer and this researcher demonstrated in a ten-minute segment reflection of feelings and content. After a brief discussion of the demonstration, the students paired up, one person was the listener/reflector and the other person, the talker. The dyads spent ten minutes with each person assuming each role.

Facilitators and students reviewed reflection of feelings. The class explored the basic skills and principles of special play times and watched a video tape of an experienced play therapist demonstrating skills of tracking behavior and reflecting

feelings. The facilitators taught tracking behaviors. High school students formed dyads and role-played, with one assuming the therapeutic role and the other, the child role.

Phase Two: Training and Supervision

While the training at the high school continued, the high school students also began to conduct twenty-minute play times with an assigned young child at Tenderfoot Primary School. High school students discussed and received feedback on their play time with the child conducted the previous week. Facilitators discussed the important benefits of encouraging instead of praising children. Next, the facilitators discussed and demonstrated the ACT (Acknowledge the feeling, Communicate the limit, Target alternatives) limit setting technique (Landreth, 1991). Students practiced limit setting in dyads.

Students watched a video tape of an experienced play therapist demonstrating all of the basic play therapy skills and techniques. While watching this tape, students filled out a tape review form (See Appendix C).

High school students discussed difficulties they encountered during their play times with the Tenderfoot students, and generated more effective ways to deal with these difficulties. Facilitators discussed and demonstrated the whisper technique. High school students reviewed important things to remember regarding their play times and completed a brief quiz that covered the concepts, skills, and techniques taught up to this point (See Appendix C).

Phase Three: Supervision

At this point, the training aspect was subsumed into a group supervision format that took place at Tenderfoot. Because high school students value and learn from their peers, group supervision is more developmentally appropriate, and was therefore chosen by the facilitators. Throughout the year, the high school students could continued to learn, generate ideas, and help one another. Those students who struggled more than others were helped by those who were more confident in their skills. High school students were divided into two supervision groups with the first occurring while the second was in their special play times. The second occurred while the first was in their play times. High school students received feedback from graduate students who have specialized in and obtained advanced training in play therapy and filial therapy. During supervision, high school students watched the videotapes and received feedback on their areas of strength and areas for growth in conducting their play sessions with Tenderfoot students.

During supervision, high school students had the opportunity to ask questions and address any concerns they had regarding their play times at Tenderfoot. Students also participated in live peer play time observations and give written and verbal feedback to their peers. Facilitators and supervisors continued to discuss the importance of the play times and the use of these skills with young children.

In March, the high school students begin reading Dibs In Search of Self (Axline, 1964) in order to experience how Axline's unconditionally accepting relationship with a young child helped the child to grow and accept himself more fully. Each week in

supervision, the group discussed the chapters the students were to have read and went over the answers to the worksheets they filled out (See Appendix D).

Analysis of Data

The test instruments used in this investigation were coded with a four-digit code to maintain confidentiality of the participants. A master list with the participants names and code numbers was kept in a secured locked file for the duration of the study. The master list was destroyed following the completion of statistical analysis of relevant data.

Following the collection of pretest and post test data, all <u>CBCL</u> instruments were computer scored and verified and all <u>ECBS</u> instruments were hand scored and verified according to recommended instrument procedures to double-check accuracy of information. The researcher collected all data, entered all pre and post scores into a computer and analyzed the data utilizing <u>SPSS for Windows 10.0.5</u> (1999). Scores obtained from the <u>CBCL</u> and <u>ECBS</u> pretests from the experimental and control groups were analyzed and compared to the <u>CBCL</u> and <u>ECBS</u> post tests from the experimental and control groups in order to determine whether individual child-centered play times with high school helpers were an effective intervention to reduce adjustment difficulties in kindergarten students.

A Multivariate Analysis of Variance (MANOVA) was computed to test the significance of the differences between the control and experimental groups. In each case, the post test specified in each hypothesis was used as the dependent variable and the pretest was the covariant. The MANOVA was used to adjust the means on the post test, on the basis of the pretest, to statistically equate the experimental and control groups. The

.05 level was set to test the significant differences in change scores between the pretest

and the post test. The .10 level was used as the threshold to note any trends in the

differences between the change scores. The hypotheses were either retained or rejected on

the basis of the results of the MANOVA. In all analyses, the assumptions of MANOVA,

specifically homogeneity, were met.

CHAPTER III

RESULTS AND DISCUSSION

This chapter presents the results of the analysis of data for each hypothesis tested in this study. A discussion of the results, implications, and recommendations for future research is also included.

Results

The results of this study are presented in the order the hypotheses were tested. Multivariate analyses of variance were performed on all hypotheses and a level of significance of .05 was established as the criterion for either rejecting or retaining the hypotheses. The .10 level was established as the threshold to note trends that are not statistically significant.

Hypothesis 1

As reported by parents, young children who receive play sessions will achieve a significantly lower mean total score on the Child Behavior Checklist (CBCL) at post testing than will the young children in the control group.

Table 3 presents the pre and post test means and standard deviations for the experimental and control groups. Table 4 presents the multivariate analysis of variance mean gain scores, showing the difference between experimental and control groups. Table 5 presents the multivariate analysis of variance data and shows the level of significance

Table 3

Mean scores of the experimental and control group for the total behaviors
on the Child Behavior Checklist (CBCL)

| | Experimental Group n = 14 | | Control Group n = 12 | |
	Pretest	Post test	Pretest	Post test
Mean	47.8571	41.8571	43.7500	44.3333
SD	10.5820	7.8334	10.8387	11.9722

Total cases = 26

Note. A decrease in the mean score indicates improved behavior.

Table 4

Mean of gain scores of the experimental and control group for the total
behaviors on the Child Behavior Checklist (CBCL)

	Experimental (n = 14)	Control (n = 12)	Total (n=26)
Gain Mean	6.0000	-.5833	2.9615
SD	6.6100	7.3788	7.6078

Table 5

Multivariate analysis of variance of the experimental and control groups
for the mean scores on the total behaviors on the Child Behavior Checklist
(CBCL)

Source of Variation	Sum of Squares	df	Mean Square	F Ratio	Sign. of F	Effect Size	Power*
Group	280.045	1	280.045	5.760	.025	.194	.634

Total cases = 26
* Computed using alpha = .05

Table 5 shows the $\underline{F}$ ratio for the main effects was significant to the .025 level indicating that there was a statistically significant difference between the experimental group and the comparison group's measure of total behaviors on the <u>Child Behavior Checklist (CBCL)</u>. On the basis of this data, hypothesis 1 was retained.

<u>Hypothesis 2</u>

As reported by parents, young children who receive play sessions will achieve a significantly lower mean score on the Internalizing Behavior Problems scale of the <u>Child Behavior Checklist (CBCL)</u> at post testing, as compared to the pretest, than will the young children in the control group.

Table 6 presents the pre and post test means and standard deviations for the experimental and control groups. Table 7 presents the multivariate analysis of variance mean gain scores, showing the difference between the experimental and control groups. Table 8 presents the multivariate analysis of variance data, showing that there is a significant difference between the experimental and control groups' post test mean scores.

Table 6

Mean scores of the experimental and control group for the internalizing behaviors
on the Child Behavior Checklist (CBCL)

| | Experimental Group n = 14 | | Control Group n = 12 | |
	Pretest	Post test	Pretest	Post test
Mean	48.0000	42.1429	42.8333	43.5000
SD	8.6023	6.3228	7.0818	9.0905

Total cases = 26

Note. A decrease in the mean score indicates improved behavior.

Table 7

Mean of gain scores of the experimental and control group for the internalizing
behaviors on the Child Behavior Checklist (CBCL)

	Experimental (n = 14)	Control (n = 12)	Total (n=26)
Gain Mean	5.8571	-.6667	2.8462
SD	5.4470	8.3919	7.5773

Table 8

Multivariate analysis of variance of the experimental and control groups
for the mean scores on the internalizing behaviors on the Child Behavior
Checklist (CBCL)

Source of Variation	Sum of Squares	df	Mean Square	F Ratio	Sign. of F	Effect Size	Power*
Group	275.004	1	275.004	5.688	.025	.192	.629

Total cases = 26

* Computed using alpha = .05

Table 8 shows the F ratio for the main effects was significant to the .025 level indicating that there was a statistically significant difference between the experimental group and the comparison group's measure of internalizing behaviors on the Child Behavior Checklist (CBCL). On the basis of this data, hypothesis 2 was retained.

Hypothesis 3

As reported by parents, young children who receive play sessions will achieve a significantly lower mean score on the Externalizing Behavior Problems scale of the Child Behavior Checklist (CBCL) at post testing, as compared to the pretest, than will the young children in the control group.

Table 9 presents the pre and post test means and standard deviations for the experimental and control groups. Table 10 presents the multivariate analysis of variance mean gain scores, showing the difference between the experimental and control groups. Table 11 presents the multivariate analysis of variance data, showing that there is no significant difference between the experimental and control groups' post test mean scores.

Table 9

Mean scores of the experimental and control group for the externalizing behaviors
on the Child Behavior Checklist (CBCL)

| | Experimental Group n = 14 | | Control Group n = 12 | |
	Pretest	Post test	Pretest	Post test
Mean	47.9286	43.6429	44.0000	45.4167
SD	11.9129	6.5587	11.7241	11.6888

Total cases = 26

Note. A decrease in the mean score indicates improved behavior.

Table 10

Mean of gain scores of the experimental and control group for the externalizing
behaviors on the Child Behavior Checklist (CBCL)

	Experimental (n = 14)	Control (n = 12)	Total (n=26)
Gain Mean	4.2857	-1.4167	1.6538
SD	8.4892	6.5291	8.0400

Table 11

Multivariate analysis of variance of the experimental and control groups for the
mean scores on the externalizing behaviors on the Child Behavior Checklist
(CBCL)

Source of Variation	Sum of Squares	df	Mean Square	F Ratio	Sign. Of F	Effect Size	Power *
Group	210.111	1	210.111	3.587	.070	.130	.444

Total cases = 26

* Computed using alpha = .05

Table 11 shows the $\underline{F}$ ratio for the main effects was not significant to the .05 level indicating that there was no difference between the experimental group and the comparison group's measure of externalizing behaviors on the Child Behavior Checklist (CBCL). The threshold for positive trends was set at less than .10. A positive trend on hypothesis 3 was noted ($p < .70$). However, on the basis of this data, hypothesis 3 was rejected.

Hypothesis 4

As reported by teachers, young children who receive play sessions will achieve a higher mean Total score on the Early Childhood Behavior Scale (ECBS) at post testing, as compared to the pretest, than will the young children in the control group.

Table 12 presents the pre and post test means and standard deviations for the experimental and control groups. Table 13 presents the multivariate analysis of variance mean gain scores, showing the difference between the experimental and control groups. Table 14 presents the multivariate analysis of variance data, showing that there is no significant difference between the experimental and control groups' post test mean scores.

Table 12

Mean scores of the experimental and control group for the total of scales of the Early Childhood Behavior Scale (ECBS)

	Experimental Group n = 14		Control Group n = 12	
	Pretest	Post test	Pretest	Post test
Mean	28.0714	31.2143	34.1667	33.5833
SD	9.4906	5.8596	3.9962	4.3788

Total cases = 26

Note. An increase in the mean score indicates improved behavior.

Table 13

Mean of gain scores of the experimental and control group for the total of scales of the Early Childhood Behavior Scale (ECBS)

	Experimental (n = 14)	Control (n = 12)	Total (n=26)
Gain Mean	3.1429	-.5833	1.4231
SD	5.3616	3.8009	4.9894

Table 14

Multivariate analysis of variance of the experimental and control groups for the mean scores for the total of scales of the Early Childhood Behavior Scale (ECBS)

Source of Variation	Sum of Squares	df	Mean Square	F Ratio	Sign. Of F	Effect Size	Power *
Group	89.715	1	89.715	4.043	.056	.144	.488

Total cases = 26

* Computed using alpha = .05

Table 14 shows the $\underline{F}$ ratio for the main effects approached significance at the .056

level, with alpha set at .05, indicating that there was not a statistically significant

difference between the experimental group and the comparison group's Total score on the

Early Childhood Behavior Scale (ECBS). On the basis of this data, hypothesis 4 was

rejected.

Discussion

The results of this study, along with teachers' and parents' comments and this

facilitator's and other doctoral students' observations, provide information regarding the

adjustment of the young children who received 20 weekly play sessions facilitated by

juniors and seniors in the P.A.L.s program who were trained in child-centered play

therapy procedures and skills. Of the four hypotheses, two were retained. However, the

two rejected hypotheses showed positive trends though not at the .05 level of

significance. An interpretation of the results is provided below.

Problematic Behaviors of Children

Parent report. As indicated in Tables 3 through 5 (p. 47), the experimental group

did experience a significant reduction (p<.025) of their total behavior problems as

measured by the CBCL while the control group experienced a slight increase in their total

behavior problems. These findings are robust and imply a high degree of generalizability

to the larger population. The total score includes the scores on all eight subscales of the

CBCL: a) withdrawn, b) somatic complaints, c) anxious/depressed, d) social problems, e)

thought problems, f) attention problems, g) delinquent behavior, and h) aggressive

behavior. The significantly decreased mean for total behavior problems on post-tests indicates a significant reduction of overall behavioral problems as perceived by parents.

These results hold additional meaning given that six children in the control group were reported as having slightly increased their problematic behaviors without treatment. One child in the control group attained a marked 13 point increase in the problematic behavior score. In contrast, 13 children in the experimental group demonstrated decreases in their problematic behavior scores, with three children showing marked 18, 17, and 10 point decreases in their scores.

Results on the Internalizing Behavior Problems Scale, as indicated in Tables 6 through 8 (p. 49), show that the experimental group did experience a significant reduction (p<.025) of their internalizing behavior problems such as withdrawal, depression and anxiety, as measured by the CBCL while the control group experienced a slight increase in their internalizing behavior problems. These findings are robust and imply a high degree of generalizability to the larger population.

Additionally, these findings hold particular meaning given that two of the children in the control group achieved marked 15 and 12 point increases in internalized problematic behavior scores, while twelve children in the experimental group demonstrated decreases in internalized behavior problems with two children experiencing marked 12 and 10 point decreases and four experiencing marked 11 point decreases in their scores. Four out of the six children who experienced marked decreases in internalizing behavior scores were girls. Girls had higher internalizing scores on pre-testing data, and the average positive change for girls in the experimental group on

internalizing behaviors was 8.6, while for boys in the experimental group it was only 3.3. Further analysis revealed that girls experienced a significant decrease (p = .044) in internalizing behaviors as compared to boys. A possible explanation for the gender difference in scores may be that the children in the experimental group were in a relationship with a high school student who created an environment of trust, empathy and unconditional acceptance to promote the natural process of growth within the child. The goals of child-centered play therapy are geared toward helping children more freely express feelings, thoughts, and behaviors such as low self-esteem, depression, anxiety, self-reliance, self-direction, creativity, and trust in own inner resources. The girls, who generally tend to exhibit more internalizing behaviors (Reynolds, 1992), improved in this area more than the boys did. The belief that children who receive play therapy will move toward becoming more capable, creative, self-directed individuals who can be trusted and relied upon was demonstrated through obtaining significance in internalizing behaviors on the CBCL. In fact, the control group's behaviors became slightly worse which may indicate that over time and left untreated, children may exhibit more internalizing behavior problems. Brandt's (1999) also found that play therapy had a greater effect on internalizing behaviors than on externalizing behaviors as measured by the CBCL.

Because of the permissiveness and freedom to express self and feelings, child-centered play therapy, may more quickly impact internalizing behavior problems because it allows the child the freedom to release pent up feelings that may result in less anxiety, depression, somatic complaints, and withdrawn behaviors. Children who demonstrate internalizing behavior problems tend to negotiate difficult experiences in their lives by

themselves (Gil, 1991). Because internalizing behavior problems are more difficult to detect and are oftentimes overlooked by parents, the significance of the parents' overall reduction of the mean for Internalizing Behavior Problems is particularly profound.

Children who demonstrate externalizing behaviors outwardly express their emotions, directing behaviors toward others (Gil, 1991). The experimental group showed a positive trend ($p<.070$) in the decrease of external behavior problems as indicated by the Externalizing Behavior Scale of the CBCL, Tables 9 through 11 (p. 51). The experimental group did experience a moderate reduction of their externalizing behavior problems as measured by the CBCL while the control group experienced a slight increase in their external behavior problems. The experimental group boys and girls both moderately improved their externalizing behaviors, but the parents reported that the boys showed slightly more improvement. This improvement may be explained through the experimental group's ability to be accepted and valued during their time with their P.A.L. which may have led to less need to exhibit external behaviors. In the control group, on average, girls' externalizing behavior became moderately worse and boys remained relatively constant. Overall, the control group's behaviors became slightly worse which may indicate that over time and left untreated, children, and especially girls, may exhibit more externalizing behavior problems.

Child-centered play therapy seeks to help children develop internal resources and a greater internal locus of control, rather than focusing on external behavior change (S. Bratton, personal communication, October 26, 2000). Child-centered theory postulates that the more children develop self-confidence, trust in their own internal locus of

control, and develop a positive inner self-concept the more their behavior improves

(Axline, 1947; Landreth, 1991). Since the focus of child-centered play therapy is more on

facilitating movement toward self-acceptance, internal feelings of control, and a positive

self-concept than on external behavior change, this, in part, may explain why the children

showed less improvement in externalizing than internalizing behavior problems. Once a

child feels more self-acceptance and self-control, the child is free to act out less and

become less aggressive. Therefore, after the manifestation of internal improvements,

children are freer to manifest external improvements. Consequently, obtaining a positive

trend on the CBCL points to the possibility that play therapy by high school students with

young children with adjustment difficulties facilitates changes in their undesirable

behaviors; yet, since the children only had the benefit of the intervention for 20 weeks,

there may not have been enough time for external behavioral change to be significant.

Teacher report. As indicated in Tables 12 through 15 (p. 53), the experimental

group did experience a moderate reduction of their total behavior problems as measured

by the ECBS while the control group experienced a slight increase in their total behavior

problems. As reported by teachers, behaviors of thirteen children in the experimental

group improved with one child improving 19 points. Conversely, behaviors nine out of

the eleven children in the control group became worse and two remained relatively

constant. The overall result approached significance (p< .056) with alpha set at .05. One

explanation for the failure was that one boy in the control group whose score improved by

10 points with 7 of those points in the Academic Progress subscale. However, in talking

with his teacher and mother, his academic progress did not actually improve. In fact, the

only difference was that during the last month of school, his parents decided to hold him back in kindergarten or the upcoming year. The teacher stated that her expectations for him changed knowing that he would be back next year and had another year to improve before moving on to first grade. Without the 10 point outlier, the control group, on average, became moderately worse and the experimental group moderately improved. Also without the outlier, there was no significant difference between boys and girls on the ECBS. Replication of this study with more participants would help to clarify this issue because individual anomalies would not skew the overall statistics as much.

Drop Outs

Two children in the experimental group, one Mexican-American boy and one Caucasian girl, who completed the majority of the school year but moved before the conclusion of the study and whose instruments were not included in the results had pretest total behavior scores in the clinical range on the CBCL. Those two children seemed to not benefit from the play sessions. This reinforces the findings of Baggerly (1999) and Beckloff, (1997) that children who have significant adjustment difficulties as manifested through behavior problems, need the attention of a trained therapist rather than a paraprofessional or peer mentor. Therefore, school counselors need to take special care in deciding which children will be best served by the school's professional therapist and which can be effectively helped by a peer mentor.

Service for the Control Group

At the conclusion of the study, this researcher divided the control group into four play therapy groups and held two play sessions per group per week for the last three

weeks of school with the children whose parents wanted their children to participate. During the second of the three weeks, they also met with a P.A.L. who had not received training in play therapy in order to have a play experience with a high school student. Only one child's mother did not want him to participate believing that he did not need the special play therapy time. Several of the children commented that they wanted a P.A.L. to conduct the special play times. Some of the parents expressed disappointment that their child did not have a P.A.L. all year, but were hopeful that they would get one the next year. Some parents also wanted their child to receive something for all of the paperwork they filled out to be in the study.

In addition to the group play therapy for the control children, the therapist personally invited each of the parents to receive ten weeks of free filial training during the summer on the campus of the University of North Texas at the Child and Family Resource Clinic. Many expressed interest when asked in May. Although all of the interested parents were contacted during the summer, none accepted the training with most stating that they were too busy.

Positive Relationships Developed

The Tenderfoot counselor noticed the beneficial relationships that developed between the young children and the high school students and believed that those attentive, understanding, caring relationships could only have a positive effect on the young children's behavior. The high school students were good role models for the children and provided much needed one-on-one attention. The P.A.L.s helped to create a sense of

belonging for the young children who sometimes experienced exclusion from peers because of their adjustment difficulties.

The teachers also commented that the positive relationship was one of the main benefits of the play sessions. Several teachers reported that the children assigned a high school student often asked, "Is today the day my P.A.L. comes?" The children were always happy when their P.A.L. came to take them for their special play time. Fellow classmates not part of the study and control group children asked when they would get a P.A.L. Often the children would beg the high school students to "take me today" or "take me, too."

The power of this valuable relationship was confirmed by this researcher's observations throughout the year of the young children exuding excitement when they spotted their P.A.L. coming for them. They would hurriedly make their way to their teacher and exclaim, "I've got to go!" or "He's here!" Sometimes in their excitement, they would forget to inform their teachers. This was okay because the teachers were aware that the P.A.L.s came the same time each week. The high school students as well as the young children wore huge grins as they made their way to their play area. By the end of the year, some of the young children gave their P.A.L. a big hug at the end of each session.

Throughout the play sessions, this researcher, the principal, teachers and the school counselor all readily noted positive relationship development. Both the high school and Tenderfoot students benefited from this advantageous relationship. Especially for the young children, this peer relationship appeared to be a meaningful experience that

inspired behavioral improvement within the young children who received the special play sessions.

Limitations

Although two of four hypotheses were retained, the following limitations are offered as possible confounding issues in this present study.

1. Due to the small sample size of this research study (experimental group n=14; control group n=12) low power resulted in some hypotheses. The power in this study ranged from .384 to .634 and thus there was an unacceptable level of power to confirm significance if it were present. A larger sample size would increase power to an appropriate. An increase in sample size would also have served to boost the power in retained hypotheses as well, and validate robust findings. Other research studies with an experimental group size below 15 have produced significant results (Chau & Landreth, 1997; Kale & Landreth, 1999; Yuen, 1997).

2. Participant selection was limited to volunteers from Tenderfoot Primary School in the Sanger, TX area, which produced small sample sizes in the experimental and control groups, which were not racially balanced samples.

3. This study relied on volunteer sampling. Because of the population and the purpose of this study, some bias was noted with parents who chose to return permission slips.

4. Teachers and parents who completed the CBCL and ECBS were aware of which children were receiving play times. This knowledge may have biased the ratings. In addition, due to the nature of the study, parents and teachers did not receive feedback on the children's progress to ensure that change more accurately be attributed to play

sessions with the high school students rather than to parent or teacher intervention. The lack of discussion with parents and teachers may have hindered their ability to reinforce positive changes and perceive the children's progress.

5. Teacher and parent bias of the child may also have affected the way the CBCL and ECBS were filled out.

6. Some teachers rushed to complete the ECBS, which may have led to teachers rate differently than had they taken their time to complete the instrument.

7. Although the experimental group contained an equal number of males and females, the control group contained twice as many males as females.

8. By having a control group rather than a comparison group who received some type of intervention, study results may be biased by the Hawthorne effect.

9. Instruments that measure behavioral change are inadequately sensitive to the changes in young children's behavior.

Implications

Although only two of the hypotheses were statistically significant, positive trends ($p > .05$ and $p < .10$) in the behaviors of young children were observed on the other two hypotheses. These positive results as well as observations by the researcher, parents, and teachers support the continued implementation of play sessions between young children who have adjustment problems and high schools students who have been trained in child-centered play therapy skills and procedures. Young children with behavioral, emotional and social problems need appropriate intervention for school success. This study has suggested that play sessions with trained high school students can make a positive impact

on the behavior of young children. Further research is necessary to determine whether this play intervention consistently results in significant changes in the behavior of young children.

In addition to positive changes in young children, high school students also benefited from their training. High school students learned limit setting and could more effectively set boundaries in their own lives. One high school students stated that he is now a much better friend to his friends than he had been before learning person-centered skills. Another students said that she likes who she is as a person more now than she had beginning the training. Several students said that they like and understand young children better. Another stated that prior to the study, he dreaded beginning to spend time with young children because he was unsure what to do with them, but after learning and practicing the child-centered skills and meeting with the assigned child each week, he looked forward to those times together. Another high school student confided that he now gets along better with his own parents. Several students stated that they wished their parents had had the training that they received.

Other benefits of implementing this project also occurred. The school counselor's resources and time were maximized since this project provided therapeutic intervention for 14 young children with adjustment difficulties and positive communication skills for 16 high school students. With a minimal commitment for training and supervising (all trained high school students must remain under the supervision of a trained play therapist), 30 students can receive therapeutic services. High school students trained in basic child-centered play therapy skills will also be more attuned to the emotional well

being of children. Specifically, they may someday be more patient and understanding with their own children. Clearly, implementation of this project is a valuable use of the school counselor's time.

Teachers and parents were relieved that students with adjustment difficulties were receiving the one on one attention that they needed. Teachers often asked if the high school partners of the children in their class were on campus and when they would be ready for their children. Many parents reported that their children "loved" spending time playing with their high school student. Some parents inquired whether or not the program would be implemented in the schools the next year.

This project resulted in significant results and positive trends in decreasing behavior problems of young children and had many positive effects on the high school students who received the training, parents, teachers, and the school counselor. The continuation of this project is, therefore, warranted.

<div align="center">Implications for School Counselors</div>

School counselors can utilize filial therapy techniques for peer mentoring in their school districts in order to maximize available resources to help their young students with adjustment difficulties. Requirements for implementation of this program include a) a counselor trained in filial play therapy willing to participate; b) high school student peer mentors; and c) filial play therapy toy kits. Not necessary are a large number of high school participants and video equipment.

Creating a new program for an individual school district is possible. However, because PAL programs are nationally recognized and can be offered for state-approved

credit during the school day, if school counselors have or can get Peer Assistance and

Leadership programs in their schools, their implementation of this model may be easier

(See Appendix E). High school students who participate will receive credit hours for the

class, making the program more appealing to them and requiring their attendance.

Therefore, both the high school and elementary school students can meet during their

normal school day, making participation easier for students and parents.

The best time to lay groundwork for a peer mentoring program is near the end of a

school year. High school teachers can recommend to the high school P.A.L.s

teacher/coordinator those students who they believe are good students and excellent role

models. The coordinator contacts those students to discuss the possibility of participating

in a special mentoring program to help younger children. A P.A.L.s class time is set. This

time should be planned with the young children's schedule in mind. For example, some

schools hold more academic classes in the mornings and have more flexibility in their

afternoon schedules. Counselors gather the of list of mentors (approximately 8-20

students) and schedule the students in the class. In the beginning of the next school year,

the elementary counselors with training in play therapy and filial/family play therapy hold

intensive (2-3 hours per week) training sessions to prepare the mentors to use play

therapy skills and procedures to work with the children. Mentors can be trained within the

first several weeks of school before elementary school counselors' schedules are

completely full. After the training, mentors begin their play times and the counselor

observes some of each half-hour play session and conducts a one-half hour group

supervision session with the mentors after their play times. Therefore, after the initial

investment for training, counselors can help more of their students by providing them with trained high school students, and for the remainder of the school year, the counselor need only invest approximately one hour per week per group of trained high school students.

Although counselors can fairly easily train 20 high school students, this researcher suggests that high school students can be placed into groups of ten or fewer for supervision purposes. Play times for the different groups can be staggered and on different days so that the counselor has time to observe and supervise all play times. Therefore, with twenty trained high school children, for example, the counselor may spend one hour per week (30 minutes observing and 30 minutes supervising) on Mondays with one group of ten or fewer students and one hour on Thursdays with another. With two groups of supervised, trained high school students, elementary school counselors can provide services for approximately twenty children only two hours of time invested each week after the completion of training. This has the potential to maximize the impact that counselors can have on their students as well as providing valuable training in communication skills for the high school students.

Other considerations for limiting the number of special play times being conducted at one time is the number of filial play therapy kits that are necessary and the spaces inside the building where the play times can be held. If ten play sessions are being conducted at a time, then ten filial play therapy toy kits are necessary and ten spaces in the elementary school are necessary to conduct the play times. Funding for the filial toy kits is another challenge for school counselors. Filial kits can be purchased for around

fifty dollars each or can be assembled less expensively from toys selected at dollar stores and garage sales. Counselors may have to be creative to get the necessary monies for the play kits. For example, grants may be written or high school students can hold a car wash to earn the money. Sending home with middle and high school students a list of toys needed as donations may be fruitful since children that age have usually moved on to toys for older children and the parents may wish to donate some of the old toys. A list of recommended toys for filial therapy kits is located in Landreth's 1991 text.

Physical space is another consideration for the number of play times that may be conducted at a time. The counselor office is an obvious choice for at least one session, depending on the size of the room. Also, some rooms in schools, possibly music, art, and speech are not in use every hour each day of the week. As long as the students and counselor are being respectful of those teachers, often the teachers may willingly allow play times to occur in their rooms. Another consideration of note is that in most elementary sized classrooms, two play sessions can easily be held at a time on opposite sides of the room. Some kindergarten classes meet half-days, possibly freeing up these classrooms for P.A.L use. As a last resort, hallways in scarcely trafficked areas will also suffice.

Counselors may face challenges and may need to further adapt this program to fit into their own school and district, yet this model can utilize the counselor's resources and knowledge to provide individual services to more students than the counselor alone can work with in a short amount of time. Eight trained high school students can work with two children at two different times during the week, thus helping 16 children. Therefore,

even limited numbers of trained high school students can be quite beneficial to the elementary counselor. For maximum benefit, the counselor does need to make a commitment to making this model work in their school district and needs to get a commitment from the high school students to stay with the elementary children throughout the school year.

Recommendations

Based on the results of this study, the following recommendations are offered:

1. Conduct a follow-up of this study to ascertain maintenance of behavioral changes in the young children during subsequent school years.

2. Conduct a replication of this study using a larger sample size to increase the power of statistical measures and match subjects for gender and ethnicity.

3. Train all school counselors in play therapy and filial therapy.

4. Develop a training manual that addresses the feasibility of how filial therapy can be implemented on a campus where there is only one school counselor.

5. Adapt the child-centered play therapy training model by providing intensive training (two to three meetings a week for a total of three hours a week) for the month prior to the beginning of the school year so that high school students to facilitate the application of play sessions with the young children at the beginning of the school year. This immediate application could help the young students adjust to attending school and the demands that the school day brings. The extended initial training period would serve to generate a stronger base knowledge as the high school students begin the play times.

6. Give weekly general progress feedback and provide training in basic play therapy skills to parents and teachers. Keeping parents and teachers informed as to general progress could help apply effective strategies in the home and classroom, facilitating greater positive change in the young children.

7. Provide weekly on-going supervision during the experience, which could be accomplished through group and/or individual meetings. Since incidental learning occurs in group settings, group meetings would be preferable.

8. High school students would benefit from implementation of this filial therapy training model into scholastic training. National adoption of this program is recommended.

9. Continue the school counselor's focus on providing services to children with the most severe difficulties to prevent exacerbation of their problems.

10. Pursue taking results of this study to the P.A.L.s coordinator for Texas to pursue grants to implement this program on a larger scale and/or assist the P.A.L.s coordinator in outlining training for their instructors/teachers.

Concluding Remarks

Based on a current survey of the literature, this research is the first study in the country to address young children's adjustment difficulties through play session with high school students trained in child-centered play therapy skills and procedures. The significant results in children's behavior as well as observations of the power of the therapeutic relationship compel the continued implementation of this training with high school students. The information presented in the recommendations will add to future success of this research.

APPENDIX A

SELECTION MATERIALS

September 24, 1999

Dear Tenderfoot Teacher,

We are excited about working with you and your students through the P.A.L. program and appreciate your enthusiasm and cooperation. You are a vital part of the success of this program, as you know the needs of your students better than anyone. We would greatly appreciate you taking a few minutes over the weekend to identify those children in your classroom who you perceive could benefit most from participating in the P.A.L. program. On the attached form, please write the names of as many children in your class as you think may benefit from the program.

Because parents value your input regarding their child, I encourage you to contact the parents of these children (either by phone or as they pick up their child). The attached interest letter that you sent home to parents describes the possible benefits for their child, but it would probably be helpful if you briefly reiterated those benefits (some parents may not have had time to read it). We are also giving you a few extra letters that you may give to parents directly. **If they express interest, it would be helpful if you encourage them to complete the bottom of the form right then and leave it with you.** If they have questions, they can call Leslie, Tammy or Kim at 565-2066. If you have a student who you believe could benefit from the attention of a high school P.A.L., but do not feel comfortable talking with that particular parent, please indicate that along with the child's name on the referral form.

To help you identify those children in your class who may benefit most from the P.A.L. program, we have included a list of behaviors that are associated with children who have difficulty adjusting to changes in their life, including adjusting to the particular demands of the schools setting.

If you have any questions, please do not hesitate to contact Leslie, Tammy, or Kim at the number listed above, or at their after hours numbers listed below. For you convenience, we have included numbers where we can be reached after office hours. We will also be at Tenderfoot this afternoon. Thank you again for your support and cooperation. Working together we can make a significant difference in the lives of many of the children in your class. A child's initial adjustment and experience of school is crucial in his or her future academic and personal success. Your students are fortunate to have you as their mentor in this process.

Sincerely,

Leslie Jones   Tammy Rhine   Kim Hilpl
972-254-6032   972-335-7039   940-383-8256

Criteria for Identifying Children for the P.A.L. Program

To nominate pre-kindergarten and kindergarten children for this program, please identify students who meet at least one of the following criteria:

The child demonstrates:
    A. Shy behavior (may have difficulty separating from parent)
    B. Withdrawn behavior
    C. Anxious behavior (fearful, self-conscious, nervous, may have trouble transitioning from one activity to another)
    D. Somatic complaints (stomach ache, dizzy)
    E. Depressed behavior (cries excessively, sad, loner)
    F. Inattentive behavior (doesn't concentrate, day-dreams)
    G. Aggressive behavior (temper, screams, fights)
    H. Social problems (teased, doesn't get along with others, difficulty joining in group activities)

OR

The child has experienced a life change within the last year such as:
    I. Parents' divorce
    J. Death in the family
    K. Family Move
    L. New Sibling

TENDERFOOT PRIMARY SCHOOL
P.A.L. PLAYTIME PROGRAM
STUDENT REFERRAL FORM

Teacher Name: _____Date: _____

Name of child referred	Teacher will contact parent	Teacher has contacted parent	Please have UNT contact parent
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			

Please return these forms to the UNT box on Monday, September 27.

TENDERFOOT PRIMARY SCHOOL
PARENT INFORMATION – WEEKLY P.A.L PLAYTIMES

September 1999

Dear Parent:
Recently you received a letter regarding the opportunity for your child to participate in the Sanger ISD Peer Assistance and Leadership (P.A.L.) program, which is a joint effort between Sanger High School and Tenderfoot. The P.A.L. program carefully screens and trains high school juniors and seniors to work one on one with students at Tenderfoot. A positive relationship with a caring high school mentor can help insure your child's successful adjustment to the school setting. Research supports that children who experience school positively perform better academically and have a higher attendance rate.

Specifically, the P.A.L. program is designed to benefit your child in the following ways:
1. Facilitate positive adjustment to the school setting as a foundation for future academic success.
2. Increase your child's self-confidence
3. Improve your child's self-control
4. Develop your child's sense of responsibility

If you choose for your child to participate in the P.A.L. program, your child will meet with his or her high school mentor once a week for 30 minutes. Interactions between the P.A.L. student and your child are closely monitored by the high school P.A.L. teacher, Mrs. Cassie Miller, as well as University of North Teas doctoral students who are participating in the P.A.L. program. In addition, the high school P.A.L. students receive weekly training and supervision as part of their P.A.L. class.

Feel free to contact any of the project coordinators, Leslie Jones, Tammy Rhine, or Kim Hilpl, at 565-2066 or Cassie Miller at 458-7497 for more information. For your convenience, project coordinators will be available after school on September 28 and 29 from 3:00 p.m. to 4:00 p.m. To answer any questions, there will be two informational meetings on Tuesday, September 28 from 11:00 a.m.-12:30 p.m. and Tuesday, September 28 from 6:00 –7:00 p.m. at Tenderfoot Primary School. Refreshments and childcare will be provided. Because parents are so important in the academic adjustment of their child, meetings will be scheduled throughout the year for parents of children involved in the P.A.L. program on "Tips for Parents on Growing Happy ☺, Healthy Children."

Sincerely,
Robin Macke, Ph.D.
Tenderfoot Principal

I would like to sign my child up for the program. Contact me at the number below;

I would like to receive more information, please have a project coordinator contact me at:

Parent's name: _____Child's name (optional): _____
Address:_____
Home phone:_____OK to leave message (please circle): Yes   No
Work phone:_____OK to leave message (please circle): Yes   No
Other phone:_____OK to leave message (please circle): Yes   No

APPENDIX B

PARTICIPANT PACKET MATERIALS
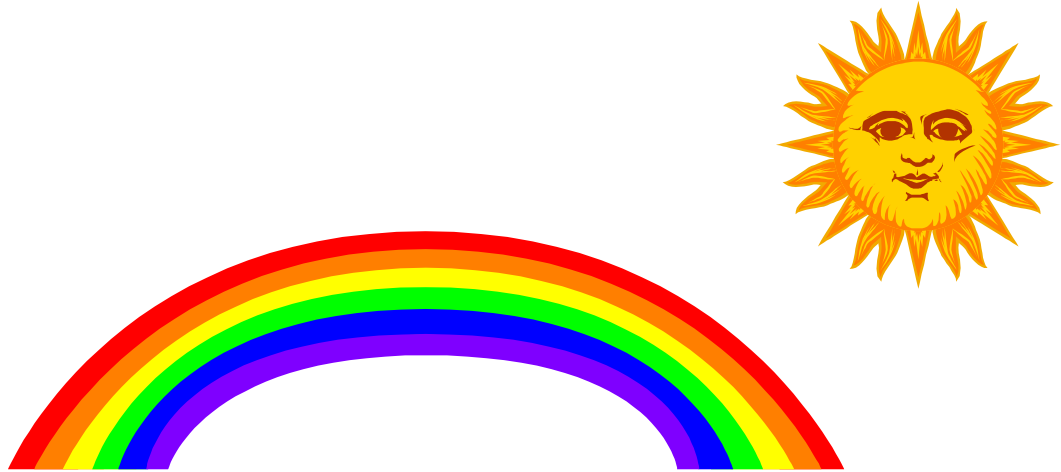
Thank you for your interest in the Sanger ISD Peer Assistance and Leadership program, a joint effort between Sanger High School and Tenderfoot. The response to this program has been overwhelming. Because there are a limited number of high school mentors specially trained to serve as P.A.L.s to young children, children will be assigned a P.A.L. upon our receipt of the enclosed forms, on a first come, first served basis.

The forms enclosed provide valuable information about how you see your child, and they help us identify common parenting concerns for future parenting classes/workshops. Our goal is to be as helpful to you and your child as possible. If you have any questions or would like feedback on the forms you complete, please feel free to call us.

Again, remember to get your forms back as quickly as possible. We are currently in the process of assigning P.A.L.s to those children whose paperwork is complete and anticipate filling all spots by the first of next week.

Sincerely,
Leslie Jones
Tammy Rhine
Kim Hilpl

PALS – RESEARCH INFORMED CONSENT FOR PARENTS/GUARDIANS

You and your child are invited to participate in a study to determine the effectiveness of Child Centered Play Times provided by PALS trained in play time techniques. Participation is completely voluntary.

Your child will be asked to participate in a 20-minute play time once a week during the 1999-2000 school year. Your child will also be asked to complete a self-assessment at the beginning of the study, the middle of the study, and again at the completion of the study. You and your child's teacher will be asked to complete some questionnaires at the beginning, middle and then at the end of this study.

The play times are based on the fact that play is the natural medium of communication for children. Selected play materials are utilized to help young children express feelings, thoughts, experiences, and behaviors. This interaction between children, selected play materials, and the trained PALS student will help to enhance your child's self esteem, self-control, and self-confidence. The PALS students will continue to receive training and supervision throughout the study.

The information you provide with you answer the questionnaires will be kept confidential, and will not be disclosed in any publication or discussion of this material. All information will be recorded with code numbers to preserve confidentiality. Only the researchers, Leslie Jones, the PALS teacher, and the children's teachers will know the participants' names. At the end of the study the list of names will be destroyed. The only exceptions to confidentiality are if a) the child discloses abuse, neglect, or exploitation, b) the child is a danger to oneself or to someone else, c) a court orders disclosure of information, or d) the parent or legal guardian requests release of information.

There is no personal risk or discomfort directly involved with this study. You and/or your child may choose to withdraw at any time without penalty or prejudice. Your decision whether or not to participate will not affect your child's standing at school. At the conclusion of the study, a summary of results will be made available to all interested parents and teachers.

If you agree to participate, please fill out and sign this consent form. For further information, please contact the High School PALS teachers; the research Leslie Jones at 565-2066; or Dr. Sue Bratton, Faculty Supervisor, at 565-2066.

_____

Your signature below indicates that you understand all the information presented on this form and any questions that you have about the research have been answered to your satisfaction. Participation is completely voluntary and you and/of your child may choose to withdraw at any time during the study.

Signature of Parent or Legal Guardian_____Date_____
Name of Child_____
Phone number_____OK to leave message____Yes____No
Signature of Investigator_____Date_____

This project has been reviewed and approved by the University of North Texas Institutional Review Board for the protection of human subjects (940) 565-3940.

P.A.L. Playtimes
Child Background Information

Child's name: _____ Date of birth: _____ Teacher's Name: _____

Completed by: _____ Relationship to child: _____

Home phone: _____ may leave message: _____ yes _____ no

Work phone: _____ may leave message: _____ yes _____ no

Best time and place to call: _____

Child's address: _____
                Street   City   State   Zip

Child's gender: _____ male _____ female

Child's ethnicity: _____ Caucasian _____ African American _____ Hispanic/Latin _____ Asian

Native American _____ Bi-racial _____ Other (explain) _____

Primary Household (anyone who currently lives with child)
Name   age   gender   relationship to the child

_____   _____   _____   _____

_____   _____   _____   _____

_____   _____   _____   _____

_____   _____   _____   _____

_____   _____   _____   _____

Current Concerns: Please indicate any current concerns you have for your child.

___ Adjustment to life changes (starting school, moving)   ___ Feeling anxious
___ Speech problem (not talking, stuttering, etc.)   ___ Feeling sad a lot
___ Loss of a family member or close friend   ___ Feeling angry or irritable
___ Health concerns (physical or medical problems)   ___ Feeling guilty or shameful
___ Difficulties interacting as a family   ___ Behavior problems
___ Parent-Child relationship (discipline, single parent, etc.)   ___ Learning/Academic difficulties
___ Sleeping problems (nightmares, sleeping too much   ___ Problems with teachers/peers
    or too little, fitful sleep)

Does your child have any of the following:
Physical Disability: Yes ___ No ___ (If yes, explain) _____
Chronic Illness: Yes ___ No ___ (If yes, explain) _____
Terminal Illness: Yes ___ No ___ (If yes, explain) _____
Please check any services your child has received.
___ Individual counseling   ___ Family counseling   ___ Group counseling
___ Hospitalization   ___ School counseling   ___ None

Have you attending parenting classes? Yes ___ No ___ (If yes, where and when) _____

APPENDIX C

HIGH SCHOOL STUDENT TRAINING MATERIALS

Identifying Feelings

Identify the feeling expressed by each of the following statements.

1. "That's a stupid old dart gun. It won't work."

   Feeling: _____

   Reflection of feeling: _____

2. "I'm invited to Dana's birthday party!"

   Feeling: _____

   Reflection of feeling: _____

3. "I'm big and strong. Pow! See how I knocked that down"

   Feeling: _____

   Reflection of feeling: _____

4. "I got to be line leader all day today I was first everywhere we went."

   Feeling: _____

   Reflection of feeling: _____

5. "Jason knocked down my castle. He did it on purpose, too."

   Feeling: _____

   Reflection of feeling: _____

Facilitating Reflective Communication

What response would you make to the following situations if you were practicing reflective communication?

1. Joe: (with red face and tears in his eyes) We lost. That team didn't play fair!

    _____

    _____

2. Jill: (enters with C- test paper) I tried so hard but it didn't do any good.

    _____

    _____

3. John: (playing with a Barbie doll) I don't get to play with these at home.

    _____

    _____

4. Carol: (looking through the doorway to a dark room) What's in there? Will you come with me?

    _____

    _____

5. Charlie: (showing his torn paining from school) Look. Isn't it neat? My teacher said I was a good artist!

    _____

    _____

The Basic Principles of Special Play Times

1. Develop a warm, friendly relationship with the child, in which good rapport is established as soon as possible.

2. Accept the child exactly as the child is.

3. Establish a feeling of permissiveness in the relationship so that the child feels free to express feelings completely.

4. Recognize the feelings the child is expressing and reflect those feelings back to the child.

5. Know the child has the ability to solve problems on their own.

6. Let the child lead. Do not try to direct the child's actions.

7. Only set limits that are necessary.

Play Time Responses

Circle the response that you think is better.

1. Child sets up the bowling pins and then rolls the ball and knocks them down.

    a. You are setting those up then knocking them down.
    b. Let me show you how to play bowling.
    c. You are doing a great job!

2. Child says, "Let's play house. You be the baby and I will be the mommy."

    a. Ok but I'll be the mommy and you be the baby.
    b. Let's play with the play-do instead
    c. You decided what you want us to play.

3. Child is standing in the middle of the toys looking at them and then looking at you.

    a. You are not sure what you want to play with first.
    b. You can play with the doll or the army men.
    c. What do you want to do?

4. Child picks up the snake, moves it across the floor, and makes a hissing sound.

    a. That snake is scary.
    b. You are making that move and hissing.
    c. You are making a great hissing sound.

5. Child asks, "What do you want to play next?"

    a. Let's play crayons and paper.
    b. In here you can decide what you want to play.
    c. I don't care.

Limit Setting During Play Time

1. Acknowledge the child's feelings, wishes, and wants:
   Ex: Johnny, I know you really want to . . .
       Johnny, you seem really upset

2. Communicate the limit:
   Ex: The wall is not for painting
       People are not for hitting

3. Target Acceptable Alternatives:
   Ex: You can paint the paper on the table
       You can hit the pillow

The Ultimate Limit: You can choose _____ or you can choose _____.
   Ex: Johnny, you can choose to paint on the paper or you can choose not
   to play with the paint next time.

Examples of basic limits:

1. Jimmy, I know you would like to shoot the gun at me
2. But I'm not for shooting
3. You can choose to shoot the floor or that (point at something acceptable)

1. Susie, I know you would like to paint the wall
2. But the wall is not for painting
3. You can choose to paint on that paper in front of you or that paper over
    there.

Tape Review

1. List three tracking responses you heard.

   a. _____

   b. _____

   c. _____

2. List three reflections of feelings you heard.

   a. _____

   b. _____

   c. _____

3. List three things you thought the play time leader did well.

   a. _____

   b. _____

   c. _____

4. List three things you would do differently.

   a. _____

   b. _____

   c. _____

Self-Evaluation for PAL Play Sessions

1. What did I do well? (Use examples)_____

_____

_____

_____

2. What did I do poorly? (Use examples)_____

_____

_____

_____

3. I would like to improve on . . ._____

_____

_____

_____

4. What did my PAL play the most during the session? _____

_____

_____

_____

5. What feelings did I have during the session? _____

_____

_____

_____

Common Problems

1. My PAL notices I talk differently in the play times, and wants me to talk normally.

   _____

   _____

2. My PAL asks many questions during the play time and gets upset when I don't answer.

   _____

   _____

3. My PAL just plays and has fun. What am I doing wrong?

   _____

   _____

4. I'm bored. What's the value of this?

   _____

   _____

5. My PAL doesn't respond to my comments. How do I know I'm right?

   _____

   _____

6. When is it o.k. for me to ask questions?

   _____

   _____

7. My PAL hates the play time. What can I do?

   _____

   _____

Do's and Don'ts of Playtimes

Don'ts

1. Don't criticize any behavior
2. Don't praise the child
3. Don't ask leading questions
4. Don't give information or teach

5. Don't preach
6. Don't initiate new behavior
7. Don't be passive

Dos

1.   Do set the stage

    _____

2.   Do let the child lead

    _____

3.   Do track behavior

    _____

4.   Do reflect the child's feelings

    _____

5.   Do set limits

    _____

6.   Do focus on the child's efforts

    _____

7.   Do join in the play as a follower

    _____

8.   Do be verbally active

    _____

Order of Toys for Play Time Set-up

Doctor's kit
Baby doll/bottle/blankets
Dishes/food
Doll family/furniture (put these in box top)
Paper/scissors/crayons/Play Doh
Deck of cards
Tambourine
Bowling/Dart game
Mask
Money
Phone
Compass/Walkie-talkie
Soldiers
Car
Animals/Dinosaurs/Bugs
Alligator/snake
Rope
Bop bag

Play Session 1

Identify three feelings your child expressed during your play session:

1. Feeling 1: _____
What child was doing when the feeling was noticed: _____
_____

2. Feeling 2: _____
What child was doing when the feeling was noticed: _____
_____

3. Feeling 3: _____
What child was doing when the feeling was noticed: _____
_____

4. Feeling 4: _____
What child was doing when the feeling was noticed: _____
_____

List three tracking responses you used during your playtime.

4. Child's behavior: _____
_____

My Response: _____
_____

5. Child's behavior: _____
_____

My Response: _____
_____

6. Child's behavior: _____
_____

My Response: _____
_____

QUIZ

Answer the following as either **True** or **False**.

_____ 1. You should answer children's questions.

_____ 2. Always praise creativity and freedom.

_____ 3. What a child doesn't do is as important as what the child does.

_____ 4. In play, children express what their lives are like now, what their needs are, or how they wish things could be.

_____ 5. It is not important what the child knows or believes.

_____ 6. Recognizing children's feelings can help them feel understood.

_____ 7. Children should be pushed so they can become something more in the future.

_____ 8. By simply noticing the child, the child's self-esteem will rise.

_____ 9. Children live in their minds, not their hearts.

_____ 10. You should solve children's problems for them so they learn how to solve them in the future.

_____ 11. If you think something is too difficult for a child, you should let the child know that they can't do it.

_____ 12. You should reflect questions back to the child.

_____ 13. Don't give children credit for making decisions because they might want more responsibility in the future.

_____ 14. What a child believes is very important.

_____ 15. You should be flexible in your time with you child.

Things to remember

1. Reflective responses can lessen anger.

2. What's important is not what the child knows, but what the child believes.

3. When you solve the problem for the child, you lose sight of the child.

4. Give children credit for making decisions: "You've decided to _____."

5. Today is enough. Don't push children toward the future.

6. One of the best things we can communicate to our children is that they are competent. Tell children they are capable and they will think they are capable. If you tell children enough times they can't do something, and sure enough, they can't.

7. In the play times, the older person is not the source of answers. Reflect questions back to the child.

8. Free the child. With freedom comes responsibility.

9. Noticing the child is a powerful builder of self-esteem.

10. Support the child's intent even if you can't support the child's behavior.

11. When we are flexible within our play time, we can handle surprises and emotions (such as anger) much more easily.

12. Questions imply non-understanding. Questions put people in their minds. Children live in their hearts.

13. Where there are no limits, there is no security.

14. In the play times, encourage creativity and freedom.

15. In play, children express what their lives are like now, what their needs are, or how they wish things could be.

16. What a child doesn't do is as important as what the child does.

APPENDIX D

DIBS IN SEARCH OF SELF MATERIALS

The following Dibs materials are compressed.

Dibs: In Search of Self

Prologue, Introduction, Chapters 1 and 2 (pages ix-32)   Name _____

1. What are your initial reactions to Dibs?
        1.
        2.
        3.

2. What problems are getting in the way of Dibs doing well in school?

3. Describe the behaviors she saw in the classroom?

4. Would you consider this behavior normal for a five-year-old child?

5. What did the author (Axline) tell Dibs as they entered the play room?

6. How is that similar to how you introduced the play area and toys to your PALee?

List some words you did not understand.

Dibs: In Search of Self

Chapters 3 through 5 (pages 32-60)   Name _____

1. Describe Dibs' mom.

2. What did you think of her?

3. How did the author respond to Dibs in the playroom?

4. How was what she did helpful?

5. How did that benefit the child?

6. What did the author hope Dibs would get from their time spent together?

7. What did Axline do to work toward her hopes/goals for Dibs?

8. Reread the last paragraph of page 46 through the end of the chapter.
Why is it important that Dibs not sense criticism from the author?

9. What would you have done differently from the author?

10. How is Dibs different from the first time he was in the playroom?

Dibs: In Search of Self

Chapters 6 through 8 (pages 60-93)   Name _____

1. How is what Axline stated on page 63 similar to how you interact with your PALee?
   I did not press him to tell me what he was thinking. I wanted him to experience more than a question-and-answer exercise. I wanted him to feel and experience his total self in our relationship—and not to confine it to any one kind of behavior. I wanted him to learn that he was a person of many parts, with his ups and downs, his loves and hates, his fears and courage, his infantile desires and his more mature interest. I wanted him to learn by experience the responsibility of assuming the initiative to use his capacities in his relationships with people. I did not want to direct it into any single channel by praise, suggestion, questions. I might miss completely the essence of this child's total personality if I jumped to any premature conclusions. (Axline, 1964, 63)

2. What are the two basic truths that Axline is trying to communicate through her play times with Dibs?

3. How did Dibs deal with his disappointment differently in chapter 7 than he had previously?

4. How does the father respond to Dibs? What kind of messages does that send to the child as compared to Axline's comments?

5. In what ways is Dibs like his parents?

6. What are some similarities between how Axline interacts with Dibs and his mother?

7. In chapter 8 Dibs' mom describes her experience with her son; how do you think that has affected Dibs?

8. How has your interactions with your PALee changed your ideas of kids?

9. At one point a psychiatrist told Dibs' parents that it was the parents that needed the help, not Dibs. Explain why you agree or disagree with this.

Dibs: In Search of Self

Chapters 9 through 12 (pages 94-127)   Name _____
Due: <u>Monday, April 17, 2000</u>

1. Describe how Dibs continues to change during the special play times.

2. How would you reflect the feelings that Dibs is singing about in chapter 9?

3. What is it about the special play time that he enjoys so much that he doesn't want to leave? The author uses many questions.

4. Write down three questions she uses and three reflections you would have made instead.
    1.
    Better response:
    2.
    Better response:
    3.
    Better response:

5. Why do you think Dibs had such strong negative feelings toward his father?

6. What was it about Dibs' father's parenting style that triggered such strong negative feelings in Dibs?

7. If you were Dibs' father, how would you treat Dibs that's different that how Dibs' father does? Give at least two specific examples.
    1.
    2.
    3.
    4.

8. Describe the types of people that Dibs feels the most connected to such as Miss. A and Jake.

9. How does Dibs act freer in Chapter 12 than he did prior to Chapter 12?

10. Why are material things not enough for a child to flourish and grow? What do you think are the most important non-tangible things that a parent can offer a child?

Dibs: In Search of Self

Chapters 13 through 15 (pages 127- 155)   Name _____
Due: <u>Wednesday, April 19, 2000</u>

1. When Dibs' put a big X on the calendar and said it is his most important day, why do you think that day was so important to him?

2. What feelings did Dibs' express through his play?

3. How have Dibs' mother's feelings changed?

4. How is Dibs relating to Miss A in the following passage:
   "You do not call me stupid, he said. I say help, you help. I say I don't know, you know. I say I can't, you can."

5. How does he perceive Miss A?

6. How is that different from how he perceives other adults in his life?

7. How did Dibs respond when Miss A gave him specific instructions regarding the scouring powder?

8. Why is it important to let kids discover things on their own?

9. How can you tell that Dibs is starting to himself?

10. What does Dibs say about his relationship with his father in chapter 15?

11. What is it about being in the play room with Miss A that makes him feel safe that he doesn't feel at his home?

12. What are the parents' expectations about the lamp that Dibs' expresses?

13. Do you believe these to be realistic expectations?

14. What has Miss A. shown him that has unlocked all the doors for Dibs?

Dibs: In Search of Self

Chapters 16 through 19 (pages 127- 155)   Name _____
Due: Friday, April 21, 2000

1. What was the reasoning behind Dibs' not talking?

2. How does Dibs act out his aggression?

3. What is it significant that Dibs begins talking in first person?

4. "In here it's all right to just be." How might this be similar to your PALee's experience in the special play time with you?

5. What didn't Dibs' mother like about her own parenting style?

6. How would she like to change her parenting style?

7. How does Dibs' behavior change at school?

8. What do you think Dibs dislikes the most about his father's parenting style?

9. What was it that changes Dibs' attitude toward his dad?

Dibs: In Search of Self

Chapters 20 through 24 (pages 189- 214)   Name_____
Due: <u>Monday, April 24, 2000</u>

1. How does Dibs now feel about his sister?

2. What resolution about his family did Dibs come to in the playroom?

3. What are the indicators that Dibs has matured?

4. What feelings is Dibs now exhibiting in his play?

5. How are those feelings different from his beginning play behaviors?

6. Explain what you think is important in Chapter 22?

7. What did Miss A say Dibs had learned about himself through the play sessions?

8. Why is it important for Dibs to say "Goodbye" to all of the playroom toys?

9. How have Dibs' family's interactions changed?

10. How did you, personally, feel as you read about Miss A's last interaction with Dibs (when they met on the street)?

11. Years later, Dibs remembers his special play time with Miss A. What do you hope your PALee will remember most about the special play times with you?

12. How do you think your special play times will impact your PALee in the future?

APPENDIX E

CONTACT INFORMATION FOR PEER ASSISTANCE

AND LEADERSHIP PROGRAM

P.A.L. Contact Information

P.A.L.s is a professional service of Workers Assistance Program.

Workers Assistance Program

3410 Far West Blvd., Suite 250

Austin, Texas 78731

512-343-9595

800-522-0550

Fax: 512-343-8558

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