

CHILD-CENTERED GROUP PLAY THERAPY

WITH CHILDREN EXPERIENCING

ADJUSTMENT DIFFICULTIES

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This research study investigated the effectiveness of child-centered group play therapy with children experiencing adjustment difficulties. Specifically, this study determined the effectiveness of child-centered group play therapy in: (a) improving self-concept, (b) reducing externalizing, internalizing, and overall behavior problems, (c) enhancing emotional and behavioral adjustment to the school environment, and (d) increasing self-control of kindergarten children experiencing adjustment difficulties. Also investigated were child-centered group play therapy effects on reducing parenting stress of the parents of kindergarten children experiencing adjustment difficulties.

The experimental group consisted of 15 kindergarten children who received one 40-minute child-centered group play therapy session per week, for twelve weeks. Group facilitators were play therapists who were doctoral students at the University of North Texas. The control group consisted of the 14 kindergarten students that had been assigned to the control group in Baggerly's (1999) study. Before the group play therapy sessions began and after termination of the sessions: the researchers administered the Joseph Pre-School and Primary Self-Concept Screening Test; parents completed the Child Behavior Checklist-Parent Report, Self-Control Rating Scale, Filial Problem Checklist, and Parenting Stress Index; and teachers completed the Child Behavior Checklist-Teacher Report, Early Childhood Behavior Scale, and Self-Control Rating Scale.

Although the general results of this study did not show statistically significant change due to child-centered group play therapy sessions, positive trends in the children's behavior, self-control, and self-concept were observed by the researcher, play therapists, and teachers. These trends and observations support the continued application of child-centered group play therapy with children experiencing adjustment difficulties.

Several factors may have contributed to the lack of statistical significance demonstrated within this study. These factors include a) a small sample size; b) the sample was drawn from only one school; c) a minimum of interactions between therapists and teachers, and therapists and parents; d) two unforeseen and unfortunate events; and e) pre-existing strength and resilience of the children comprising the control group.

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TABLE OF CONTENTS

LIST OF TABLES	v
Chapter	Page
I. INTRODUCTION	1
Statement of the Problem	6
Review of Related Literature	6
History of Play Therapy	6
Child-Centered Play Therapy	10
Play Therapy in Elementary School Settings	14
Group Play Therapy	18
Self-Concept	23
Externalizing and Internalizing Behaviors	26
Parenting Stress	27
Summary	29
II. METHODS AND PROCEDURES	30
Definition of Terms	30
Hypotheses	33
Instrumentation	35
Selection of Participants	42
Procedures	44
Collection of Data	46
Analyses of Data	47
III. RESULTS AND DISCUSSION	48
Results	48
Discussion	65
Self Concept	65
Behavior Problems	68
Parenting Stress	72
Self Control	73
Limitations	74
Implications	77
Recommendations	77

APPENDICES	
A. Teacher Selection Form	79
B. Play Therapy Information and Consent Form	82
C. Parent Consent and Child Consent Forms	85
REFERENCES	88

LIST OF TABLES

Table		Page
1.	Mean Total Scores on the Joseph Pre-School and Primary Self-Concept Screening Test	49
2.	Analysis of Covariance Data for the Mean Scores on the Joseph Pre-School And Primary Self-Concept Screening Test	49
3.	Mean Total Scores on the Child Behavior Checklist-Teacher Report	50
4.	Analysis of Covariance Data for the Mean Total Scores on the Child Behavior Checklist-Teacher Report	50
5.	Mean Externalizing Behavior Problems Subscale Scores for the Child Behavior Checklist-Teacher Report	51
6.	Analysis of Covariance Data for the Mean Scores on the Externalizing Behavior Problems Subscale of the Child Behavior Checklist-Teacher Report	52
7.	Mean Internalizing Behavior Problems Subscale Scores for the Child Behavior Checklist-Teacher Report	53
8.	Analysis of Covariance Data for the Mean Scores on the Internalizing Behavior Problems Subscale of the Child Behavior Checklist-Teacher Report	53
9.	Mean Total Scores on the Child Behavior Checklist-Parent Report	54
10.	Analysis of Covariance Data for the Mean Total Scores on the Child Behavior Checklist-Parent Report	54
11.	Mean Externalizing Behavior Problems Subscale Scores for the Child Behavior Checklist-Parent Report	55
12.	Analysis of Covariance Data for the Mean Scores on the Externalizing Behavior Problems Subscale of the Child Behavior Checklist-Parent Report	56
13.	Mean Internalizing Behavior Problems Subscale Scores for the Child Behavior Checklist-Parent Report	57

14.	Analysis of Covariance Data for the Mean Scores on the Internalizing Behavior Problems Subscale of the Child Behavior Checklist-Parent Report . . .	57
15.	Mean Total Stress Scores for the Parenting Stress Index	58
16.	Analysis of Covariance Data for the Mean Total Stress Scores on the Parenting Stress Index	58
17.	Mean “Parent Domain” Scores for the Parenting Stress Index	59
18.	Analysis of Covariance Data for the Mean Scores on the “Parent Domain” of the Parenting Stress Index	60
19.	Mean “Child Domain” Scores for the Parenting Stress Index	61
20.	Analysis of Covariance Data for the Mean Scores on the “Child Domain” of the Parenting Stress Index	61
21.	Early Childhood Behavior Scale - Total Score: Pre-test and Post-test Mean Scores and <i>t</i> -test Analysis Data	62
22.	Filial Problem Checklist: Pre-test and Post-test Mean Scores and <i>t</i> -test Analysis Data	63
23.	Self-Control Rating Scale (Teacher Report): Pre-test and Post-test Mean Scores and <i>t</i> -test Analysis Data	64
24.	Self-Control Rating Scale (Parent Report): Pre-test and Post-test Mean Scores and <i>t</i> -test Analysis Data	65

CHAPTER 1

INTRODUCTION

Children with adjustment difficulties attract considerable unwanted attention—unwanted by themselves, by teachers, and by caregivers. Moustakas (1997) stated that these children are often perceived as aggressive, moody, demanding, cruel, uncontrollable, anxious, depressed, isolated, silent, frightened, lazy, and indecisive. According to Pianta (1997), children must have emotional and social well being in order to succeed in school. Otherwise, their readiness for academic learning and achievement will be impaired.

The number of preschool children in the United States that were identified as developmentally delayed during the 1993/1994 school year exceeded 582,000 (National Center for Education Statistics, 1996). Mash and Dozois (1996) claimed that “many childhood problems have lifelong consequences for the child and for society; (also) most adult disorders are rooted in early childhood conditions and/or experiences” (p. 3). They also reported that “estimates of developmental, emotional, and behavioral disorders in children have ranged from 14% to 22% of all children” (p. 9). As indicated by Helmer and Laliberte (1987), children who later had adjustment difficulties, could be identified as having difficulties in their preschool years. Heller, Baker, Hanker, and Hinshaw (1996) indicated that emotional, cognitive, and behavioral problems seen in preschool children are reasonable predictors for similar problems during their following school year. Therefore, an appropriate strategy is needed to protect, preserve, and enhance young

children's emotional and social development and success, and to avert later, more serious problems.

Mash and Dozois (1996) also credited recent conditions and social changes for placing children at greater risk for developing adjustment difficulties and disorders, and for developing more severe problems at younger ages. These conditions and social changes that impact children's growth and development include single parenting, pressures of broken families, financial pressures, adjustment problems within immigrant families, maltreatment, drug and alcohol use in the family, prematurity, and HIV.

Due to the nature of elementary schools, demands are placed upon children to be socially appropriate with peers, teachers, and other adults. Children with adjustment difficulties often demonstrate behaviors that are perceived as socially inappropriate. Individual play therapy has been found to be beneficial in addressing the behaviors and symptoms seen in children with adjustment difficulties (Landreth, 1991). However, many schools lack the resources and personnel to individually address the number of children that face these challenges.

Group play therapy is a viable intervention for addressing the needs of children in a school setting who are experiencing adjustment difficulties. According to Landreth, Homeyer, Glover, and Sweeney (1996), individual as well as group play therapy has been correlated with young children's positive changes which include (a) externalizing behaviors such as aggression, impulsivity, and self-control; (b) internalizing behaviors such as depression, anxiety, and somatization; (c) academic performance; and (d) increases in self-esteem, self-concept, and self-confidence. Moustakas (1997) emphasized

that play therapy facilitates children's process of making positive behavioral, emotional, social, and self-regulating changes. He maintained that play therapy provides an opportunity for children to work out

disturbing feelings . . . (that may otherwise) lose their connection to reality, become distorted, and perhaps eventually seriously damage the child. Freed from these feelings . . . (children are) able to use their energies more effectively in personal and social interactions with other children and adults. (p. 81)

Frank and Zilbach (1968) stated that "since the beginning of mankind, children at the age of 5 or 6 have started to move away from the succor of their parents and to draw together to play and work in groups" (p. 447). Children in group play therapy have the opportunity to experience a positive relationship with an adult, as well as with peers. Social development, such as that which children experience in group play therapy, is essential to children's emotional well being and academic success.

Ginott (1994) identified several salient features that provide a rationale for group play therapy. The presence of multiple children facilitates the establishment of a desired relationship between each child and the therapist. Within group play therapy, children experience mutual stimulation of ideas and feelings, which bring profound insights to the surface. The children have the opportunity to teach each other and observe each other—accelerating their awareness of the permissiveness of the setting and freeing them to engage in an increased variety of activities. Multiple children also serve to tie the play therapy experience to the real world. A tangible social setting is created in which children

are able to discover and experiment with new and more appropriate ways to relate to their peers.

According to Landreth and Sweeney (1999) group play therapy enhances the therapeutic relationship by facilitating the following dimensions: a) entering a new experience is less threatening for a child if other children are present; b) the establishment of a desired relationship between the therapist and each child is facilitated; c) having other children present reduces tension, increases spontaneity, stimulates activity, and increases participation; d) every child can benefit by receiving help, as well as giving help; e) children's awareness of the permissiveness of the setting is accelerated; f) the children must reevaluate their own behavior in the light of peer reactions; g) a tangible social setting exists in which children can discover and practice new and more satisfying ways of relating with their peers; h) the presence of multiple children helps to tie the play therapy experience to the world of reality; i) children have the opportunity for vicarious and direct learning in such areas as problem solving and alternative behaviors; and j) the therapist has access to additional insight regarding how the child may be in other real-world settings.

Schaefer, Johnson, and Wherry (1982) stated that "all humans possess social hunger—an instinctive, affective need for human association—which can be gratified only through communion with other individuals, preferably with peers" (p. 1). Group therapy with children is the best available treatment for satisfying social hunger, while simultaneously creating an environment for improving other emotional difficulties. Schaefer et al. contend that group therapy is especially effective with children because it

complements normal developmental issues that enhance children's capacity for appropriate social interaction and intimacy. They also maintain that there is growing consensus that group therapy may be the treatment of choice for a majority of children who need emotional and psychological help.

For children with adjustment difficulties, group play therapy provides a safe environment to process difficult feelings and experiences, provides peer support, breaks a sense of isolation in coping with problems, and facilitates the process of recovery (Landreth et al., 1996). They stated that "group play therapy has been demonstrated to be effective in assisting children in developing interpersonal and intrapersonal skills as well as facilitating the processing of emotional issues" (p. 99). Children who participate in group play therapy improve how they display aggression and increase their ability for self-control, which results in enhanced self-confidence and self-esteem. The combination of play therapy and the dynamics of group-work help children gain a sense of control, feel empowered, and develop mastery of overwhelming emotions.

There is a lack of controlled and comparative experimental evidence to verify the effectiveness of group play therapy with young children. Additional studies are needed in order to evidence the efficacy of play therapy, specifically group play therapy, as a viable and even a necessary modality for treatment in many young children. Although group play therapy has enormous potential as a beneficial modality for treatment with young children, it is underutilized (Johnson, 1988).

Statement of the Problem

The problem with which this investigation was concerned was that of determining the effectiveness of child-centered group play therapy in enhancing self-concept, decreasing externalizing behavior problems, decreasing internalizing behavior problems, enhancing emotional and behavioral adjustment to the school environment, enhancing self-control, and reducing overall behavior problems in children experiencing adjustment problems. In addition, this study was designed to determine the effectiveness of child-centered group play therapy in reducing parenting stress for parents of children experiencing adjustment difficulties.

Review of Related Literature

The following is a synthesis of literature related to group play therapy with children. Areas addressed are: (a) history of play therapy, (b) child-centered play therapy, (c) play therapy in elementary school settings, (d) group play therapy, (e) self concept, (f) externalizing and internalizing behaviors, and (g) parenting stress.

History of Play Therapy

According to Landreth (1991), “play therapy developed from efforts to apply psychoanalytic therapy to children” (p. 26). Landreth credited Sigmund Freud with the first published account of psychological therapy being applied to a child. In 1909 Freud’s work with Little Hans involved giving the child’s father advice based upon one brief visit with the child, and the father’s notes describing the child’s play. Anna Freud (1946) and Melanie Klein (1932, 1955, 1982) continued the application of psychoanalytic theory to work with children and used play in obtaining, analyzing, and interpreting information

provided by children. They agreed that play was needed as a means for children to fully express themselves—that verbalizations alone were insufficient and unconscious material of children was revealed through their play. Thus, Freud and Klein substituted spontaneous play for free association. Schaefer and O'Connor (1983) stated that “whereas Anna Freud advocates using play mainly to build a strong, positive relationship between a child patient and the therapist, Melanie Klein (1932) proposed using it as a direct substitute for verbalizations” (p. 5). Freud emphasized the importance of play in establishing strong emotional attachment of the child with the therapist. She viewed the strong attachment as necessary in developing a strong transference in the child-therapist relationship, and analysis of this transference as essential for effective therapy. Klein used play as a communication medium, especially for providing interpretations to children. She viewed children as being able to realize that toys represent significant people and early relations with parents, and that feelings about the toys relate to these people. As children gained insight into the content of their emotions, they could restructure those feelings, revise early relations, and thereby decrease tension and anxiety.

During the 1930's several significant contributions were made toward the development of play therapy. Levy (1938, 1982) developed a structured play approach referred to as “release therapy” to help children recreate, through play, their experience of a specific traumatic event. According to Levy, a child that has security, support, and the right play materials is able to play out a previous traumatic event, over and over, until he or she is able to abreact or let go of the fears, anxieties, and responses related to the

trauma. Using play, the child is able to gain mastery and control within the event. In the original experience the child was done to, while in the re-enactment using play, the child is a doer. The child's role changes from a passive one to an active one.

Solomon (1938, 1940) developed "active play therapy" which was a method to be used with acting out and impulsive children. This approach was also based upon the rationale that abreaction can occur through the safety of play and a supportive relationship. A child can play out difficult feelings and experiences, and thereby avoid acting them out through socially inappropriate behaviors.

According to Schaefer and O'Connor (1983), several play therapy modalities developed in the 1930's can be

grouped together under the heading of 'relationship therapies.' The original philosophical basis for relationship therapy comes from the work of Otto Rank He deemphasized the importance of . . . past events in therapy and instead focused on the realities of the patient-therapist relationship and the patient's life in the here and now. (p. 6-7)

Taft (1933) and Allen (1939) emphasized the curative power of an accepting, caring, secure, and dynamic relationship between the child and the therapist, and used play as an important factor in establishing this relationship. In relationship therapy past history and unconscious material are de-emphasized, while the primary focus is on present feelings, reactions, and the relationship. Taft and Allen recognized the importance of permitting children the freedom to direct their own activities and make their own choices to free their inner capacity to positively alter their behavior.

Another major development in the field of play therapy involved Virginia Axline's (1969) adaptation of Carl Rogers' person-centered approach to children. Child-centered play therapy, which facilitates children's innate tendency toward self-actualization and positive growth, is addressed further in the following section.

During the 1960's, the establishment of counseling and guidance programs in elementary schools contributed significantly to the development of play therapy (Landreth, 1991). Use of play therapy in schools was encouraged in order to meet many developmental, social, preventive, and emotional needs of all children, as well as helping children who were identified as maladjusted. Numerous authors described their early success in using play therapy to address the developmental needs of children in elementary schools (Alexander, 1964; Landreth, 1972; Muro, 1968; Myrick and Holdin 1971; Nelson, 1966; and Waterland, 1970).

There have been several recent trends in the development of play therapy. The establishment of the Association for Play Therapy (APT) in 1982 was a major advancement in the field of play therapy (Landreth, 1991). The Center for Play Therapy, which has become the largest play therapy training program in the world, was established in 1988 on the campus of the University of North Texas. Numerous universities and other institutions also offer training programs and workshops, as well as masters and doctoral level courses and supervised practicum experiences. The use of play therapy concepts and procedures has also been extended into many other applications, such as family play therapy, filial therapy, adult play therapy, play therapy in hospitals, and play therapy with a multitude of diverse populations.

Child-Centered Play Therapy

Louise Guerney (1983) credits Virginia Axline as “the creator of child-centered or client-centered play therapy” (p. 21). Axline (1969) applied Carl Rogers' non-directive therapy principles to play therapy, and stated that non-directive (child-centered) play therapy is much more than a technique. Child-centered play therapy is based on a basic philosophy of human capacities, and emphasizes the capacity and innate tendency within the child to be self-directive. Axline stressed (a) the importance of the relationship between the child and the therapist, (b) the importance of the therapist’s acceptance of the child, (c) the therapist’s permissiveness with the child, and (d) the therapist’s reliance on the belief that the child has within self the ability “to be self-directive” and to become “the kind of a person that satisfies the self” (p. 26).

Axline (1969) clarified the child-centered approach and the dynamics of the child-therapist relationship in her eight basic principles:

1. The therapist must develop a warm, friendly relationship with the child, in which good rapport is established as soon as possible.
2. The therapist accepts the child exactly as he is.
3. The therapist establishes a feeling of permissiveness in the relationship so that the child feels free to express his feelings completely.
4. The therapist is alert to recognize the feelings the child is expressing and reflects those feelings back to him in such a manner that he gains insight into his behavior.

5. The therapist maintains a deep respect for the child's ability to solve his own problems if given an opportunity to do so. The responsibility to make choices and to institute change is the child's.
6. The therapist does not attempt to direct the child's actions or conversation in any manner. The child leads the way; the therapist follows.
7. The therapist does not attempt to hurry the therapy along. It is a gradual process and is recognized as such by the therapist.
8. The therapist establishes only those limitations that are necessary to anchor the therapy to the world of reality and to make the child aware of his responsibility in the relationship. (p. 73-74)

Child-centered play therapy, according to Landreth (1991):

is a complete therapeutic system . . . and is based on a belief in the capacity and resiliency of children . . . (who) are quite capable of appropriately directing their own growth . . . (when) granted the freedom to be themselves in the process of playing out feelings and experiences. (p. 55)

Landreth also maintains that "the child's behavior is at all times caused by the drive for complete self-realization. The objectives of child-centered play therapy are self-awareness and self direction by the child" (p. 32).

DeMaria and Cowden (1992) stressed that "in client-centered play therapy, a therapist treats the child with respect, acceptance, sincerity, honesty, patience, sensitivity, and steadiness" (p. 53). Lockwood and Harr (1973) proposed that the relationship between a child and a nurturing adult is the most important factor in facilitating the

child's emotional growth. Barber and Olsen (1997) contended that children who experience the child-centered play therapy characteristics of (a) a consistent, positive, and significant relationship, (b) consistent and fair limits, (c) being valued as a person, and (d) permissiveness and acceptance, are more likely to meet the basic needs of healthy human development—socialization, self-concept, love, acceptance, and self-control. Moustakas (1997) credited the child-centered therapist's high level of acceptance with enhancing the child's own resources and self-esteem. This is because the child is provided with the freedom to make choices and direct one's life. "Only in a relationship in which the child is accepted and cherished as a lovable, whole person will he or she be able to recover a real self" (p. 8).

In Axline's (1964) classic case study of five-year-old Dibs, child-centered play therapy was demonstrated to have profound benefits. Prior to the onset of play therapy, Dibs had exhibited a variety of challenging behaviors including severe withdrawal, mutism, crawling around the classroom floor, and violent temper tantrums. He also displayed occasional moments of superior intelligence. Through the process of child-centered play therapy, Dibs demonstrated significant and positive changes including improved social interaction with his teacher and classmates, appropriate expression of negative and positive emotions, happier affect, cessation of temper tantrums, and improved classroom performance.

The effectiveness of child-centered play therapy was also observed by Axline (1948) in a case study of a five-year-old boy with extremely withdrawn behavior. This child received 45-minute play therapy sessions, once a week, and after ten weeks of

therapy, the child appeared less tense, demonstrated improvement in alertness, increased verbal communication, and improved social interaction.

In Colbert's (1971) case study, a nine-year-old girl from an unstable and inconsistent home entered therapy as an angry, destructive, negative, and defiant child, who had felt completely rejected. This child received 55-minute child-centered play therapy sessions twice a week for seven months. With the child-centered play therapy intervention, the child learned to acknowledge and accept her anger, relate to others, and feel liked, accepted, and understood.

Gorman (1972) reported on her case study of a 10-year-old boy who exhibited dissociative, bizarre, and problematic behaviors. This child received two child-centered play therapy sessions per week for twenty weeks. The child exhibited positive progress including improved communication skills, ability to claim his own behaviors, and mastery of certain motor skills.

Oalline (1975) conducted a study of child-centered play therapy with preschool children who had impaired hearing. Her research design involved 24 children who were randomly assigned to either a treatment or control group. The experimental group received 50-minute play therapy sessions, once a week, for ten weeks. Children in the experimental group showed statistically significant increases in mature behavior patterns, as compared to the control group. Parents and teachers also reported positive behavior changes in these children.

Barlow, Strother, and Landreth, (1985) found child-centered play therapy to be effective in helping a four-year-old child with behavior problems overcome such issues

as thumb sucking, temper tantrums, and hair pulling that was so severe that it led to baldness.

Significant benefits of intensive child-centered play therapy with child witnesses of domestic violence were reported by Kot (1995). She used a pre-test post-test control group design with children aged 3-10 who resided in domestic violence shelters. The experimental group received twelve 45-minute play therapy sessions within a period of two weeks. Kot's study found the children in the experimental group showed significant improvement in self-concept, externalizing behavior problems, total behavior problems, play behaviors of physical proximity, and play themes as compared to the control group.

Play Therapy in Elementary School Settings

Landreth (1987) stated that "play therapy in the elementary school is considered to be a vital and integrated part of the total educational process" (p. 260). Play therapy in schools facilitates emotional, physical, intellectual, and social development in children. Through play therapy and the safety provided by unconditional positive regard in the therapeutic relationship, children are able to express pent-up emotions and modify perceptions of themselves and the world. The lack of emotional threats experienced in the therapeutic relationship frees children to move toward resolution of behavioral, emotional, and social difficulties, and thus, toward academic success (Landreth, 1987).

Bishop (1971) reported that play therapy is an integral part of the methods elementary school counsellors employ in their work with school children Learning cannot occur without full participation on the part of the learner. Children need to be involved with their hands, ideas,

feelings and elbows Hence methods used by counsellors should provide structures from which activities take on new perspectives and feelings have new meanings. (p. 41)

School counselors can effectively use play therapy to help children with numerous developmental problem areas. Research has consistently verified that play therapy in the schools enhances the learning potential and academic performance of children. One of the earliest studies of the use of play therapy in an elementary school setting was by Axline (1947), who investigated the application, by teachers, of play therapy concepts and procedures with second-grade underachieving readers. For four months, the children were encouraged to interact on a one-to-one basis with the teacher, while the teacher responded to the individual children based on child-centered procedures such as respecting and accepting the child, focusing on the child, and validating the child's feelings. Axline observed significant improvement in reading skills. In addition, four children received eight individual play therapy sessions that were provided once a week for 30 minutes. Of these four children, three showed significant increases in IQ scores.

Bills (1950) studied the effectiveness of child-centered play therapy with third-graders who had been identified as slow learners with underdeveloped reading skills. Children in the treatment group received six individual and three group play therapy sessions. As compared to a control group, the children in the treatment group exhibited significant increases in reading performance.

A case study was conducted by Schiffer (1957) of group play therapy with three emotionally disturbed children in an elementary school setting. One-hour sessions were provided once a week for two years. The three boys exhibited improved classroom behavior, happier affect, decreased truancy, and better interactions with teachers and classmates.

Alexander (1964) studied the effects of child-centered play therapy in a school setting with a child exhibiting adjustment difficulties. He reported that the process of play therapy led toward growth and self-actualization in the child, and the child's ability to establish a close, trusting relationship. Also, the child was able to transfer the experience of this relationship with the therapist to everyday life and relationships outside of the playroom. The child developed increased levels of self-control through his experience of appropriate limits that regulated his behavior. Also, the impact of the therapist-child relationship on the child resulted in the child becoming a catalyst in an enhanced teacher-child relationship.

The effect of child-centered play therapy on retained first grade children in an elementary school setting was studied by Crow (1989). Twenty-four children were divided between an experimental group and a control group. The children in the experimental group participated in 30-minute child-centered individual play therapy sessions, once a week, for ten weeks. After treatment, children in the experimental group scored significantly higher on self-concept when compared to the control group.

Azar (1979) studied the effects of one play therapy session each week and one reading enrichment session each week for three months on second through fifth grade

children who had been identified as having poor self-concept and low reading achievement. The sample consisted of 40 children who were randomly assigned to either an experimental group or a control group. She found that concurrent 50-minute play therapy and reading enrichment sessions resulted in significant increases in self-concept and reading achievement.

Research was conducted in a school environment by Gould (1980) to examine the effects of nondirective (child-centered) group play therapy and discussion groups with elementary school children. Children in the play therapy and discussion groups demonstrated statistically significant improvement in self-concept as compared to a control group, with the greatest increase reported by the children who participated in the child-centered group play therapy. Gould reported that the school setting provides a unique opportunity for children to experience significant mental health benefits. Children are able to interact with peers in group play therapy, while learning and practicing new social skills in a controlled setting—resulting in enhanced self-concept.

Quayle (1991) studied the effects of school-based individual play therapy sessions with five- to nine-year-old elementary school children, who had exhibited adjustment difficulties. Children in the experimental group received twenty 30-minute play therapy sessions. As compared to children in control and comparison groups, children in the experimental group exhibited the most positive growth in such areas as self-confidence, interactive participation, social skills, task orientation, and learning skills.

Group Play Therapy

In group play therapy, children are able to learn about themselves because they are allowed to communicate with play, their natural language. Children also learn about themselves as they perceive the regard of the therapist and other children toward them. They learn the importance of individuality and uniqueness, cooperation and compliance, creativity and originality. For many children, a play therapy group may provide the closest experience to family structure and acceptance as is possible (Sweeney & Homeyer, 1999).

Group play therapy may be the chosen treatment modality for many reasons. According to Ginott (1994), the presence of more than one child in therapy facilitates the establishment of a therapeutic relationship between the therapist and each child because interacting with the therapist is less threatening and much safer with other children present. Each child can learn by observing the interactions between the therapist and other group members. The group experience also helps children learn to assume responsibility in peer relationships, which helps to anchor the therapy experience to reality.

Berg, Landreth, and Fall (1998) concluded that, unlike individual therapy, the focus in group therapy with children shifts from intrapersonal processes to interpersonal interactions and processes, and children are able to learn and practice new relationship skills. In addition, children have the opportunity to both receive and give help—helping others is self-healing and greatly enhances self-concept.

Ginott (1994) maintained that children in group play therapy benefit from the many opportunities for vicarious learning, wherein they learn about themselves by learning about others. As children better understand others in the group, they better understand themselves. By watching another child in an activity, children can more easily muster the courage to attempt similar and new activities. Children also benefit from group play therapy by discovering that their peers have problems too, which reduces barriers caused by feeling completely alone (Berg et al., 1998). Identification with the group can take place and the children are able to develop a sense of belonging.

The group format facilitates anchoring the play therapy experience to the world of reality. Learning about permissiveness within the setting is accelerated (Ginott, 1994). In addition, Sweeney (1997) reported that limit setting and reality testing occur between group members, and not only between the therapist and individual children. Group play therapy provides a concrete and safe environment in which the child can observe, learn, experiment with, and practice new ways of being and interacting with peers. By observing the children's interactions within the group play therapy experience, the therapist is better able to gain insight into how the children are in the real world (Landreth & Sweeney, 1999).

Fleming and Snyder (1947) described nondirective (child-centered) play therapy as a permissive, free play environment in which the therapist encourages the expression of feelings, with his or her main function involving the reflection of those feelings. They proposed that a primary difference between group and individual play therapy involves the therapist's choices of responses. "With the group, instead of having one child's

feelings to recognize and respond to, he (the therapist) has three or four. He may respond either to what he perceives to be the outstanding feeling of a child at the moment, or to several feelings at once” (p. 104).

According to Slavson, Thau, Tandler, and Gabriel (1949), the interactions between children, selected play materials, and trained therapists help to enhance children's self-esteem, self-control, and self-confidence. DeMaria and Cowden (1992) reported that, in group play therapy, therapeutic benefits are generated by all of the group members as well as by the therapist.

Johnson (1988) reported that play therapy group members, through identification with the group, increased their comfort levels in interacting with peers and improved peer interaction. She stated that group play therapy provides children with the additional benefits of “experimentation with reality, expression of excess energy, a form of mastery, the discharge of aggression and intense anxiety (and it) stimulates the growth of self-expression” (p. 108).

Abramowitz (1976) reviewed empirical outcomes related to a variety of children’s therapy groups. Included in the outcomes of play therapy groups were increased nonverbal IQ, increased vocabulary, increased maturity as judged by teachers, improved reading, improved grades, improved attitude toward school, improved social attitudes, reduced anxiety, increased leadership skills, increased popularity, and improved self-concept.

Fleming and Snyder (1947) studied the effects of nondirective (child-centered) group play therapy with children selected from a children’s home. Children in the

experimental group participated in child-centered group play therapy sessions, once a week, for twelve weeks. Fleming and Snyder concluded that (a) the group play therapy sessions resulted in favorable changes in adjustment; (b) therapeutic limit setting was beneficial to the results of group play therapy; (c) paints, water, and baby bottles were effective media for the expression of emotions; (d) the establishment of rapport with children in the 10 year old age range was likely to be influenced by the therapist's gender; and (e) "for best therapeutic effect, the children in group should not vary too greatly in degree or intensity of maladjustment" (p. 116).

Schiffer (1967) conducted a study of the effects of group play therapy with boys between the ages of nine and eleven years. Sessions were provided once a week for five months. Schiffer found that the children who participated in group play therapy demonstrated stabilized peer relations as compared to control and comparison groups. In addition, the children that did not participate in group play therapy exhibited increased social maladjustment.

House (1970) conducted a study of nondirective (child-centered) group play therapy with twelve second-grade children who were identified as under-chosen on a sociometric test. Thirty-six children were randomly assigned to one experimental group and two control groups. The experimental group was divided into two groups of six children, who participated in twenty 30-minute sessions during a period of ten weeks. He found that the children in the play therapy groups demonstrated significant increases in self-concept as compared to the children in the control groups.

Pelham (1972) studied the effectiveness of group play therapy with kindergarten children who had been identified by their teachers as being socially immature. Three groups of three children received six to eight 45-minute group play therapy sessions. Eight children received six to eight 45-minute individual play therapy sessions. Eighteen children were placed in the control group. Pelham found that the children who participated in the play therapy sessions developed more complex self-concepts and demonstrated greater improvement in classroom behavior, than did children in the control group. There were no significant differences between the children who received group play therapy and those who received individual play therapy.

Thombs and Muro (1973) investigated the effects of relationship group play therapy with twelve second-grade children. The play therapy groups met for 30 minutes each day, for fifteen consecutive school days. Thombs and Muro found that the children in the play therapy groups showed greater improvement in social behaviors as compared with a control group of children who did not participate in group play therapy.

A study comparing individual and group play therapy with child victims of sexual abuse was conducted by Perez (1987). Fifty-five children between the ages of four and nine years were divided among (a) a group that received individual play therapy, (b) a group that participated in group play therapy, and (c) a control group. The children who received group play therapy participated in twelve weekly group play therapy sessions. Three to five children were assigned to each play therapy group. The children who received group play therapy exhibited significant improvements in self-concept and self-mastery as compared to the control group.

Tyndall-Lind (1999) compared the effects of intensive group play therapy and intensive individual play therapy on child witnesses of domestic violence. The participants in her study were ten children who received twelve 45-minute sibling group play therapy sessions provided daily, within a period of two weeks. Data collected from her study was compared to Kot's (1995) study of intensive individual play therapy with child witnesses of domestic violence. Both studies were compared to a wait list control group. Tyndall-Lind found that the children who received intensive sibling group play therapy demonstrated significantly greater improvement on self-concept, behavior problems, externalizing behaviors, aggressive behaviors, internalizing behaviors, anxiety, and depression as compared to the control group. There were no significant differences between intensive individual play therapy and intensive group play therapy.

Self-concept

DeMaria and Cowden (1992) defined self-concept in a social context, and proposed that self-esteem is based upon one's beliefs about how others think of him or her.

Self concept broadens the scope of self esteem (It) is a learned perceptual system involving a feedback loop that influences behavior and is in turn changed by behavior (Thus) changes in the self concept cannot be made directly, but must be accomplished through the experience and activity of the person him/herself. (p. 57)

According to Rogers (1961), the person is viewed as being able to move from maladjustment toward health and he or she is at the center of an ever-changing world of

experience. Through interactions with others and perceptions of their regard, the children develop a sense of self or self-concept. Over time, this self-concept becomes unified into a structure of self—an organized, fluid, consistent pattern of perceptions, behaviors, and interactions with others.

DeMaria and Cowden (1992) contend that a positive self-concept is based on one's belief that he or she is "wanted, liked, valued, and healthy" (p. 57). A child is likely to develop a positive self-concept if he or she perceives that warmth, respectful treatment, and clearly defined limits are communicated by significant caregivers. Changes in self-concept are not made directly, but rather through the child's experiences based on his or her perceptions of others and the environment. Self-concept is a process of perceiving and learning that involves environmental feedback and influences behavior. Therefore, as children experience positive regard in group play therapy—from the therapist and other group members—positive changes can be made to their own self-concept.

Every person has an innate tendency toward growth and actualization. Mature behavior is more rewarding for people than immature behavior (Axline, 1969). Play provides a medium for the therapist to exhibit unconditional positive regard, acceptance, empathic understanding, and congruence. In the absence of emotional threats, the child is able to face new experiences, process what is learned, and revise his or her self-concept and structure of self (Landreth, 1991). The child-centered play therapist creates and maintains an environment, in both individual and group play therapy, wherein the child can feel valued, appreciated, nurtured, respected, and safe.

Self-concept can be enhanced through the relationship established within child-centered play therapy. Axline (1969) indicated that, in play therapy, the child experiences genuine warmth, caring, respect, and acceptance from the therapist. The child feels safe and senses permissiveness within the therapist-child relationship. The child has the freedom to experience self-control, to act responsibly, to be the leader, and to be self-directed. Also, the child experiences only those therapeutic limits that help the child accept personal responsibility and appropriate relationship responsibility. Through the experience of these relationship qualities, the child is able to develop and enhance a positive self-concept.

According to Axline (1955), group play therapy is a means for children to experience self-discovery, self-understanding, self-respect, and a sense of positive self-worth. The therapist ensures that the group is emotionally safe for the children, which provides the means for them to explore themselves in a safe social context, experience a variety of social situations, experience regard from others, and develop relationship skills. Through these safe interactions children can examine, modify, and enhance their self-concept. Children develop self-concept and beliefs about themselves based upon interactions and relationships with parents, siblings, peers, teachers, and other school personnel. The child-centered group play therapy experience can thus have tremendous impact on the emotional well-being, academic performance, appropriate behavior, and self-concept.

Children experience opportunities for self-exploration, self-growth, and enhanced self-concept through group play therapy (Sweeney, 1997). The therapist maintains an

environment of permissiveness, acceptance, mutual respect, and overall emotional safety. Group members can achieve insight into themselves as they evaluate and reevaluate themselves in the light of therapist and peer feedback. Thus, by using this safe environment, the responses and reactions of group members, and play, children are able to reduce defenses, explore self, experiment with new behaviors, realize the power within themselves, learn to trust their own abilities, and experience enhanced self-concept.

Child-centered group play therapy provides opportunities for children to do things for themselves and experience successes and mastery. Such experiences contribute to the development of a positive self-concept (Landreth, 1991). In addition, Berg et al. (1998) report that children in group therapy have the opportunity to receive help, as well as, “receive a tremendous boost to their self-concept through being helpful to someone else” (p. 258).

Externalizing and Internalizing Behaviors

Externalizing behaviors are those behaviors that are outwardly manifested and typically can be observed visually (Albano, Corpita, & Barlow, 1996). Examples of externalizing (problem) behaviors are aggression, hyperactivity, impulsivity, inappropriate running or talking, noisiness, distractibility, and inattentiveness.

Internalizing behaviors are those that occur within the child, and are likely to be associated with the child’s emotions. According to Albano et al. (1996), “children with internalizing disorders, however, suffer for the most part in silence and are not easily identified as problematic” (p. 198). Examples of internalizing (problem) behaviors include depression, fears and phobias, somatic complaints, withdrawal, and anxiety.

According to Mash and Dozois (1996), most adult disorders can be traced back to childhood problems, conditions, and experiences. Bowlby (1969, 1980) has contended that children that do not develop secure social and emotional bonds have increased likelihood of developing lifelong personality, emotional, behavioral, and relationship disorders, as well as physical health problems.

Radke-Yarrow, Cummings, Kuczynski, and Chapman, (1985) reported that behavior problems are also known to aggregate in families and be transmitted from one generation to the next. Significantly higher frequencies of psychopathology have been reported among children of families with mood and behavioral disorders as compared to children of families without these problems. As reported by Zahn-Waxler, Cummings, McKnew, and Radke-Yarrow (1984), children of families with mood and behavior problems often show increased difficulties in sharing, helping their peers, and maintaining friendly social interactions, as well as maladaptive patterns of aggression toward adults and peers. Thus, there is an intergenerational transmission of behavioral and mood problems. Children that do not experience basic needs of acceptance, warmth, attention, love, permissiveness, and appropriate limit setting are likely to grow up and pass their problems on to their children.

Parenting Stress

All children require considerable commitment, effort, and acceptance on the part of their parents. Children that exhibit unwanted behaviors, especially externalizing behaviors, are often met with a reduced amount of acceptance from their parents. This is largely due to the fact that parents of children with academic, behavioral, and adjustment

problems experience larger amounts of parenting stress than do parents of children without these difficulties (Breen & Barkley, 1988).

According to Baker (1994), parents of children who exhibit externalizing behaviors such as impulsivity, hyperactivity, and aggression, experience greater amounts of parenting stress than do parents of children who do not exhibit these behaviors. Solnit and Stark (1961) reported that, unfortunately, parents often perceive their child as defective, and grieve the loss of the hopes and dreams they had for their child. Heller et al. (1996) reported that parenting stress levels could be used as reasonable predictors of their children's externalizing behaviors. Greater levels of parenting stress tend to increase externalizing behaviors in their children and greater levels of externalizing behaviors in children tend to increase stress in parenting. Clearly, these are interrelated and reciprocal. Hinshaw and Anderson (1996) stated that

parent-child interaction(s) display moderate to strong relationships with children's aggressive and antisocial behavior What emerges is a pattern of harsh, ultimately unsuccessful interchanges between parent and child Such mutual training in aversive responding fuels both aggressive child behavior and greater levels of harsh, nonresponsive parenting Aversive interchanges serve to intensify aggressive behavior outside the home and to precipitate a widening array of negative consequences for the child and family, including risk for academic underachievement and peer rejection. (p. 138)

Family members are also likely to experience depression and stress, and the child is likely to exhibit increasing levels of externalizing behaviors.

Summary

Individual play therapy and group play therapy are effective modalities that promote children's emotional, intellectual, social, behavioral, and academic development. Children with adjustment difficulties tend to develop low self concepts, with related unwanted behaviors. These children also tend to experience considerable conflict in their relationships with peers as well as adults. Typically, children's externalizing behaviors are socially inappropriate and interfere with successful interactions with others. Children with adjustment difficulties often perceive themselves as being rejected by adults and by their peers. This frequently leads to the development of poor self-concepts, as the children identify themselves as "outcasts" or "failures." Group play therapy provides an opportunity for children to experience acceptance from peers, learn social skills, resolve difficulties within an accepting environment, and utilize play which is their natural medium for communication.

Although the process of group play therapy presents positive potential, this therapeutic medium is underutilized; perhaps because of the lack of comparative experimental research to verify the effectiveness of group play therapy.

CHAPTER 2

METHODS AND PROCEDURES

The purpose of this study was to determine if child-centered group play therapy was effective in: 1) enhancing self-concept in children experiencing adjustment difficulties; 2) decreasing externalizing behavior problems in children experiencing adjustment difficulties; 3) decreasing internalizing behavior problems in children experiencing adjustment difficulties; 4) enhancing emotional and behavioral adjustment within the school environment for children experiencing adjustment difficulties; 5) enhancing self-control in children experiencing adjustment difficulties; and 6) reducing parental stress in parents of children experiencing adjustment difficulties. This chapter provides a definition of terms, hypotheses, instrumentation, selection of subjects, collection of data, procedures, and statistical analysis.

Definition of Terms

Adjustment difficulties were defined as problems that interfere with a child's adjustment to school, classroom experiences, and learning opportunities. Examples of adjustment difficulties include depression, anxiety, withdrawal, inattentiveness, impulsivity, phobias, excessive shyness, and grief reactions to life changes such as a recent move, death of a family member, or parental divorce.

Emotional and behavioral adjustment to the school environment refers herein to behaviors related to success in the school setting. Such behaviors include the ability to remember and follow instructions, attempt new assignments, work independently, solve

problems, interact appropriately with adults and peers, and conform to socially appropriate behavior patterns. For the purpose of this study, emotional and behavioral adjustment to the school environment was operationally defined as the score on the Early Childhood Behavior Scale (McCarney, 1994).

Externalizing behaviors were defined as problematic behaviors that are outwardly undercontrolled, delinquent, and disruptive. Examples include impulsiveness, hyperactivity, inattentiveness, and aggressiveness. For the purpose of this study, externalizing behaviors were operationally defined as the score on the Externalizing Behavior Problems subscale of the Child Behavior Checklist (CBCL) (Achenbach, 1991).

Group Play Therapy refers herein to a psychological and social process involving peer interactions, interactions with a trained play therapist, and child-centered play therapy principles to implement social, emotional, and behavioral changes. Children are able to utilize selected play materials to play out issues of concern and fully express thoughts, feelings, and experiences (Sweeney & Homeyer, 1999).

Internalizing behaviors were defined as problematic inward manifestations of emotional difficulties. Examples include depression, anxiety, withdrawal, phobias, and somatic complaints. For the purpose of this study, internalizing behaviors were operationally defined as the score on the Internalizing Behavior Problems subscale of the Child Behavior Checklist (CBCL) (Achenbach, 1991).

Overall behavior problems refer herein to wide variety of problems that children frequently experience and can greatly effect the demands of parenting and parenting stress. Such behaviors include overeating, bedwetting, excessive crying, inattentiveness,

restlessness, bad dreams, aggressiveness, and disobedience. For the purposes of this study, overall behavior problems were operationally defined as the score on the Filial Problem Checklist (Horner, 1974).

Parenting stress was defined as the stress related to the parent-child relationship, as perceived by the parent. For the purpose of this study, parenting stress was operationally defined as the parents' scores on the Parenting Stress Index (PSI) (Abidin, 1983).

Play Therapy refers herein to the application of child-centered play therapy concepts and procedures, and has been defined by Landreth (1991) as

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)

Self-concept was defined as the attitude, belief, and feelings that a child has about himself or herself, and how the child values his or her own worth. For the purpose of this study, self-concept was operationally defined as the score on the Joseph Pre-school and Primary Self-concept Screening Test (Joseph, 1979).

Self-control was defined as the degree to which behavior could be described as self-controlled as compared to impulsive. Observed behaviors that indicated the degree of self-control included patience, persistence, attentiveness, impulsivity, dependability, and

quality of work. For the purpose of this study, self-control was operationally defined as the score on the Self-Control Rating Scale (Kendall & Wilcox, 1979).

Hypotheses

To carry out the purposes of this study, the following hypotheses were formulated:

1) The kindergarten children in the experimental group will attain a significantly higher mean total score on the Joseph Pre-School and Primary Self-Concept Screening Test (JPPSST) post-test than will the children in the control group.

2) The kindergarten children in the experimental group will attain a significantly lower mean total score on the Child Behavior Checklist-Teacher Report (CBC-Teacher Report) post-test than will the children in the control group.

2a) The kindergarten children in the experimental group will attain a significantly lower mean score on the Externalizing Behavior Problems subscale of the Child Behavior Checklist-Teacher Report (CBCL-Teacher Report) post-test than will the children in the control group.

2b) The kindergarten children in the experimental group will attain a significantly lower mean score on the Internalizing Behavior Problems subscale of the Child Behavior Checklist-Teacher Report (CBCL-Teacher Report) post-test than will the children in the control group.

3) The kindergarten children in the experimental group will attain a significantly lower mean total score on the Child Behavior Checklist-Parent Report (CBCL-Parent Report) post-test than will the children in the control group.

3a) The kindergarten children in the experimental group will attain a significantly lower mean score on the Externalizing Behavior Problems subscale of the Child Behavior Checklist-Parent Report (CBCL-Parent Report) post-test than will the children in the control group.

3b) The kindergarten children in the experimental group will attain a significantly lower mean score on the Internalizing Behavior Problems subscale of the Child Behavior Checklist-Parent Report (CBCL-Parent Report) post-test than will the children in the control group.

4) The parents of the kindergarten children in the experimental group will attain a significantly lower mean total score on the Parenting Stress Index (PSI) post-test than will the parents of children in the control group.

4a) The parents of the kindergarten children in the experimental group will attain a significantly lower mean total score on the “Parent Domain” of the Parenting Stress Index (PSI) post-test than will the parents of children in the control group.

4b) The parents of children in the experimental group will attain a significantly lower mean total score on the “Child Domain” of the Parenting Stress Index (PSI) post-test than will the parents of children in the control group.

5) The kindergarten children in the experimental group will attain a significantly lower mean total score on the Early Childhood Behavior Scale (ECBS) post-test than they attained on the pre-test.

6) The kindergarten children in the experimental group will attain a significantly lower mean total score on the Filial Problem Checklist (FPC) post-test than they attained on the pre-test.

7) The kindergarten children in the experimental group will attain a significantly lower mean total score as rated by their teachers on the Self-Control Rating Scale (SCRS) post-test than they attained on the pre-test.

8) The kindergarten children in the experimental group will attain a significantly lower mean total score as rated by their parents on the Self-Control Rating Scale (SCRS) post-test than they attained on the pre-test.

Instrumentation

Joseph Pre-School and Primary Self-Concept Screening Test (JPPSST)

The Joseph Pre-School and Primary Self-Concept Screening Test (JPPSST), developed by Joseph (1979), was designed to measure the self-concept of children. It was originally designed for preschool children, and was later modified to include children in upper grade levels.

The JPPSST can be used with children in the age range of three years, six months to nine years, eleven months. The JPPSST does not require the child to have reading or verbal skills, it requires minimal training of the examiner, and it requires minimal time in its administration.

When administering the JPPSST, pictures are presented to each child to stimulate responses. The child first identifies the pictures as representing himself or herself. He or she then describes activities and feelings associated with each picture. The test

administrator rates the child's self-concept on a global index scale of zero to 30, based on these responses by the child.

Reliability of the JPPSST was established using a test-retest sample which produced a reliability coefficient of .87. The Kuder-Richardson 20 formula estimated the internal consistency to be within the range of .59 to .81, with a median correlation coefficient of .73. Correlation coefficients indicated that each item contributes significantly to the overall test performance. Construct validity was established by correlating the Global Self Concept Scores of the JPPSST with the Self Concept Judgment Scale at a .51 significance at a .01 level of confidence (Joseph, 1979).

Child Behavior Checklist (CBCL)

The Child Behavior Checklist Parent Report Form (CBCL-Parent Report) was developed to identify behavior and emotional difficulties in children who are within the age range of four to eighteen years (Achenbach, 1991). It is categorized as a self-administered test that takes approximately 20 minutes and requires a fifth grade reading level to complete. The CBCL-Parent Report is comprised of 113 items that have been factor analyzed into nine subscales—Withdrawn, Somatic Complaints, Anxious/Depressed, Social Problems, Thought Problems, Attention Problems, Delinquent Behaviors, Aggressive Behaviors, and Sex Problems. Second-order factor analysis revealed two primary factors represented by the Externalizing Behavior Problems and Internalizing Behavior Problems Subscales. A score for Total Problem Behavior can also be computed. Percentiles and T-scores can be computed for each factor and subscale.

This checklist was designed to identify and measure behavioral symptoms of children as perceived by their parents or surrogates. Lower total and subscale scores indicate a greater number of positive behaviors, or fewer negative behaviors, as observed by parents.

Content validity of the CBCL-Parent Report was established at the .01 level of significance, wherein all items were significantly related to clinical status. Criterion-related validity was supported by the ability to effectively discriminate between demographically matched referred and non-referred children.

Reliability was established using test-retest, inter-rater, and internal consistency methods. Test-retest reliability was established at a .89 level for Internalizing Behavior Problems and .93 for Externalizing Behavior Problems. Scaled scores were evaluated after two years to establish long-term stability, which were calculated at the .70 level for Internalizing behaviors and .86 for Externalizing behaviors. Scores for children who were receiving mental health services were observed to have generally lower scores, which indicates the CBCL-Parent Report is sensitive to the effects of treatment.

Inter-rater reliability was established at the .959 level. Intraclass correlations demonstrated a high level of reliability between raters, and indicated that scores for each item were relative to each of the other items.

Internal consistency was established by using Cronbach's alpha which was calculated for boys at a .89 level for Internalizing behaviors, and .93 for Externalizing behaviors. For girls, Cronbach's alpha was calculated at .90 for Internalizing behaviors,

and .93 for Externalizing behaviors. The age range for boys and girls was four to eleven years.

The Child Behavior Checklist Teacher Report Form (CBCL-Teacher Report) is based on the parent report for items, with modifications to appropriately reflect behaviors observed at school (Achenbach & Edelbrock, 1986). Twenty-five of the items on the CBCL-Teacher Report are different from items on the CBCL-Parent Report to reflect areas specific to teachers. Ninety-three of the items are the same, except some items have the word “pupils” substituted for the word “children.”

The Total Behavior Scale was factor analyzed, based on forms completed for 1,700 children who had been referred for mental health or special school services, which resulted in the following eight subscales: Withdrawn, Somatic Complaints, Anxious/Depressed, Social Problems, Thought Problems, Attention Problems, Delinquent Behaviors, and Aggressive Behaviors. A second-order factor analysis revealed two primary factors, referred to as the Externalizing Behavior Problems and Internalizing Behavior Problems Subscales. In addition, a Total Problem Behavior score can be computed. Percentiles and T-scores can be computed for each factor and subscale.

The CBCL-Teacher Report has been shown to discriminate between referred and non-referred children (Achenbach & Edelbrock, 1986) and correlate highly with scales of the Conners Teacher Rating Scale, which measures externalizing behavior problems (Baggerly, 1999; Edelbrock, Greenbaum, & Conover, 1985).

This checklist was designed to identify and measure behavioral symptoms of children as perceived by their teachers. Lower total and subscale scores indicate a greater number of positive behaviors, or fewer negative behaviors, being observed by teachers.

Early Childhood Behavior Scale (ECBS)

The ECBS (McCarney, 1997) was developed to identify and document specific behaviors of two to six-year-old children which are indicative of being emotionally disturbed or behaviorally disordered in school environments. This assessment is completed by the children's teachers and the scores are organized into three subscales: Academic, Social Relationships, and Personal Adjustment.

Test-retest reliability was established at a .88 level for the Academic subscale, .81 for the Social Relationships subscale, .91 for the Personal Adjustment subscale, and .86 for the Total score. A substantial degree of inter-rater reliability was established for all ages at the .01 level with correlation coefficients ranging from .81 to .88 with an average of .85. Internal consistency was established with the Kuder-Richardson 20 formula. The reliabilities of each of the subscales were at or above .90. Criterion-related validity was determined with coefficients exceeding the .001 level with subscales on the CBCL.

Filial Problem Checklist (FPC)

The Filial Problem Checklist was developed by Horner in 1974 to identify and assess a wide variety of problems that children frequently experience (Bratton, 1994; Harris, 1995). The instrument is self-administered by the children's parents or primary caregivers, who rate their perception of the child related to 108 potentially problematic situations and child behaviors that greatly effect the demands of parenting and parenting

stress. Parents are to consider each potential situation or behavior, and, for any items that apply to their child, they are to score these with a 1, 2, or 3. A one indicates that the situation or behavior applies to the child, but is not really a problem. A two signifies that the situation or behavior applies to the child, and is perceived to be a moderate problem. A three means that the item applies to the child, and is perceived to be a severe problem. Higher scores on the instrument reflect a greater number and severity of existing or potential problems, as perceived by parents or primary caregivers. The FPC has been used as a means to compare the results obtained from other instruments and studies involving filial therapy, play therapy, and parent dynamics. There are no available normative statistics concerning the validity or reliability of this instrument. However, the FPC has been used extensively in studies at the University of North Texas, and at Pennsylvania State University.

Self-Control Rating Scale (SCRS)

The SCRS (Kendall & Wilcox, 1979) was designed to measure the degree to which school-aged children's behaviors can be considered to be self-controlled, as opposed to impulsive. Based on a cognitive-behavioral model of self-control, the SCRS was developed due to a lack of instruments to assess children's self-control and children's behavior changes related to treatment. The 33-item instrument is self-administered by observers who rate the children, on a scale from one to seven, in such areas as impulsivity, dependability, quality of work, attentiveness, patience, and persistence. The SCRS is scored by summing item scores, with lower scores reflecting greater self-control.

Test-retest reliability has been determined with a correlation of .84, and internal consistency has an alpha of .98. Very good construct validity was evidenced by significant correlations, or a lack of specific correlations, in predicted directions with the Peabody Picture Vocabulary Test, Porteus Maze, Matching Familiar Figures, and observer ratings (Kendall & Wilcox, 1979).

Parenting Stress Index (PSI)

The PSI was developed by Abidin (1983) to measure the stress related to the parent-child relationship, as perceived by the parent. This instrument is easy to administer, requires minimal directions, and can be completed in approximately 20 minutes. It is divided into Child and Parent Domains. The Child Domain is comprised of the following subscales that identify sources of parental stress: the child's acceptability to the parent, the child's demandingness, the child's moodiness, the child's distractibility, the child's adaptability, and the child's reinforcement of the parent's role. The Parent Domain is comprised of the following subscales: parent's sense of competence, parent attachment, restriction imposed by the parenting role, parent's sense of isolation, parental depression, relationship with spouse, and the parent's health. Higher subscale and total scores indicate higher levels of the parent's stress and negatively perceived behaviors of the child.

A high degree of internal consistency was established with alpha reliability coefficients calculated at .89 for the Child Domain, .93 for the Parent Domain, and .95 for the Total score. Reliability of the PSI was established with the test-retest method.

Calculated coefficients were .778 for the Child Domain, .69 for the Parent Domain, and .88 for the Total score.

Selection of Participants

Participants in this current study included the kindergarten children that had been assigned to the control group in Baggerly's (1999) study. These children were students in a public elementary school in a school district in North Texas. The children were identified by teachers and/or parents as having school adjustment difficulties as evidenced by withdrawn, anxious, inattentive, depressed, or shy behavior, or who were experiencing significant life changes such as divorce of parents, a new sibling, or moving. The kindergarten teachers referred children in their classrooms who met the criteria on the Teacher Selection Form (See Appendix A).

All parents of kindergarten children at this public elementary school received a Filial Problem Checklist (FPC), and were instructed to complete the instrument by marking the items that are currently problematic for their family (Baggerly, 1999). The parents of children referred by teachers and parents of children that scored above 20 on the FPC received a packet with intake and consent forms and information about the purpose and confidentiality of the study (See Appendix B). Baggerly selected 30 children whose families granted permission to participate in her study based on the following criteria:

- (a) the family must expect that the child will remain in the school through December 1998,

- (b) the primary caregivers must be able to read, write, and speak the English language,
- (c) the primary caregivers must be able to complete pre-tests and post-tests,
- (d) neither the participants nor their primary caregivers will already be in counseling,
- (e) the participants and their primary caregivers must both agree to participate in 20-minute play sessions, with a trained fifth grade student, once a week, for ten weeks, and
- (f) the parent or legal guardian must sign the consent form that addresses pre-test and post-test videotaping.

Baggerly (1999) initially assigned fifteen children to her control group. However, one child was excluded from her study because the child required immediate assistance from the school counselor. The children in the control group were assured of receiving play therapy at the conclusion of Baggerly's study, and parental consent for the children to participate in a follow-up play therapy study was obtained. For additional assurance, the identified children took letters home to their legal guardians. These letters included a basic description of play therapy, assurance of confidentiality, and a place for signature that acknowledged informed consent and granted permission to participate in the study. Informed consent of all participants and their guardians was obtained prior to the beginning of this study. The children were asked to sign or make their mark if they agreed to participate. Copies of both the guardian consent form and the child consent form are attached (See Appendix C).

After Baggerly (1999) had assigned children to her experimental and control groups, teachers and parents referred several additional kindergarten children to her program based on the above criteria. After completion of Baggerly's study, the school counselor assigned one of these children to the experimental group of this current study. Also, at the request of the school counselor, five of these children were assigned to play therapy groups, although assessments were not completed for these children.

The experimental group for this current study was comprised of fifteen kindergarten children, aged five and six year old. Nine of these children were girls and six were boys. Twelve of the children were Caucasians, two were African Americans, and one was Latino.

Procedures

The 15 participants in this study and five additional children referred by the school counselor were assigned to ten play therapy groups consisting of two children each. Two of the groups included two girls each, three of the groups included two boys each, and five of the groups included one girl and one boy. Assignment to groups was based upon the convenience of a schedule for the sessions, developed by the elementary school principal, the school counselor, the kindergarten teachers, and the group facilitators. This schedule was designed in a manner to adhere to school policy and minimize the disruption of academic instruction and other school activities. The child-centered group play therapy sessions of this study began approximately ten weeks following post-testing for Baggerly's (1999) research.

The children participated in one 40-minute child-centered group play therapy

session per week, for twelve weeks. Group play therapy sessions were conducted within the elementary school, in a portable classroom building utilized as an overflow classroom. This room was divided into two play therapy areas by long tables and cardboard partitions. For three weeks the portable classroom was unavailable, and group play therapy sessions were held backstage in the auditorium. This location was similarly divided into two play therapy areas.

The child-centered group play therapy sessions were facilitated by the researcher and three other play therapists who, at the time of the study, a) were doctoral students at the University of North Texas, b) had completed at least one graduate level play therapy course, c) had completed or were in the process of completing an advanced play therapy course which included supervised child-centered play therapy experience, and d) had completed or were in the process of completing a doctoral level counseling practicum which also included supervised child-centered play therapy experience. The play therapists met each week in peer supervision to ensure the consistent application of child-centered play therapy principles and practices.

Play materials utilized in the group play therapy sessions were selected based upon Landreth's (1991) recommendations for play therapy travel kits. Materials included (a) creative expressive media such as crayons, Play-Do, Nerf balls, hand puppets, costume jewelry, scissors, Legos, and paper, (b) real-life items such as a doll house, doll family, a baby doll, a nursing bottle, plastic dishes, a telephone, a small car, and a small plane, and (c) aggressive release materials such as an inflatable punching (bop) bag, a dart gun, handcuffs, a rubber knife, and toy soldiers.

Collection of Data

This study of child-centered group play therapy utilized an own-control group design. The data collected about these children while they comprised the experimental group was compared to the data collected about them as they represented the control group in the Baggerly (1999) study. Baggerly collected post-test data from the parents, who completed the CBCL-Parent Report and PSI; from the teachers, who completed the CBCL-Teacher Report; and from the children, who were administered the JPPSST by the researchers. The post-test data from Baggerly's study was used as pre-test data in this study. Additional pre-test data was obtained from the parents, who completed the FPC and SCRS, and from the teachers, who completed the ECBS and SCRS. Immediately following the 12 weeks of group play therapy sessions, the CBCL-Parent Report, PSI, CBCL-Teacher Report, FPC, SCRS, ECBS, and JPPSST were again administered to obtain post-test data for this study.

Tables presenting the results of this study in the following chapter indicate varying sample sizes. This is due to the unavailability of scores for some of the children, on some of the assessments. Although the experimental group was originally comprised of 15 children, two of the children moved without prior notice, before the post-test assessments were completed. Three additional parents failed to complete and return some, or all, of the post-test instruments, although JPPSST post-tests and teachers' post-test assessments were able to be completed. Despite persistent effort and follow-up by the researcher, complete post-test data was unavailable from the parents of these five

children in the experimental group. For one child in the control group, parent assessment data was unavailable on the PSI and the CBCL-Parent Report.

Analyses of Data

After collection of the post-test assessments from the children, their teachers, and their parents, the instruments were blind-scored on the computer by the researcher and checked for accuracy by a research assistant.

Analysis of covariance (ANCOVA) was performed to test the significance of differences between control group and experimental group data, based on the adjusted post-test means for each of the hypotheses. The post-test specific in each hypothesis was used as the dependent variable, and the pre-test was used as the covariate. ANCOVA was applied to adjust the group means of the post-test data on the basis of the pre-test data, and thus statistically equate the control and experimental groups. Significance of the differences between the means was tested, and based on ANCOVA the related hypotheses were either retained or rejected. Additional data about the experimental group was collected using the ECBS, FPC, and SCRS assessments, which were not utilized in the Baggerly (1999) study. Therefore, data from these instruments was analyzed using a one group, pre-test/post-test design. A *t*-test was applied to test the significance of the differences between the means of the repeated measures. Based on the data provided by the *t*-tests, the corresponding hypotheses were either retained or rejected.

CHAPTER 3

RESULTS AND DISCUSSION

The purpose of this chapter is to present the results of the analyses of data related to each of the hypotheses of this study. Findings regarding the instruments used, instrument subscales, ANCOVA, and *t*-tests are included. Also presented is a discussion of the results, implications, and interpretations, along with recommendations for further research.

Results

Results of this study are provided in the order in which the hypotheses were presented. Analyses of variance are presented on each of the hypotheses. A .05 level of significance was established as the criterion for retaining or rejecting each hypothesis.

Hypothesis 1

The kindergarten children in the experimental group will attain a significantly higher mean total score on the Joseph Pre-School and Primary Self-Concept Screening Test (JPPSST) post-test than will the children in the control group.

Table 1 presents the pre-test and post-test means and standard deviations for the experimental and control groups. Table 2 presents the analysis of covariance data, showing the significance of difference between the experimental and control groups' post-test mean scores.

Table 1.

Mean Total Scores for the Joseph Pre-School and Primary Self-Concept Screening Test (JPPSST)

	<u>Experimental (n = 13)</u>		<u>Control (n = 14)</u>	
	Pre-test	Post-test	Pre-test	Post-test
Mean	24.6923	26.4615	24.7857	25.5714
<u>SD</u>	4.5348	2.5038	5.2062	4.7184
Total Cases = 27				

Note. An increase in mean scores implies an increase in self-concept.

Table 2.

Analysis of Covariance Data for the Mean Total Scores on the Joseph Pre-School and Primary Self-Concept Screening Test (JPPSST)

Source of Variation	Sum of Squares	df	Mean Square	<u>F</u> Ratio	Sign. of <u>F</u>	Effect Size	Power
Group	5.652	1	5.652	.425	.521	.017	.096
Total Cases = 27							

Table 2 shows the F ratio for the main effects was not significant at the < .05 level indicating there was not a significant difference between the experimental group and the control group's self-concept as measured by the JPPSST. On the basis of this data, hypothesis 1 was rejected.

Hypothesis 2

The kindergarten children in the experimental group will attain a significantly lower mean total score on the Child Behavior Checklist-Teacher Report (CBCL-Teacher Report) post-test than will the children in the control group.

Table 3 presents the pre-test and post-test means and standard deviations for the experimental and control groups. Table 4 presents the analysis of covariance data, showing the significance of difference between the experimental and control groups' post-test mean scores.

Table 3.

Mean Total Scores for the CBCL-Teacher Report

	<u>Experimental (n = 13)</u>		<u>Control (n = 14)</u>	
	Pre-test	Post-test	Pre-test	Post-test
Mean	51.1538	49.0769	44.2143	49.5000
<u>SD</u>	9.9737	11.5792	14.5029	9.2632
Total Cases = 27				

Table 4.

Analysis of Covariance Data for the Mean Total Scores on the CBCL-Teacher Report

Source of Variation	Sum of Squares	Df	Mean Square	<u>F</u> Ratio	Sign. of <u>F</u>	Effect Size	Power
Group	31.830	1	31.830	.312	.582	.013	.084
Total Cases = 27							

Table 4 shows the F ratio for the main effects was not significant at the $< .05$ level indicating there was not a significant difference between the experimental group and the

control group's mean total score as measured by the CBCL-Teacher Report. On the basis of this data, hypothesis 2 was rejected.

Hypothesis 2a

The kindergarten children in the experimental group will attain a significantly lower mean score on the Externalizing Behavior Problems subscale of the Child Behavior Checklist-Teacher Report (CBCL-Teacher Report) post-test than will the children in the control group.

Table 5 presents the pre-test and post-test means and standard deviations for the experimental and control groups. Table 6 presents the analysis of covariance data, showing the significance of difference between the experimental and control groups' post-test mean scores.

Table 5.

Mean Externalizing Behavior Problems Subscale Scores for the CBCL-Teacher Report

	<u>Experimental (n = 13)</u>		<u>Control (n = 14)</u>	
	Pre-test	Post-test	Pre-test	Post-test
Mean	51.2308	52.8462	49.4286	50.2143
<u>SD</u>	9.9428	10.8155	17.0371	9.0058
Total Cases = 27				

Table 6.

Analysis of Covariance Data for the Mean Scores on the Externalizing Behavior

Problems Subscale of the CBCL-Teacher Report

Source of Variation	Sum of Squares	Df	Mean Square	F Ratio	Sign. of F	Effect Size	Power
Group	26.376	1	26.376	.349	.560	.014	.088
Total Cases = 27							

Table 6 shows the F ratio for the main effects was not significant at the $< .05$ level indicating there was not a significant difference between the experimental group and the control group's externalizing behaviors as measured by the CBCL-Teacher Report. On the basis of this data, hypothesis 2a was rejected.

Hypothesis 2b

The kindergarten children in the experimental group will attain a significantly lower mean score on the Internalizing Behavior Problems subscale of the Child Behavior Checklist-Teacher Report (CBCL-Teacher Report) post-test than will the children in the control group.

Table 7 presents the pre-test and post-test means and standard deviations for the experimental and control groups. Table 8 presents the analysis of covariance data, showing the significance of difference between the experimental and control groups' post-test mean scores.

Table 7.

Mean Internalizing Behavior Problems Subscale Scores for the CBCL-Teacher Report

	<u>Experimental (n = 13)</u>		<u>Control (n = 14)</u>	
	Pre-test	Post-test	Pre-test	Post-test
Mean	49.6154	51.6154	43.7143	48.2143
<u>SD</u>	8.4906	10.1451	15.5436	7.2130
Total Cases = 27				

Table 8.

Analysis of Covariance Data for the Mean Scores on the Internalizing Behavior Problems Subscale of the CBCL-Teacher Report

Source of Variation	Sum of Squares	Df	Mean Square	<u>F</u> Ratio	Sign. of <u>F</u>	Effect Size	Power
Group	28.648	1	28.648	.399	.534	.016	.093
Total Cases = 27							

Table 8 shows the F ratio for the main effects was not significant at the $< .05$ level indicating there was not a significant difference between the experimental group and the control group's internalizing behaviors as measured by the CBCL-Teacher Report. On the basis of this data, hypothesis 2b was rejected.

Hypothesis 3

The kindergarten children in the experimental group will attain a significantly lower mean total score on the Child Behavior Checklist-Parent Report (CBCL-Parent Report) post-test than will the children in the control group.

Table 9 presents the pre-test and post-test means and standard deviations for the experimental and control groups. Table 10 presents the analysis of covariance data, showing the significance of difference between the experimental and control groups' post-test mean scores.

Table 9.

Mean Total Scores for the CBCL-Parent Report

	<u>Experimental (n = 10)</u>		<u>Control (n = 13)</u>	
	Pre-test	Post-test	Pre-test	Post-test
Mean	47.3000	46.3000	52.6154	48.7692
<u>SD</u>	10.0890	8.8700	9.4564	9.6709
Total Cases = 23				

Table 10.

Analysis of Covariance Data for the Mean Total Scores on the CBCL-Parent Report

Source of Variation	Sum of Squares	df	Mean Square	<u>F</u> Ratio	Sign. of <u>F</u>	Effect Size	Power
Group	15.779	1	15.779	.539	.471	.026	.108
Total Cases = 23							

Table 10 shows the F ratio for the main effects was not significant at the $< .05$ level indicating there was not a significant difference between the experimental group and the control group's mean total score as measured by the CBCL-Parent Report. On the basis of this data, hypothesis 3 was rejected.

Hypothesis 3a

The kindergarten children in the experimental group will attain a significantly lower mean score on the Externalizing Behavior Problems subscale of the Child Behavior Checklist-Parent Report (CBCL-Parent Report) post-test than will the children in the control group.

Table 11 presents the pre-test and post-test means and standard deviations for the experimental and control groups. Table 12 presents the analysis of covariance data, showing the significance of difference between the experimental and control groups' post-test mean scores.

Table 11.

Mean Externalizing Behavior Problems Subscale Scores for the CBCL-Parent Report

	<u>Experimental (n = 10)</u>		<u>Control (n = 13)</u>	
	Pre-test	Post-test	Pre-test	Post-test
Mean	49.3000	48.000	51.0769	49.1538
<u>SD</u>	8.6030	8.8569	11.5648	10.0486
Total Cases = 23				

Table 12.

Analysis of Covariance Data for the Mean Scores on the Externalizing Behavior Problems Subscale of the CBCL-Parent Report

Source of Variation	Sum of Squares	Df	Mean Square	F Ratio	Sign. of F	Effect Size	Power
Group	.352	1	.352	.014	.907	.001	.051
Total Cases = 23							

Table 12 shows the F ratio for the main effects was not significant at the $< .05$ level indicating there was not a significant difference between the experimental group and the control group's externalizing behaviors as measured by the CBCL-Parent Report. On the basis of this data, hypothesis 3a was rejected.

Hypothesis 3b

The kindergarten children in the experimental group will attain a significantly lower mean score on the Internalizing Behavior Problems subscale of the Child Behavior Checklist-Parent Report (CBCL-Parent Report) post-test than will the children in the control group.

Table 13 presents the pre-test and post-test means and standard deviations for the experimental and control groups. Table 14 presents the analysis of covariance data, showing the significance of difference between the experimental and control groups' post-test mean scores.

Table 13.

Mean Internalizing Behavior Problems Subscale Scores for the CBCL-Parent Report

	<u>Experimental (n = 10)</u>		<u>Control (n = 13)</u>	
	Pre-test	Post-test	Pre-test	Post-test
Mean	46.7000	43.000	49.7692	47.9231
<u>SD</u>	10.6463	8.7686	8.9550	9.6907
Total Cases = 23				

Table 14.

Analysis of Covariance Data for the Mean Scores on the Internalizing Behavior Problems

Subscale of the CBCL-Parent Report

Source of Variation	Sum of Squares	df	Mean Square	<u>F</u> Ratio	Sign. of <u>F</u>	Effect Size	Power
Group	39.490	1	39.490	1.041	.320	.049	.163
Total Cases = 23							

Table 14 shows the F ratio for the main effects was not significant at the $< .05$ level indicating there was not a significant difference between the experimental group and the control group's internalizing behaviors as measured by the CBCL-Parent Report. On the basis of this data, hypothesis 3b was rejected.

Hypothesis 4

The parents of the kindergarten children in the experimental group will attain a significantly lower mean total score on the Parenting Stress Index (PSI) post-test than will the parents of children in the control group.

Table 15 presents the pre-test and post-test means and standard deviations for the experimental and control groups, regarding the total stress scores on the Parenting Stress Index (PSI). Table 16 presents the analysis of covariance data, showing the significance of difference between the experimental and control groups' post-test mean scores.

Table 15.

Mean Total Stress Scores for the Parenting Stress Index (PSI)

	<u>Experimental (n = 10)</u>		<u>Control (n = 13)</u>	
	<u>Pre-test</u>	<u>Post-test</u>	<u>Pre-test</u>	<u>Post-test</u>
Mean	187.7000	169.1000	204.9231	199.5385
<u>SD</u>	32.8500	31.3881	41.5742	37.1475
Total Cases = 23				

Table 16.

Analysis of Covariance Data for the Mean Total Stress Scores on the Parenting Stress Index (PSI)

<u>Source of Variation</u>	<u>Sum of Squares</u>	<u>df</u>	<u>Mean Square</u>	<u>F Ratio</u>	<u>Sign. Of F</u>	<u>Effect Size</u>	<u>Power</u>
Group	2297.932	1	2297.932	2.925	.103	.128	.370
Total Cases = 23							

Table 16 shows the F ratio for the main effects was not significant at the $< .05$ level indicating there was not a significant difference between the experimental group and the control group's total stress score as measured by the PSI. On the basis of this data, hypothesis 4 was rejected.

Hypothesis 4a

The parents of the kindergarten children in the experimental group will attain a significantly lower mean total score on the “Parent Domain” of the Parenting Stress Index (PSI) post-test than will the parents of children in the control group.

Table 17 presents the pre-test and post-test means and standard deviations for the experimental and control groups, regarding the “Parent Domain” scores on the Parenting Stress Index (PSI). Table 18 presents the analysis of covariance data, showing the significance of difference between the experimental and control groups’ post-test mean scores.

Table 17.

Mean “Parent Domain” Scores for the Parenting Stress Index (PSI)

	<u>Experimental (n = 10)</u>		<u>Control (n = 13)</u>	
	Pre-test	Post-test	Pre-test	Post-test
Mean	105.2000	95.6000	111.2308	110.7692
<u>SD</u>	22.5033	21.8235	24.6852	25.3875
Total Cases = 23				

Table 18.

Analysis of Covariance Data for the Mean Scores on the “Parent Domain” of the Parenting Stress Index (PSI)

Source of Variation	Sum of Squares	Df	Mean Square	F Ratio	Sign. of F	Effect Size	Power
Group	628.029	1	628.029	2.369	.139	.106	.311
Total Cases = 23							

Table 18 shows the F ratio for the main effects was not significant at the $< .05$ level indicating there was not a significant difference between the experimental group and the control group’s mean “Parent Domain” score as measured by the PSI. On the basis of this data, hypothesis 4a was rejected.

Hypothesis 4b

The parents of children in the experimental group will attain a significantly lower mean total score on the “Child Domain” of the Parenting Stress Index (PSI) post-test than will the parents of children in the control group.

Table 19 presents the pre-test and post-test means and standard deviations for the experimental and control groups, regarding the “Child Domain” scores on the Parenting Stress Index (PSI). Table 20 presents the analysis of covariance data, showing the significance of difference between the experimental and control groups’ post-test mean scores.

Table 19.

Mean “Child Domain” Scores for the Parenting Stress Index (PSI)

	<u>Experimental (n = 10)</u>		<u>Control (n = 13)</u>	
	<u>Pre-test</u>	<u>Post-test</u>	<u>Pre-test</u>	<u>Post-test</u>
Mean	82.5000	83.5000	93.6923	88.7692
<u>SD</u>	14.3391	22.0719	18.6565	15.1281
Total Cases = 23				

Table 20.

Analysis of Covariance Data for the Mean Scores on the “Child Domain” of the Parenting Stress Index (PSI)

<u>Source of Variation</u>	<u>Sum of Squares</u>	<u>Df</u>	<u>Mean Square</u>	<u>F Ratio</u>	<u>Sign. Of F</u>	<u>Effect Size</u>	<u>Power</u>
Group	28.620	1	28.620	.133	.720	.007	.064
Total Cases = 23							

Table 20 shows the F ratio for the main effects was not significant at the $< .05$ level indicating there was not a significant difference between the experimental group and the control group’s mean “Child Domain” score as measured by the PSI. On the basis of this data, hypothesis 4b was rejected.

Hypothesis 5

The kindergarten children in the experimental group will attain a significantly lower mean total score on the Early Childhood Behavior Scale (ECBS) post-test than they attained on the pre-test.

Table 21 presents the pre-test and post-test means and standard deviations, along with the *t*-test analysis data, showing the significance of difference between the pre-test and post-test mean scores.

Table 21.

Early Childhood Behavior Scale (ECBS) - Total Score: Pre-test and Post-test Mean Scores and *t*-test Analysis Data

Pre-test Mean	Post-test Mean	Pre-test <u>SD</u>	Post-test <u>SD</u>	<i>t</i>	df	Significance of <i>t</i>
49.2667	42.6667	30.2075	35.7385	3.000	14	.010
N = 15		N = 15				

Table 21 shows the *t*-test was significant to the .010 level indicating there was a significant difference between the pre-test and post-test mean total scores on the ECBS. On the basis of this data, hypothesis 5 was retained.

Hypothesis 6

The kindergarten children in the experimental group will attain a significantly lower mean total score on the Filial Problem Checklist (FPC) post-test than they attained on the pre-test.

Table 22 presents the pre-test and post-test means and standard deviations, along with the *t*-test analysis data, showing the significance of difference between the pre-test and post-test mean scores.

Table 22.

Filial Problem Checklist (FPC): Pre-test and Post-test Mean Scores and *t*-test Analysis

Data

Pre-test Mean	Post-test Mean	Pre-test <u>SD</u>	Post-test <u>SD</u>	<i>t</i>	df	Significance of <i>t</i>
46.6364	39.9091	53.1719	47.2450	.634	10	.541
N = 11		N = 11				

Table 22 shows the *t*-test was not significant at the .05 level indicating there was not a significant difference between the pre-test and post-test mean scores on the FPC.

On the basis of this data, hypothesis 6 was rejected.

Hypothesis 7

The kindergarten children in the experimental group will attain a significantly lower mean total score as rated by their teachers on the Self-Control Rating Scale (SCRS) post-test than they attained on the pre-test.

Table 23 presents the pre-test and post-test means and standard deviations, along with the *t*-test analysis data, showing the significance of difference between the pre-test and post-test mean scores.

Table 23.

Self-Control Rating Scale (Teacher Report): Pre-test and Post-test Mean Scores and *t*-test

Analysis Data

Pre-test Mean	Post-test Mean	Pre-test <u>SD</u>	Post-test <u>SD</u>	<i>t</i>	df	Significance of <i>t</i>
101.2000	98.7333	53.5660	44.1159	.439	14	.668
N = 15		N = 15				

Table 23 shows the *t*-test was not significant at the .05 level indicating there was not a significant difference between the pre-test and post-test mean total scores on the SCRS (Teacher Report). On the basis of this data, hypothesis 7 was rejected.

Hypothesis 8

The kindergarten children in the experimental group will attain a significantly lower mean total score as rated by their parents on the Self-Control Rating Scale (SCRS) post-test than they attained on the pre-test.

Table 24 presents the pre-test and post-test means and standard deviations, along with the *t*-test analysis data, showing the significance of difference between the pre-test and post-test mean scores.

Table 24.

Self-Control Rating Scale (Parent Report): Pre-test and Post-test Mean Scores and *t*-test

Analysis Data

Pre-test Mean	Post-test Mean	Pre-test <u>SD</u>	Post-test <u>SD</u>	<i>t</i>	df	Significance of <i>t</i>
101.1818	95.5455	34.4320	35.2516	1.558	10	.150
N = 11		N = 11				

Table 24 shows the *t*-test was not significant at the .05 level indicating there was not a significant difference between the pre-test and post-test mean total scores on the SCRS (Parent Report). On the basis of this data, hypothesis 8 was rejected.

Discussion

The results of this study along with facilitator’s observations and teachers’ comments provide information regarding the adjustment of kindergarten children who received child-centered group play therapy sessions. Of the fourteen hypotheses presented, only one was retained and the other thirteen were rejected. However, several of the measures of this study showed trends, although not at statistically significant levels. An explanation of these results is discussed in the following section.

Self-Concept

The children of the experimental group showed no significant improvement as measured by the Joseph Pre-School and Primary Self-Concept Screening Test (JPPSST). Scores for both experimental and control groups increased between the pre-test and post-test. Although, there was greater increase in the scores of the experimental group, this

observation could be due to chance or normal variability. Numerous therapist observations and teacher comments suggested that most of the children in the experimental group showed increased self-confidence, improved interpersonal relationships, improved comfort in social situations, and increased autonomy. These characteristics are representative of improved self-concept (Joseph, 1979).

For example one therapist described “Janie,” who was referred to the play therapy program due to shy, withdrawn, and quiet behaviors. She rarely spoke to anyone, rarely smiled, would quickly avert her eyes rather than meeting another person’s gaze, and would withdraw quickly at any hint of conflict. During the course of the group play therapy, Janie became more relaxed around others with frequent smiling, increased verbalizations, and extended eye contact. During later sessions, she exhibited appropriately assertiveness with such comments as “No, you can’t take this paper, I’m drawing on it” and “Please don’t mess up the furniture in the doll house again.”

Early in the program, “Austin” was described by a teacher as “always clinging” to her and refusing to engage in activities with the other children. Following the seventh group play therapy session, Austin was described as demonstrating much greater involvement with peers, initiated activities with others, and appeared to no longer need the teacher’s close proximity.

Several possible explanations exist for the discrepancy between statistical results and observations by teachers and therapists. Actual change, as measured by the JPPSST, may not be revealed due to the small sample size. A larger sample size would likely provide greater variability and sources of variance to uncover observed differences. As in

the other instruments utilized in this study, low power resulted from the small sample size, which reduced the chances that statistical significance would be discovered, if a significant difference truly existed.

Late in the treatment program, two of the children in the experimental group abruptly moved without prior notice. The researcher was required to create a new group with the remaining group members, for the final three sessions. The resulting upheaval could have added to the children's adjustment difficulties near the time of post-testing, leading to scores that did not reflect existing improvement in self-concept and other adjustment characteristics.

Baggerly (1999) reported that the children in her control group (who later comprised the experimental group of this study) were not referred for treatment with a similar sense of urgency as the children in her experimental group. She proposed that, as compared to her experimental group, the children in the control group demonstrated less intense adjustment difficulties and higher self-concept as observed by the children's parents and teachers. The school counselor also confirmed that the children perceived to have greater behavioral concerns were assigned to the experimental group. Therefore, the children with fewer adjustment difficulties were assigned to the control group—and subsequently to the experimental group of this study. In addition, the sample was derived from one public elementary school and a typical, middle class, demographic pool of North Texas.

Consequently, these children likely began both studies with typical low levels of stressors and challenges to their overall adjustment, resulting in positive levels in the

characteristics being measured, with less room to grow. Differences between scores at different measurement points could simply have reflected normal levels of variability in perceived emotions, behaviors, and self-concept.

Behavior Problems

Experimental group children exhibited no significant improvement in behavior problems as measured by the CBCL-Teacher Report, CBCL-Parent Report, and FPC. However, analysis of ECBS scores, teacher comments, and therapist observations support the belief that the children in the experimental group experienced a decrease in behavior problems.

The data in Table 3 indicates that children in the experimental group demonstrated improvement in their total behavior problems as measured by the CBCL-Teacher Report, although not statistically significant, while the control group's scores increased indicating an increase in total behavior problems. Although the data in Table 7 suggests an increase in internalizing behavior problems for the experimental group, a greater increase in similar problems were reported for the control group on the CBCL-Teacher Report. Table 13 shows improvement in internalizing behaviors for both the experimental and control groups, although not statistically significant, as measured by the CBCL-Parent Report. The data in Table 13 also suggests greater improvement for the experimental group, as observed by parents. However, the change reflected in these scores could be due to chance or normal variability.

Experimental group children demonstrated statistically significant improvement on total scores rated by teachers for the ECBS. These scores, shown in Table 21, indicate

improvement in these children's emotional and behavioral adjustment, within the school environment. Lower ECBS scores also suggest decreases in the likelihood that the children will develop emotional and behavioral disorders (McCarney, 1994).

Additional *t*-test analysis was performed on data related to the subscales of the ECBS. Teacher scores for the "Academic Progress" subscale of the ECBS showed statistically significant improvement (.001 level) in behaviors that interfere with learning. Thus, improvement in these scores indicates that the experimental group children are more likely to learn successfully and respond to traditional educational experiences without major changes to their education program (McCarney, 1994).

Scores for the "Social Relations" and "Personal Adjustment" subscales of the ECBS also showed improvements, although not at statistically significant levels (.221 and .253 levels, respectively). Improvements in "Social Relations" subscale scores suggest increased abilities to make and keep friends, share, resolve conflicts, and other behaviors that enhance daily interactions. Improved scores on the "Personal Adjustment" subscale indicate increased abilities to follow rules, conform to socially appropriate behavior patterns, and increased responsibility, dependability, and stability (McCarney, 1994).

Results on the ECBS specific to improved adjustment to the school setting are particularly noteworthy. Elementary school is a principle setting in which children interact with others, learn social skills, receive positive or negative regard from others, experience successes and failures, are evaluated, and develop an identity. Rogers (1961) proposed that, based on interactions with others, children's sense of self or self-concept

develops. Over time, self-concept develops into a structure of self—an organized and consistent pattern of characteristics, perceptions, and interactions with others.

Experiences of success, positive regard from others, and favorable evaluations help children develop a positive identity, emotional security, and a pattern of expectations that they take into adulthood. A successful and positive elementary school experience leads to a life course of positive self-esteem, gratifying relationships, and personal success. As indicated by the results of this study, the unconditional acceptance, positive regard, empathic understanding, and safe interactions with peers within child-centered group play therapy enhance children's emotional and behavioral adjustment to the school setting. Although this study did not investigate the area of school success, these areas of adjustment certainly affect school success.

Comments from the teachers and therapists supported the premise that the child-centered group play therapy sessions helped the children decrease their behavior problems. For example, one teacher initially reported that Bobby exhibited “incredible activity and impulsivity. He continually disrupts the classroom and interferes with the other children's activities.” Near termination of the group therapy program, this teacher stated that Bobby “is much calmer, stays on-task much better, and is more respectful of others.” As described by a therapist, “Francis initially showed a lot of aggressive behaviors with Bobo and the other toys. She frequently screamed for no apparent reason, and, at times, she tests limits regarding physical aggression with the other child.” At termination of the group play therapy sessions, Francis was described as “much more

pleasant, more friendly and respectful, and she exhibited much more constructive and nurturing play behaviors.”

As shown in Tables 5 and 7, teachers’ ratings of the experimental group children increased on the Externalizing Behavior Problems and Internalizing Behavior Problems subscales of the CBCL-Teacher Report. These results could be due to expected behaviors of children within stages of the child-centered play therapy process that have been identified by Guerney (1983). Children tend to demonstrate an increase in a variety of acting-out and limit-testing behaviors as they develop increased awareness of their accountability and responsibility for their choices and related consequences (Landreth, 1991). As children learn that they are primarily responsible for what takes place in play therapy, and generalize this awareness to decisions outside of the sessions, they tend to experience frustration that is a necessary component of modifying their self-concept, self-structure, and view of the world. Due to the fact that children express feelings more through behaviors than words (Axline, 1947; Landreth, 1991), such frustrations and changes are likely to be manifested through such externalizing and internalizing behaviors as those identified in the CBCL-Teacher Report (i.e., withdrawal, anxiety, attention problems, and aggressive behavior). In addition, based on her study of kindergarten children who received child-centered play sessions with fifth grade facilitators, Baggerly (1999) suggested that a greater number of sessions would help to prevent the development of problematic behaviors and lead to more positive and longer-lasting change.

Parenting Stress

As shown in Tables 17 and 18, parents of the children in the experimental group exhibited a decrease in their total stress and “Parent Domain” stress as measured by the Parenting Stress Index (PSI), although not at the predetermined .05 level of significance. However, these PSI scores approached statistically significant levels of .103 and .139, respectively. Additional data analysis revealed statistically significant improvement as measured by the “Life Stress” subscale of the PSI at the .011 level. As shown in Tables 19 and 20, scores for the “Child Domain” of the PSI suggest increases in parenting stress for the experimental group and improvement for the control group, also below statistically significant levels. It must be noted that measured change below the level of statistical significance could be due to chance or normal variability.

Parents who experience elevated levels of stress have negative influence on their children’s emotional and behavioral adjustment and their self-concept. The two are interrelated, have reciprocal influences, and can interfere with the development of healthy parent-child relationships. Parenting factors that lead to normal healthy development in children include emotional warmth, availability, acceptance, positive regard, empathic understanding, and tolerance for assisting the child to deal with intense feelings—especially rage, frustration, anxiety, and sadness (VanFleet, 1994). Parents with elevated levels of stress are typically unable to consistently provide these parenting essentials. According to Bowlby (1969, 1980), children that fail to develop secure social and emotional attachments with significant others, tend to develop a life course of emotional, behavioral, personality, and relationship disorders, as well as physical health problems.

Parents who experience elevated stress levels, regardless of the source, will have tremendous difficulty meeting the demands and skills needed for effective parenting. Parenting demands are frequently pushed aside as the demands of coping with life stress take priority. According to Hammen and Rudolph (1996), families with members who experience adjustment and emotional difficulties are very likely to experience significant disruption within the family unit. Children in these families are at risk for increased emotional adjustment difficulties. According to Heller et al. (1996), parenting stress contributes to the children's behavior problems and impairs the parent-child relationship.

Timing of the post-test assessments, at the end of the school year, may also explain the lack of significant improvement. Three of the children's families were reportedly leaving for vacations immediately after the semester. Two of the families were in the process of moving. In addition, the parents were faced with the urgent need to complete four assessments regarding this play therapy program involving their children.

Self-Control

Analysis of the ratings by parents on the SCRS, as shown in Table 24, indicates improvement in self-control that approached statistical significance (.150 level). Data in Table 23, although not statistically significant, also suggests improvement in self-control as rated by teachers on the SCRS. Increased levels of children's self-control, within and outside of the group play therapy sessions, were also observed by the therapists.

For example, one therapist reported that the children had to walk with the therapist through long school hallways to the playroom. During the earlier sessions in the treatment process, four of the kindergartners (two boys and two girls) had great difficulty

following school-imposed rules for behavior in the hallways due to high levels of impulsiveness, distractibility, and physical activity. These rules included walking calmly, being quiet, no running, and no jumping. As the group play therapy process continued, these children exhibited much improved self-control, walked quietly to the playroom, and consistently observed hallway rules.

As reported by another therapist, Dustin was initially observed “running away from me to the playroom, interrupting the other child’s play, and knocking over the boundary dividers of our play area.” Following several group play therapy sessions, the therapist stated that Dustin “walks beside me all the way to the playroom, respects the boundaries of the play area, and is very considerate of the other child.”

Limitations

Several factors may have contributed to the lack of statistical significance demonstrated within this study. These factors include the a) small sample size; b) sample was drawn from only one school; c) lack of interactions between therapists and teachers, and therapists and parents; d) two unforeseen and unfortunate events; and e) pre-existing strength and resilience of the children comprising the control group.

Specific behaviors within the broad selection criteria for which the children were identified were not specified.

The small sample size of this study resulted in very low statistical power. For example, Table 2 shows the low statistical power related to scores for the Joseph Pre-School and Primary Self-Concept Screening Test to be .096. This indicates that there was only a 9.6% chance of discovering statistical significance, if the significance truly

occurred. A more appropriate level of statistical power is .80, which would be much more likely to uncover existing significance. Such power could be obtained by studying a considerably larger sample. Greater variability and sources of variance to be measured would also be available in a larger sample, which would provide greater probability of discovering statistical significance, if true differences existed.

The lack of statistical significance could also be due to the small sample size of children being from only one school. If a larger sample had been obtained from several schools with differing demographics, then more variability in children's adjustment characteristics would likely have been observed. The greater statistical power and variability provided by a larger and more diverse sample would have had a greater likelihood of revealing significant changes (Hinkle, Wiersma, & Jurs, 1998).

The therapists provided minimal information regarding children's progress in the treatment to parents and teachers. This lack of interaction reduced the effects of parent or teacher interventions on the children. Thus, differences between the experimental and control groups and differences between pre-test and post-test scores could be attributed to the effects of child-centered group play therapy. However, by not involving teachers and parents in the therapy process, potential therapeutic interventions were not implemented. Also, teachers and parents may not have been able to recognize positive change in the children. Thus, ratings on the CBCL-Teacher Report, CBCL-Parent Report, ECBS, FPC, SCRS, and PSI may not have indicated changes that actually occurred.

Late in the experiment, two unfortunate events occurred. First, without warning, two of the kindergartners in this study had suddenly moved. A new play therapy group

had to be created with the remaining children, for the last three sessions. This disruption likely added to the children's adjustment challenges. Second, near the end of the treatment and administration of the post-tests, TAAS testing took place at the elementary school. Although the kindergarten children did not actually participate in TAAS, there existed an environment of anxiety and tenseness throughout the entire school. During this period, the play therapy groups were required to move their setting, from the portable classroom to the backstage of the auditorium. Because of these changes, along with the emotional complexities associated with play therapy termination, the children's adjustment difficulties were put under additional stress near the time of post-testing. Hence, post-test scores possibly did not reflect true improvement in emotional, behavior, self-concept characteristics that were measured to assess the children's adjustment.

The experimental group for this study also represented the control group for the Baggerly (1999) study. Likewise, the data collected in the Baggerly research was used to construct the control group data for this study. According to Baggerly, children were assigned to her experimental group first, as parental consent forms were received. She hypothesized that the parents who had greater concern about their children's adjustment difficulties were more prompt and motivated about entering their children into the therapy program. Also, the school counselor confirmed that the children with greater emotional and behavioral concerns were assigned to the experimental group. Therefore, the children with fewer adjustment difficulties were assigned to the control group—and subsequently to the experimental group of this study. Additionally, the children

participating in this research were selected from one elementary school, in a typical middle class demographic area of North Texas.

Implications

Although the general results of this study did not show statistically significant benefits due to child-centered group play therapy sessions, positive trends in the children's behavior, self-control, and self-concept were observed by the researcher, play therapists, and teachers. Teachers also expressed appreciation and described reduced personal stress because students with adjustment difficulties were receiving intense and necessary attention. These trends and observations support the continued application of child-centered group play therapy with children experiencing adjustment difficulties.

Children's adjustment has been shown to benefit from individual child-centered play therapy (Landreth, 1991), child-centered group play therapy (Fleming & Snyder, 1947; House, 1970; Tyndal-Lind, 1999), as well as child-centered procedures provided by teachers (Brown, 2000), and parents (Bratton, 1994; VanFleet, 1994). According to Baggerly (1999), behavior problems demonstrated by preschool children tend to continue into the first grade. Therefore, it is imperative that kindergarten children experiencing adjustment difficulties have the opportunity to experience the safety and beneficial influences provided by child-centered play therapy.

Recommendations

1. The utilization of child-centered group play therapy to assist kindergarten children's emotional and behavioral adjustment to the school environment.

2. Further research to investigate the effects of child-centered group play therapy with children experiencing adjustment difficulties. A larger sample size may provide more powerful and statistically significant results.
3. A follow-up study to investigate long-term effects of child-centered group play therapy with children experiencing adjustment difficulties.
4. Further research to investigate the effects of increased involvement of parents and teachers in the therapeutic process, in addition to child-centered group play therapy sessions.
5. Further research to investigate the effects of intensive (i.e., five sessions per week) child-centered group play therapy with children experiencing adjustment difficulties.
6. A case analysis approach, a survey instrument to assess teacher observations, and observation of children's classroom behavior be included as measurements of change.

APPENDIX A

TEACHER SELECTION FORM

**McNAIR ELEMENTARY SCHOOL
KINDERGARTEN ADJUSTMENT PROGRAM
STUDENT REFERRAL FORM**

The Kindergarten Adjustment Program provides kindergarten students 10 thirty minute individual special play sessions with a selected, trained, and supervised fifth grade student. The benefits to participating kindergarten children are:

- Increased Self-Esteem
- Increased Self-Direction
- Increased Self-Confidence
- Increased Self-Control
- Increased Social Skills
- Decreased Dependency
- Decreased Behavioral Difficulties

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

The child demonstrates:

- A. Shy behavior
 - B. Withdrawn behavior
 - C. Anxious behavior (fearful, self conscious, nervous)
 - 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)
- OR

The child has experienced a life change within the last year such as:

- A. Parents divorce
- B. Death in the family
- C. Family move
- D. New sibling

Please give your nominations of children to Kevin Moffitt, School Counselor, by **Friday, August 14**. Please send home Parent Survey Forms with each child on **Monday, August 31**. Please collect all Parent Survey Forms and give them to Kevin Moffitt by **Friday, August 14**.

If you have questions about nominating children or about the program, please contact Kevin Moffitt, School Counselor, Jennifer Baggerly, or Julie Ziegler at (940) 565-3864. Thank you so much for your cooperation! Together, we can make a significant difference in your kindergarten children's adjustment to school.

**McNAIR ELEMENTARY SCHOOL
KINDERGARTEN ADJUSTMENT PROGRAM
STUDENT REFERRAL FORM**

Teacher Name: _____

Date: _____

Names of Children Being Nominated

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

10. _____

Please return this form to Kevin Moffitt, School Counselor, by **FRIDAY, AUGUST 14**.
He will give it to Jennifer Baggerly. Thank you.

APPENDIX B

PLAY THERAPY INFORMATION AND CONSENT FORM
USED IN THE BAGGERLY (1999) STUDY

**PARENT INFORMATION
FOR KINDERGARTEN ADJUSTMENT PROGRAM**

Dear Parent,

August 19, 1998

Your and your child are invited to participate in a special program at McNair Elementary School to help kindergarten children adjust to the school environment. This program consists of 10 once-a-week 30 minute individual, special structured play times with a fifth grade student who is trained and supervised by a school counselor. This program is designed to increase your child's self-esteem, self-direction, and self-confidence.

This program is part of a study to determine the effectiveness of special structured play session with kindergarten children led by trained and supervised fifth grade students. The program is under the direction of Dr. Garry Landreth, Regents Professor in the Department of Counselor Education at the University of North Texas. The coordinators of this program, Jennifer Baggerly and Julie Ziegler, are trained and experienced Play Therapists and Doctoral Candidates at the University of North Texas.

Your participation and your child's participation is completely voluntary. If you choose to participate, you will be asked to complete three questionnaires before and after a ten week period. Your child will be asked to participate in a twenty minute videotaped play session with the fifth grader before and after the ten week period, to participate in a twenty minute play session once a week for ten weeks during the school day, and to complete two screening instruments administered by a trained professional. Your child's teacher will also be asked to complete a questionnaire before and after the ten week period.

The information you provide when you and your child answer the questionnaires will be kept confidential. Your name and your child's name will not be disclosed in any publication or discussion of this material. Information obtained from the questionnaires will be recorded with a code number. Only the coordinators, the school counselor, and the teachers of the children in the program will have a list of the participants' names. The video taped play sessions of you child will be viewed only by graduate research assistants. The research assistants will have no knowledge of participants' names and they will abide by the same confidentiality standard. The only exceptions to confidentiality are a) the child discloses abuse, neglect, or exploitation, b) the child is a danger to himself/herself or to someone else, c) a court orders disclosure of information, or d) the parent or legal guardian requests release of information.

Participants in the program will be randomly selected to be in either the group receiving play sessions or the group not receiving play sessions. If your child is not selected to receive the play sessions, your name will be placed on a waiting list and you will be contacted regarding other play session options that you may pursue after the completion of the ten week study.

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 in no way affect your child's standing in his or her classroom or school. At the conclusion of this study, a summary of group results will be made available to all interested parents and teachers.

If you agree to participate, please fill out and sign the attached consent form. For further information, please contact, Kevin Moffitt, McNair School Counselor at (940) 383-4744, or Jennifer Baggerly, Researcher, at (940) 565-3864, or Dr. Garry Landreth, Faculty Supervisor, at (940) 565-2916. Thank you for your cooperation. We look forward to getting to know you and your child.

**PARENT INFORMED CONSENT
FOR KINDERGARTEN ADJUSTMENT PROGRAM**

You are making a decision whether or not to participate in this program. You should not sign until you understand all the information presented in the attached letter and until all your questions about the program have been answered to your satisfaction. You understand that participation is voluntary and you and/or your child may choose to withdraw at any time during the program. Your signature indicates that (1) you have read the information in the attached letter, (2) you and your child have decided to participate, and (3) you will meet all the requirements for participation as indicated below.

REQUIREMENTS FOR PARTICIPATION

- (1) Parent(s) and their kindergarten child are willing for the kindergarten child to participate in ten once-a-week twenty minute play sessions with a trained fifth grade student.**
- (2) Parent(s) and their kindergarten child are willing for the kindergarten child to be video taped in some play sessions.**
- (3) The family must be planning to remain in McNair Elementary School through December of 1998.**
- (4) The kindergarten child and parent(s) are not currently receiving counseling.**
- (5) Parent(s) and the kindergarten child must be able to complete assessments before and after the project.**
- (6) Parent(s) must be able to read, write, and speak the English language and the kindergarten child must be able to speak the English language.**

Signature of Parent or Legal Guardian Date

Printed Name of Parent of Legal Guardian

Signature of Kindergarten Child Date

Printed Name of Kindergarten Child

Signature of Witness Date

Signature of Researcher Date

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

APPENDIX C

PARENT CONSENT FORM AND CHILD CONSENT FORM
USED IN THIS STUDY

PLAY THERAPY - 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 Therapy provided by trained McNair counseling interns. Participation is completely voluntary.

Your child will be asked to participate in 40-minute play therapy sessions once a week during the Spring 1999 school semester. Your child will also be asked to complete a self-assessment at the beginning of the study, and again at the completion of the study. You and your child's teacher will be asked to complete three questionnaires at the beginning and then at the end of this study.

Play therapy is 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 McNair counseling intern will help to enhance your child's self esteem, self-control, and self-confidence. The McNair counseling interns will continue to receive training and supervision throughout the study.

The information you provide when you answer the questionnaire 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, Jennifer Baggerly and Donald (Mac) McGuire, the McNair school counselor, Kevin Moffitt, 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 McNair school counselor, Kevin Moffitt at 383-4744; researchers Jennifer Baggerly or Donald (Mac) McGuire at 565-2066; or Dr. Garry Landreth, Faculty Supervisor, at 565-2916.

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/or your child may choose to withdraw at any time during the study.

Signature of Parent or Legal Guardian _____ Date _____

Name of Child _____ Date _____

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.

CHILD'S CONSENT FORM

My name is: _____

It is OK with me to:

- 1) Go to play therapy and have special play times
- 2) To answer some questions

I know that people will not say what I said and did during the special play times. The only time someone will say what I said and did is if an older person is hurting me really bad or if my parent says OK.

When I write my name or make my mark on this paper, it means all of this is OK with me.

Child's Name or Mark _____

Signature of Witness _____

Signature of Investigator _____

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.

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