ADJUSTMENT OF KINDERGARTEN CHILDREN
THROUGH PLAY SESSIONS FACILITATED BY
FIFTH GRADE STUDENTS TRAINED IN
CHILD-CENTERED PLAY THERAPY
PROCEDURES AND SKILLS

DISSERTATION

Presented to the Graduate Council of the
University of North Texas in Partial
Fulfillment of the Requirements

For the Degree of

DOCTOR OF PHILOSOPHY

By

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Denton, Texas
May, 1999
Baggerly, Jennifer, Adjustment of Kindergarten Children Through Play Sessions Facilitated by Fifth Grade Students Trained in Child-Centered Play Therapy Procedures and Skills. Doctor of Philosophy (Counseling and Student Services), May 1999, 119 pp., 35 tables, references, 162 titles.

This research study investigated the effectiveness of the application of child-centered play therapy procedures and skills by trained fifth grade students in play sessions with kindergarten children who had adjustment difficulties. Specifically, this research determined if play sessions with trained fifth grade students facilitated change in kindergarten children's self-concept, internalizing behavior, and externalizing behavior and their parents' stress level.

The experimental group children (N=15) received 10 weekly twenty minute play sessions from fifth grade students who completed 10 thirty-five minute training sessions in child-centered play therapy procedures and skills and who received weekly supervision. The control group (N=14) received no treatment during the 10 weeks. Before the play sessions began and after the play sessions ended, the parents of the kindergarten children completed The Child Behavior Checklist-Parent Report and the Parenting Stress Index, the teachers of the kindergarten children completed the Child Behavior Checklist-Teacher Report, and the researchers administered the Joseph Pre-School and Primary Self-Concept Screening Test and the Haak Sentence Completion to each kindergarten child.

Analyses of Variance of gained scores revealed that children in the experimental
group showed a marginally significant decrease in "Somatic Complaints." Other variables revealed slightly positive trends in self concept, total behavior problems, externalizing behavior problems, delinquent behavior, and demandingness, although none of these were at statistically significant ranges. Detailed observation and teacher reports revealed an increase in self acceptance, self esteem, self confidence, self control, creativity, and positive relationships and a decrease in aggression and withdrawn behavior. Possible reasons for the lack of statistical significance in the overall reduction of problems and increase in self control are the small sample size and the limited number of play sessions.

The positive trends in kindergarten children's self concept and behavior and the observed power of the therapeutic relationships compel the continued implementation of this innovative project.
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CHAPTER 1

INTRODUCTION

Over 582,000 preschoolers in the United States were identified as developmentally delayed in the 1993/1994 academic year (Synder, Hoffman, & Geddes, 1996). These staggering numbers are of concern because kindergarten children’s social and emotional well being are essential for their future school success and can hinder their readiness for learning (Pianta, 1997). Psychologists have recognized that children’s underlying social and emotional concerns must first be addressed in order to free their energy for higher cognitive pursuits (Maslow, 1970; Rogers, 1951, 1969). Teachers have also recognized that social and emotional skills are more important than academic skills for school readiness. In a national survey, seventy six percent of kindergarten teachers agreed that “enthusiasm and curiosity in approaching new activities” are very important or essential for kindergarten readiness while only twenty four percent agreed that “identifying primary colors and basic shapes” are important. In addition, fifty six percent of kindergarten teachers agreed that “taking turns and sharing” are very important or essential for kindergarten readiness while only ten percent agreed that “knowing letters of the alphabet” is important (Synder, Hoffman, & Geddes, 1996).

Heller, Baker, Hanker, & Hinshaw (1996) reported that preschool children’s externalizing behavior and cognitive functioning problems were stable and sound predictors for similar difficulties in first grade. Without early intervention young children
will continue to demonstrate emotional, behavioral, or academic problems. Thus, a developmentally appropriate strategy is needed for addressing kindergarten children’s social and emotional difficulties to facilitate their future school success. Play is widely recognized as the most developmentally appropriate learning strategy for children. The National Association for the Education of Young Children’s Position Statement on developmentally appropriate practice in programs for 4 and 5 year old children includes the following statements:

Young children learn by doing. The work of Piaget (1950), Montessori (1964), Erikson (1963), and other child development theorists and researchers (Elkind, 1988; Kamii, 1982) has demonstrated that learning is a complex process that results from the interaction of children’s own thinking and their experiences in the external world. . . . Children acquire knowledge about the physical and social worlds in which they live through playful interaction with objects and people. (Bredekamp, 1987, p.51)

Play is also developmentally appropriate because it is the natural language of children (Erikson, 1963; Ginott, 1961; Landreth, 1987, 1993; Oaklander, 1978). Developmentally, children do not have the cognitive ability to express their deep feelings, reactions, and perceptions of themselves, others, and their world through verbal communications. However, they naturally express these feelings, reactions, and perceptions in their play. According to Ginott (1961), “the child’s play is his talk and the toys are his words” (p.51). Through play, children are not limited in self expression to the words they know. Rather, they can live out, in play, a moment in their life that is troubling
or joyous. Piaget (1951) stated that fantasy play “provides the child with the live, dynamic, individual language indispensable for the expression of his subjective feelings for which collective language alone is inadequate” (p.166).

Play can provide children the needed emotional distance to confront frightening or anxiety producing experiences. A child portraying a baby doll running through the house frantically looking for daddy who moved away is less threatening than the child talking about his or her own daddy being gone. Projecting the desire for a compassionate daddy on the daddy doll is less painful than the child speaking unmet wishes for daddy’s affection. In addition, play allows for the needed practice of new social strategies. A child using a puppet to ask another puppet to come over to play helps a child build confidence to implement the social script. Play also engages children in a relationship with others. A child pushing a car around can build a friendship with another child who pretends to own the gas station.

Based on a review of the literature, Schaefer (1993) identified twenty-five therapeutic powers of play including release of hostility toward parents, alleviation of guilt feelings, overcoming resistance, catharsis, mastering developmental fears, desensitization by repetition, insight, attachment, self-actualization and ego strength. Thus, play has many functions in children’s social, emotional, and psychological growth and adjustment (Erikson, 1963; Piaget, 1950).

Although play is frequently used in the kindergarten classroom, play alone is not enough to address the intense needs of some children who have adjustment difficulties. Kindergarten children may experience school adjustment difficulties for several different
reasons. First, children's emotional disorders may cause adjustment difficulties which make it impossible for them to have successful learning experiences. If children experience depression or anxiety, they will not be able to focus on the learning tasks teachers present. For example, if a depressed, withdrawn girl is worried about who will roll the ball to her during the alphabet game, she will not be able to think of the words beginning with “A” that the teacher requested. If an anxious, aggressive boy is worried about getting to be the captain, he will not hear the instructions in the math baseball game. Second, children's learning disabilities may cause adjustment difficulties because learning problems reverberate through the child's being (Landreth, Allen, & Jacquot, 1969). A disturbance in a child's speech may affect that child's social development. A child's dyslexia may result in frustrations that distract others and disrupt the classroom. Third, adjustment difficulties may arise from stresses on children in the home. Inner turmoil due to a move, a parent's divorce, a new baby in the home, or the death of a loved one may preoccupy the thoughts of children during instructional periods. Fourth, adjustment difficulties may be due to friction between children's developmental status such as increased sensitivity and school situational factors such as an authoritarian teacher (Adelman & Taylor, 1991).

Children with adjustment difficulties need a type of play intervention that is beyond the regular play in the classroom. Play therapy procedures and skills can meet this need by providing children the opportunity to resolve adjustment difficulties that hinder emotional and social development and thus academic progress (Axline, 1947; Campanelle, 1971; Quayle, 1991).
Statement of Problem

The problem that was investigated in this research was the effectiveness of the application of child-centered play therapy procedures and skills by trained fifth grade students in special play sessions with kindergarten children who had adjustment difficulties. Specifically, this research investigated whether or not the self concept and the internalizing and externalizing behavior of kindergarten children changed as a result of play sessions with trained fifth grade students. In addition, this research sought to determine if the stress level of the kindergarten children's parents was effected by their children receiving play sessions with trained fifth grade students.

Review of the Literature

The following review is a synthesis of theoretical constructs and research related to seven major areas: (a) history of play therapy, (b) effectiveness of play therapy, (c) play therapy in elementary schools; (d) filial therapy; (e) student mentor and peer helper programs, (f) self concept, (g) externalizing and internalizing behaviors, and (h) parenting stress.

The History of Play Therapy

The first historical account of using play in counseling children was recorded by Freud (1955) in the classic case of Little Hans in 1909. Freud gave advise to Little Hans' father based on the father's reports of Little Hans' play. Freud's work was the first of five major developments in the field of play therapy. Melanie Klein (1955) continued the first major development as she used play with children as an alternative to free association. She believed play reflected the child's unconscious and she, therefore, gave interpretations to
the children. Anna Freud (1965) also employed play in counseling children but used play as a means to develop an alliance with the child before making interpretations.

The second major development in the field of play therapy was Levy's (1938) development of release play therapy. He presented a structured play situation with selected toys to a child to recreate the scene of a specific trauma that the child had experienced. The reenactment of the traumatic event allowed the child to release anxiety and pain associated with the event. Rather than interpretation of play behaviors, Levy stressed the abreactive benefits of play. The third major development in play therapy involved the work of Taft (1933), Rank (1936), and Allen (1939). They applied play in relationship therapy as a means of developing a dynamic, curative relationship with children. The fourth major development, child-centered play therapy, was initiated by Virginia Axline who adapted Carl Rogers' person centered approach to children. She provided the eight basic principles of play therapy to facilitate children's self actualizing potential through play (See Appendix A).

The fifth major development of play therapy began in the 1960's with the establishment of guidance and counseling programs in elementary schools (Landreth, 1991). This availed play therapy to all children, not just children who were considered maladjusted. The early success of play therapy in addressing the developmental needs of children in elementary schools has been reported by Alexander (1964), Landreth (1972), Muro (1968), Myrick and Holdin (1971), Nelson (1966), and Waterland (1970). Although behavior modification replaced play therapy as the primary intervention in the 1970's and early 1980's, play therapy has made a come back in the 1990's, even to the point that time
out rooms have been converted to play therapy rooms (Campbell, 1993).

**The Effectiveness of Play Therapy**

A comprehensive review of research studies and case studies by Landreth, Homeyer, Glover, and Sweeney (1996) has shown play therapy to be effective with a wide range of children's problems including abuse and neglect, aggression, chronic illness, disabilities, emotional disturbance, grief, low self-concept, selective mutism, or traumatization were identified by. (See Appendix B). In addition, a comprehensive national survey (n=1166) by Phillips and Landreth (1998) found that play therapists identified numerous disorders as amenable to play therapy including physical/sexual abuse, depression/withdrawal, acting-out/impulse control, school adjustment/academic difficulties, phobias, and enuresis/encopresis.

A recent meta-analysis of outcome research by LeBlanc (1998) also supported the effectiveness of play therapy. This comprehensive statistical study showed an average treatment effect of 0.66 standard deviations which is similar to overall effect sizes of traditional therapies. This meta-analysis suggests that play therapy is as effective as non-play therapies in treating children experiencing emotional difficulties.

Siegel (1970) conducted a year long study of forty-eight second to fifth grade children with learning disabilities. The children were divided into a group that received play therapy, a group whose parents received counseling, a group that received both play therapy and parental counseling, and a control group. Analysis of measured results revealed that learning disabled children who received play therapy significantly improved in cognitive, affective, psychomotor, and environmental dimensions.
Clatworthy (1981) conducted a quantitative study of play therapy over a period of four years. Fifty-five children in the treatment group received seven consecutive days of individual play therapy by a nurse trained in play therapy and fifty-nine children in the control group received no treatment. Results indicated that children in the experimental group had significantly lower levels of anxiety at the conclusion of the study than did children in the control group.

Kot, Landreth, and Giordano (1998) reported on an unusual study in which child witnesses of domestic violence who were residing with their mothers in a women’s shelter received child-centered play therapy sessions each day for two weeks. Results revealed the 11 children in the experimental group significantly increased in self-concept, play behavior of physical proximity to the therapist, and play behavior of nurturing and creative play themes and significantly decreased in external and total behavior problems as compared to the children in the control group.

**Play therapy in Elementary Schools**

Play therapy in elementary schools is an essential tool that facilitates the intellectual, emotional, physical, and social development of children.

Play therapy in the elementary school is considered to be a vital and integrated part of the total educational process. . . . For children who may be deprived, hard to reach, or unsuccessful in school or who may have poor self-concepts, play therapy becomes a highly treasured and rewarding experience (Landreth, 1987, p. 260).

Play therapy procedures and skills provide opportunities to resolve social, emotional, and behavioral problems that hinder the learning process (Landreth, 1987). During play
sessions, children receive the needed emotional outlet to get back on track in the classroom. The person trained in play therapy procedures builds a living, dynamic relationship with the child by providing therapeutic toys and therapeutic responses. In this warm and accepting context, the child expresses perceptions of self and the world as well as joy, fear, anger, surprise, acceptance, rejection, love, or hate. As a result of this experience, children are more free to use their energies for further school success. The self understanding, self acceptance, personal power, self control, and self discipline developed in play sessions helps children accomplish academic, social, and personnel goals (Campanelle, 1971).

The power of play therapy procedures and skills in promoting the educational potential of children has been consistently verified by research. One of the first studies in child-centered play therapy demonstrated the effectiveness of play therapy with poorly adjusted slow readers (Bills, 1950). After six individual and three group play therapy sessions, children in the treatment group showed significant increases in their reading ability when compared to a control group. Results of other research studies have proven play therapy to be an effective intervention for children with learning difficulties (Siegel, 1970) and learning readiness by addressing socially immature kindergarten children (Pelham, 1972).

Gould (1980) randomly assigned eighty-four elementary school children with low self-image either to an experimental group which received non directive group play therapy, a placebo group which participated in group discussions, or a control group with no intervention. Results indicated that children who participated in group play therapy
showed the strongest positive change as compared to the other groups.

Quayle (1991) studied the effectiveness of play therapy with children who had school adjustment problems such as acting out, moodiness, or learning difficulties. Fifty-four children, ages 5 to 9, were divided into an experimental play therapy group, a comparison tutoring group, and a control group that received no intervention. Children who received play therapy showed more positive growth in areas such as improving in learning skills, assertive social skills, task orientation, peer social skills, interactive participation, and self confidence than did the children in the comparison and control groups.

Although play therapy is a widely used tool in elementary schools, referrals to school counselors exceed their capacity to address each student’s needs individually. Yet, if children are to succeed in school, some type of effective intervention to address children’s emotional and social difficulties is needed. As Landreth (1987) aptly stated, “it is not a question of whether the elementary school counselor should use play therapy but, instead, of how play therapy procedures and skills should be used in the schools” (p. 255).

Filial Therapy

One way to use play therapy procedures and skills in the schools to meet the needs of students is to train caring and available individuals. One proven model of training non professionals is filial therapy, a method of enhancing the parent child relationship by parents implementing child-centered play therapy procedures with their own children. Filial therapy was developed by Bernard and Louise Guerney in the 1960’s (Guerney, 1964) and revised into a ten week training model by Landreth (1991).
Unlike other behavioral or educational parent training programs, filial therapy combines didactic instruction, role playing, supervision, and a support group format for an optimal learning experience. During the filial small group training, parents learn the basic skills of structuring the play sessions, tracking behavior, reflecting feelings and content, facilitating decision making and creativity, building self esteem and therapeutic limit setting (VanFleet, 1994). After skills are learned, parents conduct thirty minute play sessions with their children once a week in their home. They receive feedback from supervisors through videotape review and support from other parents during weekly sessions.

Numerous studies have demonstrated the efficacy of training parents to bring about change in their own children through play sessions. Harris (1995) trained twelve incarcerated mothers in filial therapy. Results showed significant increases in their level of empathic interactions with their children and in their attitude of acceptance toward their children, as well as a significant reduction in the number of reported problems with their children's behavior. Kale (1997) provided ten weeks of filial therapy training to parents of children with learning difficulties and found that these parents had less parenting stress and their children had higher self concepts after training than control group participants.

Other research studies have demonstrated the effectiveness of filial therapy with parents of children with mild to moderate emotional and behavioral difficulties (Lebovitz, 1983; Oxman, 1973; Payton, 1981), parents of children with severe emotional disturbance (Sensue, 1981; Sywulak, 1978), parents of children with cognitive disabilities (Boll, 1972), single parents (Bratton, 1994), and parents in an ethnic minority group (Chau,
Student Mentor and Peer Helper Programs

Twenty years ago, peer counseling programs were recommended to be part of school guidance services by the American School Counselor Association (Myrick, Highland, & Sabella, 1995). Several researchers have demonstrated the effectiveness of peer facilitators and peer helpers in improving the behavior of students receiving the help. Huey & Rank's (1984) study with 48 African American adolescent boys who were aggressive in the classroom showed that peer facilitators were equally as effective as professional counselors in teaching them assertiveness skills which reduced the aggressive boys' negative behavior.

In a quantitative study of eighth grade peer facilitators with sixth graders who had disruptive behavior, Tobias (1992) found that peers effectively helped decrease the negative behavior of the sixth graders identified as disruptive. Myrick, Highland, & Sabella's (1995) survey of 138 students who received assistance from peer facilitators at seven elementary and two middle schools indicated that students receiving help enjoyed their peer friend and looked forward to being with them. Their results revealed no statistical difference between the elementary school children and middle school children's response, indicating peer helpers are just as valued by elementary school children as middle school children.

Seidenberg (1978) applied the peer helper model to six sibling dyads who were in junior high school and elementary school. These eleven, twelve, and thirteen year old participants received training in Rogerian interpersonal communication skills and
experienced significant positive results in their sibling relationships. In twelve sessions, these siblings were taught how to communicate acceptance, empathy and express feelings appropriately. Training techniques included modeling and role playing. When compared with the control group, children in the experimental group demonstrated: (a) increased interpersonal communication skills, (b) increased number of positive statements made about siblings, (c) decreased number of negative statements made about siblings, and (d) increased communication and empathy with each other.

Elementary school peer helper programs have also demonstrated improved behavior in children receiving help. Bowman & Myrick (1987) matched fifth grade peer facilitators with second and third grade students who had disruptive behavior. Their results indicated a significant increase in the second and third grade students’ appropriate classroom behavior. McHale (1983) found that elementary school children with autism who received 10 weeks of play sessions from schoolmates exhibited increased social interactions. Based on this research, Buse, Coke, Rubin, and Fletcher (1988) studied the effects of play sessions on children who had severe behavioral disorders and another disability (communication disorder, mental retardation, or a physical disability). After ten weeks of daily play sessions facilitated by first, second, and third grade students, the children with disabilities were observed to have increases in positive social interactions. The positive behavioral change was even more pronounced when children were paired with the same partner and when the playmates participated in activities that the child with the disability appeared interested in.

Brake & Gerler (1994) demonstrated the benefits of elementary school peer helper
programs to students who gave help and students who received help. In their study, fourth and fifth grade students identified as discipline problems participated in a developmental program called “Discovery.” These students developed group cohesiveness, learned skills and attitudes for helping kindergarten children, and then read or played games with kindergarten children. Teachers reported that the kindergarten children enjoyed and looked forward to the play time and that it was important experience for them.

Peer helper programs have a number of other benefits. When younger children watch empathetic behavior, they are more likely to demonstrate it themselves (Yarrow, Scott & Waxler, 1973); students providing peer helper training gain greater emotional development; and peer helper programs foster a sense of community within schools (Foster-Harrison, 1995).

**Self Concept**

Self concept refers to the thoughts, feelings, and perceptions one has about self. Since self concept is based on external experiences and internal perceptions, positive school experiences are an important part of children’s development of a positive self concept (Rogers, 1951; 1969). A strong self concept is a necessary component for learning and thus school success. “The attitudes that a child holds toward himself and the extent to which he values his own worth will significantly influence his . . . academic achievement . . . “ (Joseph, 1979, p. 1).

Play therapy is an important key in facilitating a positive self concept and school success. Play therapy has been considered “the prescription of choice” to facilitate stronger self-concepts (Henniger, 1995). Several quantitative research studies have shown
increases in children's self concept as a result of play therapy. House (1970) measured the self concept in 36 second grade children. Twelve children were randomly assigned to the experimental group that received child-centered group play therapy while the remaining children were randomly assigned to one of two control groups. The children who participated in twenty 30 minute play therapy sessions with a group of five other children showed significant increases in their self-concept as compared to the children in the control groups. Crow (1989) demonstrated that twelve first grade children who were low achievers in reading had significant increases in their self concepts after receiving ten 30 minute child-centered play therapy sessions as compared to a matched control group.

In ten sessions of filial therapy, Glass (1987) trained fifteen parents to address the behavioral concerns of their 5 to 10 year old children through regularly scheduled special parent-child play sessions at home. Results showed that the experimental group who received filial therapy had positive changes in self concept in the children and parents. In Lobaugh's (1991) study, sixteen incarcerated fathers were trained in child-centered play therapy procedures and skills. The fathers implemented these skills during 10 weekly 30 minute play therapy sessions with their children. The children who had play sessions with their fathers showed significant increases in their self concepts.

Significant increases in children's self concepts were also demonstrated in several other play therapy studies and filial therapy studies: Kale (1997), Kot (1995), and Yuen (1997). Hence, research confirms that child-centered play therapy experiences increase children's self concept and thus the probability of academic success is increased.
**Externalizing and Internalizing Behaviors**

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

Externalizing behaviors in young children are of concern due to the existence of the developmental pathway, a behavioral continuum in which successive behaviors become more severe. For example, the developmental pathway of conduct disorder begins with non compliance in the toddler stage, impulsivity in preschoolers, oppositional-defiance and aggression in primary school years, and then full blown conduct disorder by middle childhood (Merrell, 1996). Almost 94% of preschoolers classified with externalizing behavior problems were still classified as borderline or pervasive in their symptoms at first grade (Heller, Baker, Henker, & Hinshaw, 1996). Thus, early intervention for children with externalizing behaviors is important to prevent the solidification of negative behavior patterns, to address underlying causes and to promote positive behavior strategies.

Although externalizing behaviors are easier to see and thus are the more common reason for referral, internalizing behaviors may become serious problems in children. Bowlby (1977) has shown that children who do not develop the ability for maintaining social attachments are more likely to have health problems, emotional difficulties, and personality disturbances in adulthood. Other research has shown that socially detached children are more likely to suffer from mental illness, heart disease, and hypertension (Thomas & Duszynski, 1974). A developmental pathway of internalizing behavior
problems has been tentatively suggested (Merrell, 1996). Zahn-Waxler’s (1987) research implies that extreme dependency by young children on their mothers, poor social skills, few playmates and maternal depression is a pathway to internalizing behavior problems that develops between 2 and 6 years of age. Other research which supports an internalizing pathway has identified insecure attachment (Miller, Boyer, & Rodelitz, 1990) and object loss or learned helplessness in early childhood (Cantwell, 1990) as contributors in the internalizing pathway. However, this internalizing pathway is more discrete than externalizing pathways of conduct disorder problems since internalizing problems are less stable over time (Quay & Werry, 1986).

Implementation of child-centered play therapy procedures and skills has resulted in significant decreases in children’s internal and external behavior problems such as aggression, dependence, and withdrawal (Lebovitz, 1983; Packer, 1990; Sywulak, 1978) and overall greater improvement in behavior (Bavin-Hoffman, 1994; Oxman, 1973; Payton, 1981). Thus, the use of play therapy procedures may be a safeguard from progression in internalizing and externalizing pathways.

**Parenting Stress**

Parents of children with potential academic and/or adjustment problems report more parenting stress than parents whose children do not have these difficulties (Anderson, Lytton, & Romney, 1986; Breen & Barkley, 1988; McKinney & Peterson, 1987). In a study of 116 parents of kindergarten children, the parents of children with lower Early Screening Profile scores reported higher levels of parenting stress (Bramlett, Hall, Barnett, & Rowell, 1995). Fuller & Rankin (1994) found that mothers of children
who are emotionally impaired and mothers of children with learning disabilities indicated significantly higher stress than mothers of children in regular education.

Several research studies have shown that children’s behavior is positively correlated with parenting stress. For example, in a 6 month longitudinal study of 27 families with toddlers aged 24 months, parents with toddlers who exhibited more externalizing behaviors (e.g. aggression) experienced more parenting stress associated with the child (Creasey & Jarvis, 1994). This impact of externalizing behavior problems on parenting stress was also found by Baker (1994). His research revealed that the total number of problem behaviors of children with ADHD was found to be a contributor to increased parenting stress in 20 sets of parents of children with ADHD. Parenting stress is predicted when children have a high number of behavior problems, leaving parents feeling exhausted and ineffective. On the other hand, Heller, Baker, Hanker, and Hinshaw’s (1996) found that parenting stress was a significant predictor of a child’s externalizing behavior. This finding may indicate that parental stress may exacerbate a child’s negative behavior which in turn creates more stress on the parent, thus, producing a cyclical effect. Implementation of child-centered play therapy procedures and skills through filial therapy has resulted in significant decreases in parenting stress as measured by the Parenting Stress Index (Bratton, 1994; Chau, 1996; Glover, 1996; Kale, 1997; Lobaugh, 1991).

Summary

A review of the literature reveals that play therapy is a well established discipline with a long history and demonstrated effectiveness in treating children with social, emotional, and behavioral problems. Since the 1960s, play therapy procedures and skills
have been utilized to help accomplish the goal of elementary schools which is to promote children's intellectual, emotional, physical, and social development through adequate learning opportunities.

Some school children are unable to benefit from learning opportunities due to their social, emotional, or behavioral problems that cause adjustment difficulties. These children tend to have lower self concepts, higher occurrences of internalizing behaviors, such as anxiety and depression, and higher occurrences of externalizing behaviors, such as impulsivity and aggression. In addition, their parents tend to have higher levels of parenting stress.

Application of play therapy procedures and skills provides children with adjustment difficulties an opportunity to resolve their problems in a warm, caring atmosphere through play, their natural means of communication. Through this process, children play out their concerns and increase their self esteem, self direction, and self discipline. Thus, play therapy procedures and skills free children from internal distractions and facilitate children's skill development to obtain school success. Research has consistently demonstrated that application of play therapy procedures and skills increases children's self concept, decreases internalizing and externalizing behavior, and decreases parenting stress.

Although play therapy procedures and skills are an effective tool in the elementary schools, school counselors are not able to provide individual help to all the children in need. Therefore, other resources must be tapped. The utilization of play therapy skills by parents in Filial therapy has proven to be an effective intervention. When parents have
implemented child-centered play therapy procedures, they have experienced positive results in themselves and their children. Another effective intervention has been peer mentoring programs. By spending one on one time together, older elementary school children have made a positive impact on younger elementary school children.
A pretest-posttest control group design was used to measure the adjustment of identified kindergarten children who received ten weekly twenty-minute structured play sessions facilitated by fifth grade students trained in child-centered play therapy skills and procedures. Fifth grade students and kindergarten children who met the specified criteria were selected to participate in the study and then randomly assigned to a control group and an experimental group, with only the experimental group receiving treatment. Play sessions with trained fifth grade students were provided for the control group kindergarten children after the completion of the research study.

Definition of Terms

Adjustment difficulties refers to any problem that prevents a child from adjusting to classroom or school situations and learning opportunities. Examples of adjustment difficulties are extreme shyness, withdrawn behavior, anxiety, depression, inattentiveness, dependency, or impulsivity. Adjustment difficulties also include grief reactions to life changes such as parental divorce, a recent move, or a death of a family member.

Child-centered play therapy 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)

Child-centered play therapy procedures and skills are therapeutic strategies of tracking behavior, reflecting content and feelings, building self esteem, facilitating decision making, and setting therapeutic limits. These strategies are implemented by trained facilitators who build a therapeutic relationship by demonstrating warmth, empathy, and genuineness through tone of voice, posture, and active listening. Therapeutic toys are provided as a means for children to express their thoughts, desires, perceptions, and feelings.

Externalizing behaviors are defined as outward delinquent and aggressive behaviors. For the purpose of this study, externalizing behavior problems was operationally defined as the score on the Externalizing subscale of the Child Behavior Checklist (CBCL) (Achenbach, 1991).

Filial therapy has been described by Guerney (1964) as “the training of parents of young children (in groups of six to eight) to conduct play sessions with their own children in a very specific way” (p. 305). Parents implement child-centered play therapy procedures and skills with their own children in weekly 30 minute play sessions at home.

Internalizing behaviors are defined as inward manifestations of emotional difficulties which result in withdrawal, somatic complaints, and anxiety/depression. For the purpose of this study, internalizing behavior problems was operationally defined as the score on the Internalizing subscale of the Child Behavior Checklist (Achenbach, 1991).

Parental stress describes the degree of stress in the parent-child system as
perceived by the parent. For the purpose of this study, parental stress were operationally defined as the parents' scores on the Parenting Stress Index (PSI) (Abidin, 1983).

Self concept refers to the sum total of thoughts and feelings a child holds toward himself or herself. Self concept also includes the extent to which the child values his or her own worth. For the purpose of this study, self-concept was operationally defined as the children's total scores on the Joseph Pre-School and Primary Self-Concept Screening Test (Joseph, 1979).

Hypotheses
To accomplish the purposes of this study, the following hypotheses were formulated:

1) Kindergarten children who receive play sessions will attain a significantly higher mean total score on the Joseph Pre-School and Primary Self-Concept Screening Test (JPPSST) at post-testing than will the kindergarten children in the control group.

2) Kindergarten children who receive play sessions will attain a significantly higher mean total score on the Haak Sentence Completion (HSC) at post-testing than will the kindergarten children in the control group.

3) Kindergarten children who receive play sessions will attain a significantly lower mean total score on the Child Behavior Checklist-Teacher's Report (CBCL-Teacher Report) at post-testing than will the kindergarten children in the control group.

3a) Kindergarten children who receive play sessions will attain a significantly lower mean score on the Internalizing Behavior Problems scale of the Child Behavior Checklist-Teacher Report (CBCL-Teacher Report) at post-testing than will the kindergarten children in the control group.
3b) Kindergarten children who receive play sessions will attain a significantly lower mean score on the Externalizing Behavior Problems scale of the Child Behavior Checklist-Teacher Report (CBCL-Teacher Report) at post-testing than will the kindergarten children in the control group.

4) Kindergarten children who receive play sessions will attain a significantly lower mean total score on the Child Behavior Checklist-Parent’s Report (CBCL-Parent Report) at post-testing than will the kindergarten children in the control group.

4a) Kindergarten children who receive play sessions will attain a significantly lower mean score on the Internalizing Behavior Problems scale of the Child Behavior Checklist-Parent’s Report (CBCL-Parent Report) at post-testing than will the kindergarten children in the control group.

4b) Kindergarten children who receive play sessions will attain a significantly lower mean score on the Externalizing Behavior Problems scale of the Child Behavior Checklist-Parent Report (CBCL-Parent Report) at post-testing than will the kindergarten children in the control group.

5) The parents of kindergarten children who receive play sessions will attain a significantly lower mean total score on the Parenting Stress Index (PSI) at post-testing than will the parents of children in the control group.

5a) The parents of kindergarten children who receive play sessions will attain a significantly lower mean score on the “Parent Domain” of the Parenting Stress Index (PSI) at post-testing than will the parents of children in the control group.

5b) The parents of kindergarten children who receive play sessions will attain a
significantly lower mean score on the “Child Domain” of the Parenting Stress Index (PSI) at post-testing than will the parents of children in the control group.

**Instruments**

**Joseph Pre-School and Primary Self-Concept Screening Test**

The Joseph Pre-School and Primary Self-Concept Screening Test (JPPSST) was developed by Joseph (1979) to measure the self concept of children. Although it was originally developed for preschool children, it was later adapted to include children in upper grade levels. The JPPSST can be used for children in the age range from three years, six months to nine years, eleven months. The JPPSST has many benefits such as not requiring verbal or reading skills, requiring minimal training for the questioner, and being relatively short.

In administering the JPPSST, pictures are used to stimulate responses from children. First, the child identifies the pictures as pictures of himself or herself. By using the child’s descriptions of the activities and feelings surrounding the pictures of the self, the scorer rates the child’s self-esteem on a global index scale of zero to 30.

The reliability of the JPPSST was established with a test-retest sample which produced a reliability coefficient of .87. Internal consistency was established through a split-half test. The Kuder-Richardson 20 formula was used to estimate the internal consistency which is in a range from .59 to .81 with a medium correlation of .73. An item analysis was also performed with item discrimination coefficients ranging from .30 to .70 as a function of the particular item and the age level of the sample. Every item on the scale obtained correlation coefficients indicating each item significantly contributes to the
observed in the seventh session as she made the ball crush the alligator and touched the gun for the first time; in the ninth session as she shot the gun at the divider and played with the money for the first time; and in the tenth session as she played with the egg carton. Given that toys are children’s words and play is their language, this selectively mute kindergarten girl “spoke” volumes through her play as she explored her world in the safe environment that her fifth grade facilitator provided. In addition, in the tenth session, “Christine” sustained her increase of verbalizations by making the cow “moo.” The progress in this selectively mute girl as a result of her fifth grade facilitator’s implementation of child-centered play therapy procedures and skills for ten weeks is quite notable especially since cognitive behavior therapy experts indicate treatment of selective mutism requires one to two years of therapy by a trained child psychologist or counselor (Schaefer, 1998).

A decrease in shy, withdrawn behavior was also noted in “Ross” who was described by his teacher at the beginning of the year as “cries easily and is shy.” After the ten weeks of play sessions, “Ross”’ teacher stated he “showed much improvement, doesn’t cry as much, and is an active class participant.” “Tom” was initially described by his teacher as having “low social skills; doesn’t play well with others; can’t follow directions.” After the play sessions “Tom’s” teacher reported he “copies others more often now, interacts by doing as they do and follows directions a little more frequently.”

Positive Relationship Developed

The positive relationship which developed between the kindergarten child and the fifth grade student was noted by the school counselor as the main reason for behavior
overall test score performance.

Construct validity was addressed by correlating Global self concept score derived from two self concept rating scales that were completed by teachers. The correlation coefficient between the scores of the two tests equaled .51 which was significant as the .01 level of significance (Joseph, 1979).

**Haak Sentence Completion (HSC)**

The Haak Sentence Completion (HSC) was developed by Ruth A. Haak as a screening measure to distinguish emotionally disturbed children from learning disabled children (Baker, 1989). The version for use with children from ages 5 to 12 contains five scales with a total of 87 sentence stems which require children to provide the remainder of the sentence. However, for this research study the version was shortened to only 20 questions from two of the scales. The first scale, the Perception of Self and Others, has eight questions such as “Most grown people are ________” and “My mother thinks I am ________.” The second scale, the Task Performance and Achievement, has seven questions such as “When my father gives me lots of work, I ________” and “When I don’t know what the book says, I ________.” (See Appendix C).

The HSC sentence stems are verbally administered to the child. Responses are subjectively interpreted and rated as either positive, neutral, or negative (Baker, 1989). Positive responses are scored as 2, neutral responses are scored as 1 and negative responses are scored as 0.

Internal reliability of the HSC was determined to be adequate at .77 for the Perception of Self and Others scale and .76 for the School Performance or Task
Performance and Achievement scale (Baker, 1989). In addition, correlation analyses showed a small but significant correlation ($r = -0.231, p < 0.05$) between the Perception of Self and Others Scale and the Externalizing Behavior scale of the Child Behavior Checklist-Parent Report (CBCL-Parent Report) (Baker, 1989). Convergent validity was not demonstrated by correlations between scores of the Haak and the CBCL-Parent Report.

**Child Behavior Checklist**

The Child Behavior Checklist Parent Report Form (CBCL-Parent Report) was developed by Achenbach & Edelbrock (1986). For this study, the 1991 profile (Achenbach, 1991) was utilized. The CBCL-Parent Report is a scale with 113 items and is for children from two to sixteen years of age. The CBCL-Parent Report requires about twenty minutes to complete. The 113 items have been factor analyzed into the following nine subscales (Achenbach, 1991): Withdrawn, Somatic Complaints, Anxious/Depressed, Social Problems, Thought Problems, Attention Problems, Delinquent Behaviors, Aggressive Behaviors, and Sex Problems. A second-order factor analysis of the Behavior Problem Scale yielded two primary factors termed Internalizing and Externalizing. A total Behavior Problem Scale may be computed. In addition, scores for each subscale and factor can be computed to determine T-scores and percentiles.

Internal consistency is built in as the syndrome scales are derived from principle components of the correlation among items. For girls age 4 to 11, Cronbach’s alpha is .90 for Internalizing Behavior Problems and .93 for Externalizing Behavior Problems. For boys age 4 to 11, Cronbach’s alpha is .89 for Internalizing and .93 for Externalizing.
Behavior Problems. Cronbach's alpha represents the mean of the correlations between all possible sets of half the items comprising a scale. Inter-interviewer reliability of item scores was established at .959 for the problem items by comparing scores arrived at by three interviewers with 241 matched triads of children.

Test-retest reliability was established at .89 for Internalizing Behavior Problems and at .93 for Externalizing Behavior Problems. Long-term stability (two years) of scaled scores was established at .70 for Internalizing and .86 Externalizing Behavior Problems. The fact that children who were receiving mental health services obtained long-term stability coefficients that were generally lower with significant decreases in problem scores indicates the CBCL is sensitive to the effects of interventions with children.

Content validity is supported by the fact that the CBCL items are able to discriminate significantly between demographically matched referred and non-referred children. Construct validity is supported by significant association with analogous scales on the Conners Parent Questionnaire (Conners, 1973) and the Quay-Peterson Revised Behavior Problem Checklist (Quay & Peterson, 1983). Criterion-related validity is supported by the ability of the CBCL's quantitative scale scores to discriminate significantly between demographically matched referred and non-referred children.

The Child Behavior Checklist Teacher Report Form (CBCL-Teacher Report) (Edelbrock & Achenbach, 1984; Achenbach & Edelbrock, 1986) is based on the parent report form items, with appropriate changes to reflect school related behaviors. The teacher report form has 93 of the same behavioral/emotional items as the CBCL-Parent Report, although "pupils" is substituted for "children" in some questions. Twenty five
items on the **CBCL-Teacher Report** are different from the **CBCL-Parent Report** items and reflect aspects pertinent to teachers. The scales for the **CBCL-Teacher Report** were derived from the factor analyses of **CBCL-Teacher Report** forms completed for 1,700 children referred for special school services or mental health services. The **Behavior Problem Scale** has been factor analyzed into eight subscales: Withheld, Somatic Complaints, Anxious/Depressed, Social Problems, Thought Problems, Attention Problems, Delinquent Behaviors, and Aggressive Behaviors (Achenbach & Edelbrock, 1986). Second-order factor analyses produced two broad-band groupings; Internalizing and Externalizing. A total problem behavior scale may also be computed. Each of these subscales and factors have T-scores and percentiles that can be computed.

The **Child Behavior Checklist-Teacher Report** has been shown to correlate highly with various scales of the revised **Conners Teacher Rating Scale** that assesses externalizing behavior problems (Edelbrock, Greenbaum, & Conover, 1985). The instrument has also been shown to discriminate between clinic-referred and non-referred children (Edelbrock & Achenbach, 1984).

**Parenting Stress Index**

The **Parenting Stress Index (PSI)** was developed by Abidin (1983) to measure the degree of stress in the parent-child system as perceived by the parent. This self-report inventory of 101 items is separated into two domains, the Child Domain and the Parent Domain. The parent characteristics measured by the PSI are parent's sense of competence, parent attachment, restriction imposed by the parental role, parent's feelings of social isolation, parent depression, relationship with spouse, and parental health. The child
characteristics measured are the child's acceptability to the parent, the child's level of
demandingness, the child's moodiness, the child's degree of distractibility, the child's
adaptability, and the child's reinforcement of the parent. Higher scores indicate higher
levels of stress as well as perceived negative behavior in the total score and in each of the
subscales.

Using the test-retest method, Zakreski (1983) obtained reliability coefficients of
.778 for the Child Domain, .69 for the Parent Domain, and .88 for the total index. Internal
consistency was determined by alpha reliability coefficients calculated on the total score
and on each of the domains. The coefficient reported for the child domain was .89 and the
coefficient for the parent domain was .93 with a total reliability coefficient of .95. A high
degree of internal consistency for the PSI was indicated by these findings (Hausenstein,
Scarr, & Abidin, 1987).

Selection of Participants

Kindergarten children who attended an elementary school in the Denton County
Independent School District and who were having school adjustment difficulties as
evidenced by shy, withdrawn, anxious, depressed or inattentive behavior or who were
experiencing life changes such as parental divorce, moving, or a new sibling were referred
by teachers and/or parents. All seven kindergarten teachers identified children in their
classroom who met the criteria on the selection form (See Appendix D).

Every parent of a kindergarten child received a Filial Problem Checklist, a self-
report instrument listing 108 possible problem situations developed by Horner (1974) (See
Appendix E). Parents were instructed to mark any of the items that are currently
problematic for their family with a “1” if it is “true for the child but not considered a
problem, a “2” if it is “considered a moderate problem for the child,” or a “3” if it is “a
severe problem for the child.” Parents with kindergarten children who were referred by the
teacher or that obtained a Filial Problem Checklist score over 20 received a packet of
information informing them of the purpose and confidentiality of the study and intake and
informed consent forms (See Appendix F). Thirty kindergarten children whose families
granted permission were selected to participate in the study based on the following
criteria: (a) the primary caretaker must be able to speak, read, and write the English
language, (b) the family must be planning to remain in the school through December of
1998, (c) the child and the primary caretaker must not be currently in counseling, (d) the
primary caretaker must be able to complete pre testing and post testing, (e) the primary
caretaker and the child must both agree for the child to participate in a twenty minute play
session with a trained fifth grade student once a week for ten weeks, and (f) the parent or
legal guardian must sign the consent for pre-test video and post-test video taping.

Although thirty kindergarten children were originally identified, one child dropped
out of the control group during the project because she needed immediate help from the
school counselor. By the end of the project, the experimental group consisted of eleven
boys and four girls while the control group consisted of six boys and eight girls. The ages
of the participating kindergarten children were 5 and 6 years old. In an ethnic comparison,
the experimental group with eleven Caucasians, two African Americans, and two
Hispanics closely matched the control group with eleven Caucasians, two African
Americans, and one Hispanic.
Table 1.

**Kindergarten Participants by Gender and Group**

<table>
<thead>
<tr>
<th>Kindergarten</th>
<th>Number of Boys (Percentage of Boys in Group)</th>
<th>Number of Girls (Percentage of Girls in Group)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experimental Group</td>
<td>11 (73%)</td>
<td>4 (27%)</td>
<td>15 Experimental Group</td>
</tr>
<tr>
<td>Control Group</td>
<td>6 (43%)</td>
<td>8 (57%)</td>
<td>14 Control Group</td>
</tr>
<tr>
<td>Kindergarten Total</td>
<td>17 boys (59%)</td>
<td>12 girls (41%)</td>
<td>29 Total</td>
</tr>
</tbody>
</table>

Thirty fifth grade students were selected by (a) four fifth grade teachers’ recommendations based on the following criteria: high academic achievement, good social skills, and peer acceptance; (b) a social matrix revealing classmates’ friendship preference for that particular student; (c) parent permission; and (d) an interview by the researchers. Based on the researchers’ assessment, fifteen fifth grade students who were most likely to succeed in the training were assigned to the experimental group and the remaining fifteen students were assigned to the control group.
Table 2.

Fifth Grade Participants by Gender and Group

<table>
<thead>
<tr>
<th></th>
<th>Number of Boys (Percentage of Boys in Group)</th>
<th>Number of Girls (Percentage of Girls in Group)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fifth Grade Experimental Group</td>
<td>7 (47%)</td>
<td>8 (53%)</td>
<td>15</td>
</tr>
<tr>
<td>Fifth Grade Control Group</td>
<td>2 (14%)</td>
<td>12 (86%)</td>
<td>14</td>
</tr>
<tr>
<td>Fifth Grade Total</td>
<td>9 boys (31%)</td>
<td>20 girls (69%)</td>
<td>29</td>
</tr>
</tbody>
</table>

Collection of Data

Due to the complexity of scheduling, the first fifteen kindergarten children who turned in their parent permission slips were assigned to the experimental group. The next fifteen kindergarten children were assigned to the control group. Children who were selected for the control group were given the opportunity to participate in special play sessions after the research study ended.

After obtaining parents' permission, the parents of the participating kindergarten children were asked to complete The Child Behavior Checklist-Parent Report (CBCL-Parent Report) and the Parenting Stress Index (PSI) before the play sessions began. The teachers of the kindergarten children were asked to complete the Child Behavior Checklist - Teacher Report (CBCL-Teacher Report). The researchers administered the Joseph Pre-School and Primary Self-Concept Screening Test (JPPSST) and the Haak Sentence Completion (HSC) to each kindergarten child. Each of these instruments was also
administered immediately after the kindergarten children received ten weeks of play sessions.

Each of the thirty kindergarten children was matched with one of the thirty fifth grade students based on (1) gender in which all kindergarten girls were paired with fifth grade girls except for one and kindergarten boys were paired with either fifth grade girls or fifth grade boys and (2) convenience of schedule. Each pair of kindergarten students and fifth grade students participated in a twenty minute videotaped play session before the training of the fifth grade students in the experimental group began and after the experimental group completed ten once-a-week play sessions. Research assistants supervised these video taped play sessions but did not intervene other than to inform the pair of five minutes remaining and the end of the session. Video taped sessions were conducted in three small rooms in the school library. Testing and video taping were completed in one week. All the instruments and videotapes were number coded to maintain the confidentiality of the participants.

Procedures

Training of Fifth Grade Students

After completing the pre-training assessment instruments, the fifteen fifth grade students in the experimental group received training in child-centered play therapy procedures and skills for 35 minutes twice a week for five weeks and then once a week for the duration of the ten weeks of play sessions. Didactic lectures, experiential activities such as role playing, viewing videos of play sessions and ongoing supervision were utilized.

The use of didactic lectures and role playing to train play therapy skills is
supported by two important research studies. Arnold (1976) demonstrated that training through micro counseling, “learning by doing” is effective in teaching graduate students three essential play therapy skills, namely limit setting, reflection of behavior statements, and reflection of feeling statements. However, didactic lectures are also essential. Research by Linden and Stollak (1969) demonstrated that undergraduate college students trained in play therapy procedures and skills through a didactic approach reflected significantly more feelings and content of behavior and were less directive and less restricted than students trained solely by an experiential approach.

The child-centered play therapy training was based on Landreth’s (1991) 10-week filial therapy model which was originally developed for parents. Training focused on basic child-centered play therapy principles of following the child’s lead, avoiding judgmental statements, creating a safe, accepting atmosphere, reflecting feelings, facilitating decision making, enhancing self esteem, setting therapeutic limits and providing therapeutic toys.

The child-centered play therapy approach was chosen for the participants for two reasons. First, research has shown that elementary and junior high school students can effectively implement Rogerian interpersonal communication skills (Seidenberg, 1978). Second, fifth grade students’ developmental and cognitive abilities are best suited for the child-centered approach since it does not require analysis or interpretation or rigid structure as do other therapeutic approaches.

Training sessions were held twice a week. During the Monday study hall period from 2:10 pm to 2:45 pm, all fifteen fifth graders learned new concepts through didactic lectures, video tapes of experienced play therapists, and role playing in which participants
alternated being the facilitator and the kindergarten student. Later in the week, in order to accommodate complex schedules, eight fifth grade participants came on Wednesday during “specials” (art, music, or P.E.) period from 8:15 am to 8:50 am and seven fifth grade participants came on Thursday during their “specials” period. During this second training of the week, fifth grade participants reviewed the new concepts learned on Monday and implemented the concepts through one on one role play again. The specific content of the training sessions was as follows:

**Training Session One**

Introductions of facilitators and fifth grade students were made and the project was explained. The facilitators described play as the child’s language and explained that children’s language is based on actions, not words. The skills of tracking behavior and following the child’s lead were explained and demonstrated by the facilitators. Participants learned that the purpose of tracking is to help the child feel important or special and to build the child’s self esteem.

**Training Session Two**

The concepts of tracking behavior and following the child’s lead were reviewed. Each fifth grade student participated in a role play with another student to practice the new skill.

**Training Session Three**

A review of tracking behavior was conducted. Facilitators presented and demonstrated new concepts of recognizing and reflecting feelings. Students learned that the purpose of recognizing and reflecting feelings is to help the child feel understood and
to build the child’s self understanding. Skills in returning responsibility and in building self esteem were also explained and demonstrated. Students learned the purpose for these skills is to help the child become less dependent and to build the child’s self confidence. One on one role playing with participants alternating the role of kindergarten child and fifth grade facilitator was performed.

**Training Session Four**

Facilitators and students reviewed concepts of reflecting feelings, returning responsibility, and building self esteem. These skills were practiced by each student through one on one role play.

**Training Session Five**

Facilitators presented a video tape of an experienced play therapist demonstrating skills of tracking behavior and reflecting feelings. Students were instructed to focus on the child and not to play with toys unless the child gives specific instructions. In order to facilitate the child staying in the lead, the “whisper technique” of “what should I do now” was demonstrated. Facilitators also stressed encouraging the child rather than praising the child for the purpose of building the child’s internal motivation and evaluation. Students practiced the new concepts through one on one role playing.

**Training Session Six**

Facilitators and students reviewed the skills of the “whisper technique” and encouraging the child. Students implemented these skills through role play.

**Training Session Seven**

Facilitators explained and demonstrated the therapeutic limit setting steps of (a)
acknowledging the desire, (b) communicating the limit, and (c) targeting an alternative.

Students learned the purpose of therapeutic limit setting is to build the child’s self control.

One on one role playing with participants alternating role of kindergarten child and fifth grade facilitator was performed.

**Training Session Eight**

Facilitators and students reviewed the concepts of therapeutic limit setting and implemented the skill through one on one role playing.

**Training Session Nine**

Therapeutic limit setting was reviewed and a video of an experienced play therapist setting limits was shown. The skill of setting the ultimate limit was explained and demonstrated. Students practiced setting the ultimate limit through role play. Facilitators also explained how to greet the child and how to introduce the child to the play session.

**Training Session Ten**

Facilitators and students reviewed every child-centered play therapy skill previously presented. Students implemented each skill during a one on one role play.

**Play Sessions**

After participating in training sessions twice a week for five weeks, each fifth grade facilitator and their assigned kindergarten child participated in a twenty minute play session once a week for ten weeks. These play sessions were supervised unobtrusively from a distance in the classroom by the researchers. The researchers did not intervene other than to give the time limits of five minutes remaining and the end of the session.

Play sessions were held in a portable classroom building utilized as an overflow
classroom. This classroom was sectioned off into six areas for play sessions by cardboard partitions. On one occasion when a portable classroom building was not available, play sessions were held in the library in small rooms and in between bookshelves. The play sessions were scheduled at a time designated by the teachers and principal to ensure students did not miss academic instruction.

Play materials utilized in the play sessions included Landreth's (1991) suggestions for a play therapy tote bag: (a) real life items such as a bendable doll family, a cardboard box top with rooms indicated by strips of tape, nursing bottle, plastic dishes, a small car, a small plane, and telephone, (b) aggressive release items such as handcuffs, dart gun, rubber knife, toy soldiers, and an inflatable plastic punching toy and (c) creative expressive items such as Play-Doh, small plain mask, Nerf ball, newsprint, crayons, blunt scissors, and egg cartons to smash or color.

To ensure the fifth grade students properly implemented child-centered play therapy procedures and skills, supervisors either gave feedback immediately after the play session or before the next play session, depending on the student's schedule. In addition, weekly group supervision training sessions were held to review videotapes of fifth grade student's play session, give feedback of strengths and areas for growth, address group concerns, and provide additional training as needed.

**Training after Play Session One**

Facilitators explained how to build rapport through smiling and commenting on clothing while walking to the session. Facilitators reviewed limit setting and encouraged fifth grade students to set limits on being handcuffed behind their back. Responses to
kindergarten students’ question “why won’t you play with me?” were demonstrated by facilitators.

Training After Play Session Two

The importance of liking the child and of focusing on the child rather than fidgeting with the toys was emphasized by the facilitators. Responses to requests to draw something were demonstrated.

Training After Play Session Three

Limit setting on staying in designated area was demonstrated. Facilitators encouraged an increase in identifying and reflecting feelings. Reflecting the intent of the child’s behavior with statements such as “you’re showing me you’re strong” was explained.

Training After Play Session Four

Students were encouraged to increase tracking. Facilitators demonstrated how to responding to the kindergarten child’s anger or annoyance at the fifth grade student. Students were encouraged to look for themes and changes in kindergarten children’s behavior. Facilitators explained why fifth grade students should refrain from talking about kindergarten children in front of them.

Training After Play Session Five

Students were encouraged to increase tracking and reflection of feelings. Understanding meaning behind children’s play activity was discussed. Facilitators and students also discussed the effective of temporary change of play session location on kindergarten and fifth grade participants.
Training After Play Session Six

Students were encouraged to use the ultimate limit when necessary and to increase esteem building comments. The value of setting personal limits such as “I choose not to eat the Play Doh” was explained and demonstrated by the facilitators. Students learned that as they model personal limits the kindergarten child will learn that peer compliance is not necessary if it is uncomfortable or dangerous for self. Progress of increased bond between the kindergarten child and the fifth grade student was discussed.

Training After Play Session Seven

Students were encouraged to look at the kindergarten child’s face to identify feelings. Facilitators demonstrated how to handle a role given in fantasy play and emphasized the whisper technique as well as refraining from evaluative statements. Termination issues and preparation were introduced to the fifth grade students.

Training After Play Session Eight

Facilitators and students processed feelings of termination and identified changes in the play session routine, behavior, and the relationship.

Training After Play Session Nine

Termination concerns were addressed by the facilitators. Each fifth grade student identified changes in their kindergarten child and in themselves.

Based on observations, fifth grade students who received training did appropriately implement the child-centered play therapy skills and procedures. Preliminary reports suggest the fifth grade students in the experimental group showed a significant difference in their ability to communicate acceptance, to allow the kindergarten child self-direction,
and to be involved with the child when compared to the control group.

Facilitators

Training in child-centered play therapy skills for the fifth grade students was provided by Jennifer Baggerly, Julie Ziegler, and Dr. Garry Landreth. Jennifer Baggerly is a play therapist, a Licensed Professional Counselor Intern in the state of Texas, and a doctoral candidate at the University of North Texas. She had completed an introduction to play therapy course, an advanced play therapy course, a filial therapy course, and a doctoral level practicum and internship in play therapy. Julie Ziegler is a play therapist and a doctoral candidate at the University of North Texas. She had completed an introduction to play therapy course, an advanced play therapy course, a filial therapy course, and a doctoral level practicum in play therapy. Dr. Garry Landreth is a regents professor at the University of North Texas and director of the Center for Play Therapy. He teaches an introduction to play therapy course, an advanced play therapy course, and a filial therapy course. In addition, he is an internationally recognized expert in play therapy and has trained play therapists around the world.

Pretesting and post-testing was conducted by Jennifer Baggerly, Julie Ziegler, and three other doctoral counseling interns from the Child and Family Resource Center at the University of North Texas. All researchers who conducted testing are play therapists and had completed doctoral level training in child assessment.

Analyses of Data

All instruments were blind-scored by research assistants. A missing value imputation procedure employing a regression approach (Tabachnick & Fidell, 1996) was
used to predict the missing values of one child whose parents did not complete the CBCL-Parent Report and PSI pretests and one child whose teacher did not complete the CBCL-Teacher Report pretest. A robust transformation procedure (Yuan, Chin, & Bentler, in review) determined that there were no outliers and the skewness was not significant. Therefore, the parametric assumptions of normality and homogeneity of variance were met.

Although a multivariate analysis of covariance (MANCOVA) was initially planned to test the significance of the difference between the experimental group and the control group on the adjusted post-test means for each hypotheses, it was determined that the experimental group pretest means were approximately a standard deviation higher than the control group pretest means. For example, the total mean score on the CBCL-Teacher Report for the control group was 48.0714 with a standard deviation of 7.1626 while the total mean score of the experimental group was 6.8619 points higher at 54.9333. (See Appendix H). Since MANCOVA artificially equates the experimental and control group on pretest scores, the true treatment gain for the experimental group would have been masked. Therefore, MANOVA of gain scores, which determines if there was significant change from pretreatment to posttreatment via analyzing the difference between pretest and post-test, was utilized (Maxwell & Delaney, 1990).

On the basis of MANOVA of gain scores, the hypotheses were either retained or rejected. Significant results on the instrument subscales and t-tests were determined.
CHAPTER III

RESULTS AND DISCUSSION

This chapter presents the results of the analysis of the data for each hypothesis tested in this study and significant findings on the instrument subscales and t-tests. Included also is a discussion of the results, implications, and recommendations for further research.

Results

The results of this study are presented in the order the hypotheses were tested. Multiple analyses of variance of gained scores were performed on all hypotheses and a level of significance of .05 was established as the criterion for either retaining or rejecting the hypothesis.

Hypothesis 1

Kindergarten children who receive play sessions will attain a significantly higher mean total score on the Joseph Pre-School and Primary Self-Concept Screening Test (JPPSST) at post-testing than will the kindergarten children in the control group.

Table 3 presents the pre and post-test means and standard deviations for the experimental and control groups. Table 4 presents the analysis of variance mean gain scores, showing the difference between the experimental and control groups. Table 5 presents the analysis of variance data, showing that there is no significant difference between the experimental and control groups' post-test mean scores.
Table 3.

Mean total scores on the Joseph Pre-School and Primary Self-Concept Screening Test (JPPSST)

<table>
<thead>
<tr>
<th></th>
<th>Experimental (n = 15)</th>
<th>Control (n = 14)</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Post-test</td>
<td>Pretest</td>
<td>Post-test</td>
</tr>
<tr>
<td>Mean</td>
<td>24.4000</td>
<td>25.7333</td>
<td>24.7857</td>
<td>25.5714</td>
</tr>
<tr>
<td>SD</td>
<td>4.7929</td>
<td>3.5146</td>
<td>5.2062</td>
<td>4.7184</td>
</tr>
<tr>
<td>Total cases = 29</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 4.

Mean of gain scores on the Joseph Pre-School and Primary Self-Concept Screening Test (JPPSST)

<table>
<thead>
<tr>
<th></th>
<th>Experimental (n = 15)</th>
<th>Control (n = 14)</th>
<th>Total (n = 29)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gain Mean</td>
<td>1.3333</td>
<td>.7857</td>
<td>1.0690</td>
</tr>
<tr>
<td>SD</td>
<td>4.6853</td>
<td>6.0533</td>
<td>5.2978</td>
</tr>
</tbody>
</table>

Table 5.

Analysis of variance data for the mean total scores on the Joseph Pre-School and Primary Self-Concept Screening Test (JPPSST)

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F Ratio</th>
<th>Sign of F</th>
<th>Effect Size</th>
<th>Power</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
<td>2.172</td>
<td>1</td>
<td>2.172</td>
<td>.075</td>
<td>.787</td>
<td>.003</td>
<td>.058</td>
</tr>
</tbody>
</table>

Total cases = 29
Table 5 shows the F ratio for the main effects was significant to the .787 level indicating no significant increase in the experimental group children’s mean total score for the *Joseph Pre-School and Primary Self-Concept Screening Test (JPPSST)*. On the basis of this data, hypothesis 1 was not retained.

**Hypothesis 2**

Kindergarten children who receive play sessions will attain a significantly higher mean total score on the *Haak Sentence Completion (HSC)* at post-testing than will the kindergarten children in the control group.

Table 6 presents the pre and post-test means and standard deviations for the experimental and control groups. Table 7 presents the analysis of variance mean gain scores, showing the difference between the experimental and control groups. Table 8 presents the analysis of variance data, showing that there is a significant difference between the experimental and control groups’ post-test mean scores but in the control group’s favor.

Table 6.

**Mean total scores on the Haak Sentence Completion (HSC)**

<table>
<thead>
<tr>
<th></th>
<th>Experimental (n = 15)</th>
<th>Control (n = 14)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Post-test</td>
</tr>
<tr>
<td>Mean</td>
<td>21.4667</td>
<td>20.2667</td>
</tr>
<tr>
<td>SD</td>
<td>5.0124</td>
<td>5.2026</td>
</tr>
<tr>
<td>Total cases</td>
<td>29</td>
<td></td>
</tr>
</tbody>
</table>
Table 7.

Mean of gain scores on the Haak Sentence Completion (HSC)

<table>
<thead>
<tr>
<th>Source</th>
<th>Experimental (n = 15)</th>
<th>Control (n = 14)</th>
<th>Total (n = 29)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gain Mean</td>
<td>-1.2000</td>
<td>3.8571</td>
<td>1.2414</td>
</tr>
<tr>
<td>SD</td>
<td>5.3077</td>
<td>5.5032</td>
<td>5.8959</td>
</tr>
</tbody>
</table>

Table 8.

Analysis of variance data for the mean total scores on the Haak Sentence Completion (HSC)

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F Ratio</th>
<th>Sign. of F</th>
<th>Effect Size</th>
<th>Power</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
<td>185.196</td>
<td>1</td>
<td>185.196</td>
<td>6.345</td>
<td>.018</td>
<td>.190</td>
<td>.680</td>
</tr>
</tbody>
</table>

Total cases = 29

Table 7 shows the gain mean of the experimental group was -1.2000 while the gain mean for the control group was 3.8571. Table 8 shows the $F$ ratio for the main effects was significant to the .018 level, indicating a significant increase in the control group children's mean total score for the Haak Sentence Completion (HSC). On the basis of this data, hypothesis 2 was not retained.

Hypothesis 3

Kindergarten children who receive play sessions will attain a significantly lower mean total score on the Child Behavior Checklist-Teacher's Report (CBCL-Teacher Report) at post-testing than will the kindergarten children in the control group.
Table 9 presents the pre and post-test means and standard deviations for the experimental and control groups. Table 10 presents the analysis of variance mean gain scores, showing the difference between the experimental and control groups. Table 11 presents the analysis of variance data, showing that there is no significant difference between the experimental and control groups' post-test mean scores.

Table 9.

<table>
<thead>
<tr>
<th></th>
<th>Experimental (n = 15)</th>
<th>Control (n = 14)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Post-test</td>
<td>Pretest</td>
</tr>
<tr>
<td>Mean</td>
<td>54.9333</td>
<td>53.2000</td>
<td>48.0714</td>
</tr>
<tr>
<td>SD</td>
<td>11.3608</td>
<td>10.1644</td>
<td>7.1626</td>
</tr>
<tr>
<td>Total cases = 29</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 10.

<table>
<thead>
<tr>
<th></th>
<th>Experimental (n = 15)</th>
<th>Control (n = 14)</th>
<th>Total (n = 29)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gain Mean</td>
<td>1.7333</td>
<td>-1.4286</td>
<td>.2069</td>
</tr>
<tr>
<td>SD</td>
<td>10.5996</td>
<td>6.8243</td>
<td>8.9657</td>
</tr>
</tbody>
</table>
Table 11.

**Analysis of variance data for the mean total scores on the Child Behavior Checklist-Teacher’s Report (CBCL-Teacher Report)**

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F Ratio</th>
<th>Sign. of F</th>
<th>Effect Size</th>
<th>Power</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
<td>72.397</td>
<td>1</td>
<td>72.397</td>
<td>.897</td>
<td>.352</td>
<td>.032</td>
<td>.150</td>
</tr>
</tbody>
</table>

Total cases = 29

Table 11 shows the F ratio for the main effects was significant to the .352 level indicating no significant increase in the experimental group children’s mean total scores on the Child Behavior Checklist-Teacher’s Report (CBCL-Teacher Report). On the basis of this data, hypothesis 3 was not retained.

**Hypothesis 3a**

Kindergarten children who receive play sessions will attain a significantly lower mean score on the Internalizing Behavior Problems scale of the Child Behavior Checklist-Teacher Report (CBCL-Teacher Report) at post-testing than will the kindergarten children in the control group.

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


<table>
<thead>
<tr>
<th></th>
<th>Experimental (n = 15)</th>
<th>Control (n = 14)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Post-test</td>
</tr>
<tr>
<td>Mean</td>
<td>46.4000</td>
<td>48.8667</td>
</tr>
<tr>
<td>SD</td>
<td>9.0538</td>
<td>7.3666</td>
</tr>
</tbody>
</table>

Total cases = 29

**Table 13.**

**Mean of gain scores on the Internalizing Behavior Problems scale of the Child Behavior Checklist-Teacher Report (CBCL-Teacher Report)**

<table>
<thead>
<tr>
<th></th>
<th>Experimental (n = 15)</th>
<th>Control (n = 14)</th>
<th>Total (n = 29)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gain Mean</td>
<td>-2.4667</td>
<td>-.9286</td>
<td>-1.7241</td>
</tr>
<tr>
<td>SD</td>
<td>10.2181</td>
<td>8.9052</td>
<td>9.4676</td>
</tr>
</tbody>
</table>
Table 14.


<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F Ratio</th>
<th>Sign. of F</th>
<th>Effect Size</th>
<th>Power</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
<td>17.131</td>
<td>1</td>
<td>17.131</td>
<td>.186</td>
<td>.670</td>
<td>.007</td>
<td>.070</td>
</tr>
</tbody>
</table>

Total cases = 29

Table 14 shows the F ratio for the main effects was significant to the .670 level indicating no significant decrease in the experimental group children’s mean score on the Internalizing Behavior Problems scale of the Child Behavior Checklist-Teacher Report (CBCL-Teacher Report). On the basis of this data, hypothesis 3a was not retained.

Hypothesis 3b

Kindergarten children who receive play sessions will attain a significantly lower mean score on the Externalizing Behavior Problems scale of the Child Behavior Checklist-Teacher Report (CBCL-Teacher Report) at post-testing than will the kindergarten children in the control group.

Table 15 presents the pre and post-test means and standard deviations for the experimental and control groups. Table 16 presents the analysis of variance mean gain scores, showing the difference between the experimental and control groups. Table 17 presents the analysis of variance data, showing that there is no significant difference between the experimental and control groups’ post-test mean scores.
Table 15.


<table>
<thead>
<tr>
<th>Experimental (n = 15)</th>
<th>Control (n = 14)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pretest</td>
<td>Post-test</td>
</tr>
<tr>
<td>Mean</td>
<td>57.3333</td>
</tr>
<tr>
<td>SD</td>
<td>11.3116</td>
</tr>
</tbody>
</table>

Total cases = 29

Table 16.

**Mean of gain scores on the Externalizing Behavior Problems scale of the Child Behavior Checklist-Teacher Report (CBCL-Teacher Report)**

<table>
<thead>
<tr>
<th>Experimental (n = 15)</th>
<th>Control (n = 14)</th>
<th>Total (n = 29)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gain Mean</td>
<td>2.4667</td>
<td>3.3571</td>
</tr>
<tr>
<td>SD</td>
<td>9.4405</td>
<td>5.4435</td>
</tr>
</tbody>
</table>
Table 17 shows the $F$ ratio for the main effects was significant to the .760 level indicating no significant decrease in the experimental group children’s mean score on the Externalizing Behavior Problems scale of the Child Behavior Checklist-Teacher Report. On the basis of this data, hypothesis 3b was not retained.

Hypothesis 4

Kindergarten children who receive play sessions will attain a significantly lower mean total score on the Child Behavior Checklist-Parent’s Report at post-testing than will the kindergarten children in the control group.

Table 18 presents the pre and post-test means and standard deviations for the experimental and control groups. Table 19 presents the analysis of variance mean gain scores, showing the difference between the experimental and control groups. Table 20 presents the analysis of variance data, showing that there is no significant difference between the experimental and control groups’ post-test mean scores.
Table 18.

Mean total scores on the Child Behavior Checklist-Parent’s Report (CBCL-Parent Report)

<table>
<thead>
<tr>
<th></th>
<th>Experimental (n = 15)</th>
<th>Control (n = 14)</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Post-test</td>
<td>Pretest</td>
<td>Post-test</td>
</tr>
<tr>
<td>Mean</td>
<td>55.5333</td>
<td>53.3333</td>
<td>52.3571</td>
<td>48.3571</td>
</tr>
<tr>
<td>SD</td>
<td>5.9745</td>
<td>8.5996</td>
<td>9.1366</td>
<td>9.4185</td>
</tr>
</tbody>
</table>

Total cases = 29

Table 19.

Mean of gain scores on the Child Behavior Checklist-Parent’s Report (CBCL-Parent Report)

<table>
<thead>
<tr>
<th></th>
<th>Experimental (n = 15)</th>
<th>Control (n = 14)</th>
<th>Total (n = 29)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gain Mean</td>
<td>2.2000</td>
<td>4.0000</td>
<td>3.0690</td>
</tr>
<tr>
<td>SD</td>
<td>7.5612</td>
<td>5.4913</td>
<td>6.5897</td>
</tr>
</tbody>
</table>
Table 20.

Analysis of variance data for the mean total scores on the Child Behavior Checklist-Parent's Report (CBCL-Parent Report)

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F Ratio</th>
<th>Sign. of F</th>
<th>Effect Size</th>
<th>Power</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
<td>23.462</td>
<td>1</td>
<td>23.462</td>
<td>.531</td>
<td>.472</td>
<td>.019</td>
<td>.108</td>
</tr>
</tbody>
</table>

Total cases = 29

Table 20 shows the F ratio for the main effects was significant to the .472 level indicating no significant decrease in the experimental group children's mean total scores on the Child Behavior Checklist-Parent's Report (CBCL-Parent Report). On the basis of this data, hypothesis 4 was not retained.

Hypothesis 4a

Kindergarten children who receive play sessions will attain a significantly lower mean score on the Internalizing Behavior Problems scale of the Child Behavior Checklist-Parent's Report (CBCL-Parent Report) at post-testing than will the kindergarten children in the control group.

Table 21 presents the pre and post-test means and standard deviations for the experimental and control groups. Table 22 presents the analysis of variance mean gain scores, showing the difference between the experimental and control groups. Table 23 presents the analysis of variance data, showing that there is no significant difference between the experimental and control groups' post-test mean scores.
Table 21.


<table>
<thead>
<tr>
<th></th>
<th>Experimental (n = 15)</th>
<th>Control (n = 14)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Post-test</td>
</tr>
<tr>
<td>Mean</td>
<td>50.8667</td>
<td>50.0667</td>
</tr>
<tr>
<td>SD</td>
<td>6.8751</td>
<td>9.3156</td>
</tr>
</tbody>
</table>

Total cases = 29

Table 22.


<table>
<thead>
<tr>
<th></th>
<th>Experimental (n = 15)</th>
<th>Control (n = 14)</th>
<th>Total (n = 29)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gain Mean</td>
<td>.8000</td>
<td>1.9286</td>
<td>1.3448</td>
</tr>
<tr>
<td>SD</td>
<td>6.6997</td>
<td>6.2322</td>
<td>6.3879</td>
</tr>
</tbody>
</table>
Table 23.


<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F Ratio</th>
<th>Sign. of F</th>
<th>Effect Size</th>
<th>Power</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
<td>9.223</td>
<td>1</td>
<td>9.223</td>
<td>.220</td>
<td>.643</td>
<td>.008</td>
<td>.074</td>
</tr>
</tbody>
</table>

Total cases = 29

Table 23 shows the F ratio for the main effects was significant to the .643 level indicating no significant decrease in the experimental group children's mean scores on the Internalizing Behavior Problems scale of the Child Behavior Checklist-Parent's Report (CBCL-Parent Report). On the basis of this data, hypothesis 4a was not retained.

**Hypothesis 4b**

Kindergarten children who receive play sessions will attain a significantly lower mean score on the Externalizing Behavior Problems scale of the Child Behavior Checklist-Parent Report (CBCL-Parent Report) at post-testing than will the kindergarten children in the control group.

Table 24 presents the pre and post-test means and standard deviations for the experimental and control groups. Table 25 presents the analysis of variance mean gain scores, showing the difference between the experimental and control groups. Table 26 presents the analysis of variance data, showing that there is no significant difference between the experimental and control groups' post-test mean scores.
Table 24.


<table>
<thead>
<tr>
<th></th>
<th>Experimental (n = 15)</th>
<th>Control (n = 14)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Post-test</td>
</tr>
<tr>
<td>Mean</td>
<td>57.6667</td>
<td>53.4000</td>
</tr>
<tr>
<td>SD</td>
<td>7.4801</td>
<td>7.6607</td>
</tr>
</tbody>
</table>

Total cases = 29

Table 25.


<table>
<thead>
<tr>
<th></th>
<th>Experimental (n = 15)</th>
<th>Control (n = 14)</th>
<th>Total (n = 29)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gain Mean</td>
<td>4.2667</td>
<td>2.0000</td>
<td>3.1724</td>
</tr>
<tr>
<td>SD</td>
<td>6.7132</td>
<td>5.2477</td>
<td>6.0537</td>
</tr>
</tbody>
</table>
Table 26.


<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F Ratio</th>
<th>Sign. of F</th>
<th>Effect Size</th>
<th>Power</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
<td>37.205</td>
<td>1</td>
<td>37.205</td>
<td>1.016</td>
<td>.322</td>
<td>.036</td>
<td>.163</td>
</tr>
</tbody>
</table>

Total cases = 29

Table 26 shows the F ratio for the main effects was significant to the .322 level indicating no significant decrease in the experimental group children's mean score on the Externalizing Behavior Problems scale of the Child Behavior Checklist-Parent Report (CBCL-Parent Report). On the basis of this data, hypothesis 4b was not retained.

**Hypothesis 5**

The parents of kindergarten children who receive play sessions will attain a significantly lower mean total score on the Parenting Stress Index (PSI) at post-testing than will the parents of children in the control group.

Table 27 presents the pre and post-test means and standard deviations for the experimental and control groups. Table 28 presents the analysis of variance mean gain scores, showing the difference between the experimental and control groups. Table 29 presents the analysis of variance data, showing that there is no significant difference between the experimental and control groups' post-test mean scores.
Table 27.

Mean total scores on the Parenting Stress Index (PSI)

<table>
<thead>
<tr>
<th></th>
<th>Experimental (n = 15)</th>
<th>Control (n = 14)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Post-test</td>
</tr>
<tr>
<td>Mean</td>
<td>211.8000</td>
<td>214.2000</td>
</tr>
<tr>
<td>SD</td>
<td>36.4068</td>
<td>38.7468</td>
</tr>
</tbody>
</table>

Total cases = 29

Table 28.

Mean of gain scores on the Parenting Stress Index (PSI)

<table>
<thead>
<tr>
<th></th>
<th>Experimental (n = 15)</th>
<th>Control (n = 14)</th>
<th>Total (n = 29)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gain Mean</td>
<td>-2.4000</td>
<td>5.2143</td>
<td>1.2759</td>
</tr>
<tr>
<td>SD</td>
<td>22.0836</td>
<td>29.0760</td>
<td>25.5216</td>
</tr>
</tbody>
</table>

Table 29.

Analysis of variance data for the mean total scores on the Parenting Stress Index (PSI)

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F Ratio</th>
<th>Sign. of F</th>
<th>Effect Size</th>
<th>Power</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
<td>419.836</td>
<td>1</td>
<td>419.836</td>
<td>.636</td>
<td>.432</td>
<td>.023</td>
<td>.120</td>
</tr>
</tbody>
</table>

Total cases = 29

Table 29 shows the $F$ ratio for the main effects was significant to the .432 level indicating no significant decrease in the experimental group children’s mean total scores on the Parenting Stress Index (PSI). On the basis of this data, hypothesis 5 was not
Hypothesis 5a

The parents of kindergarten children who receive play sessions will attain a significantly lower mean score on the “Parent Domain” of the Parenting Stress Index (PSI) at post-testing than will the parents of children in the control group.

Table 30 presents the pre and post-test means and standard deviations for the experimental and control groups. Table 31 presents the analysis of variance mean gain scores, showing the difference between the experimental and control groups. Table 32 presents the analysis of variance data, showing that there is no significant difference between the experimental and control groups’ post-test mean scores.

Table 30.

Mean scores on the “Parent Domain” of the Parenting Stress Index (PSI)

<table>
<thead>
<tr>
<th></th>
<th>Experimental (n = 15)</th>
<th>Control (n = 14)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Post-test</td>
</tr>
<tr>
<td>Mean</td>
<td>110.2000</td>
<td>116.4667</td>
</tr>
<tr>
<td>SD</td>
<td>20.6889</td>
<td>21.5700</td>
</tr>
</tbody>
</table>

Total cases = 29
Table 31.

Mean of gain scores on the “Parent Domain” of the Parenting Stress Index (PSI)

<table>
<thead>
<tr>
<th></th>
<th>Experimental (n = 15)</th>
<th>Control (n = 14)</th>
<th>Total (n = 29)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gain Mean</td>
<td>-6.2667</td>
<td>.2143</td>
<td>-3.1379</td>
</tr>
<tr>
<td>SD</td>
<td>14.9593</td>
<td>16.7110</td>
<td>15.8874</td>
</tr>
</tbody>
</table>

Table 32.

Analysis of variance data for the mean scores on the “Parent Domain” of the Parenting Stress Index (PSI)

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F Ratio</th>
<th>Sign. of F</th>
<th>Effect Size</th>
<th>Power</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
<td>304.158</td>
<td>1</td>
<td>304.158</td>
<td>1.214</td>
<td>.280</td>
<td>.043</td>
<td>.186</td>
</tr>
</tbody>
</table>

Total cases = 29

Table 32 shows the F ratio for the main effects was significant to the .280 level indicating no significant decrease in the experimental group children’s mean scores on the “Parent Domain” of the Parenting Stress Index (PSI). On the basis of this data, hypothesis 5a was not retained.

Hypothesis 5b

The parents of kindergarten children who receive play sessions will attain a significantly lower mean score on the “Child Domain” of the Parenting Stress Index (PSI) at post-testing than will the parents of children in the control group.

Table 33 presents the pre and post-test means and standard deviations for the experimental and control groups. Table 34 presents the analysis of variance mean gain
scores, showing the difference between the experimental and control groups. Table 35 presents the analysis of variance data, showing that there is no significant difference between the experimental and control groups’ post-test mean scores.

Table 33.

**Mean scores on the “Child Domain” of the Parenting Stress Index (PSI)**

<table>
<thead>
<tr>
<th></th>
<th>Experimental (n = 15)</th>
<th>Control (n = 14)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Post-test</td>
</tr>
<tr>
<td>Mean</td>
<td>101.7333</td>
<td>97.7333</td>
</tr>
<tr>
<td>SD</td>
<td>18.8205</td>
<td>20.6067</td>
</tr>
<tr>
<td>Total cases</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 34.

**Mean of gain scores on the “Child Domain” of the Parenting Stress Index (PSI)**

<table>
<thead>
<tr>
<th></th>
<th>Experimental (n = 15)</th>
<th>Control (n = 14)</th>
<th>Total (n = 29)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gain Mean</td>
<td>4.0000</td>
<td>5.0000</td>
<td>4.4828</td>
</tr>
<tr>
<td>SD</td>
<td>9.2659</td>
<td>14.7544</td>
<td>12.0108</td>
</tr>
</tbody>
</table>
Table 35 shows the F ratio for the main effects was significant to the .827 level indicating no significant decrease in the experimental group children’s mean scores “Child Domain” of the Parenting Stress Index (PSI). On the basis of this data, hypothesis 5b was not retained.

Statistical Results of Subscales

In addition to these hypothesis, subscales of the Child Behavior Checklist- Parent Report (CBCL-Parent Report), the Child Behavior Checklist - Teacher Report (CBCL-Teacher Report), and the Parenting Stress Index (PSI) were analyzed through ANOVA of gained scores to determine if this analysis would reveal any areas of significance. Of particular interest was the Somatic Complaints subscale of the CBCL-Teacher Report. When compared to the control group, children in the experimental group showed a marginally significant decrease in the Somatic Complaints subscale of the Child Behavior Checklist-Teacher Report (CBCL-Teacher Report), $F(1,29) = 3.244, p = .083$. In addition, the Delinquent Behavior subscale of the CBCL-Parent Report shows an effect size of .065 indicating there is a meaningful relationship between the
variables related to delinquent behavior.

Two subscales of the Parenting Stress Index (PSI) also were of interest. Parents of children in the experimental group scored significantly higher than parents of children in the control group on the Health subscale of the PSI, $F(1,29) = 5.782, p = .023$, and the Spouse subscale, $F(1,29) = 4.717, p = .039$. These findings indicate parents of children in the experimental group experienced more stress related to their health and spouse than did the control group.

**Statistical Results Based on $t$-test**

A $t$-test for the experimental group was performed on pre-test data and post-test data to determine if children in the experimental group showed statistically significant increases in their post-test scores. Findings of statistical significance based on the $t$-test included the following. For the Externalizing Behavior scale of the CBCL-Parent Report, the pre-test and post-test paired differences mean of 4.2667 with a standard deviation of 6.7132 resulted in a $t$ score ($t = 2.462$) significant at the .027 level. These findings indicate a significant decrease in the experimental group children's post-test scores on the Externalizing Behavior scale of the CBCL-Parent Report.

For the Delinquent Behavior subscale of the CBCL-Parent Report, the pre-test and post-test paired differences mean of 3.000 with a standard deviation of 5.1409 resulted in a $t$ score ($t = 2.260$) significant at the .040 level. These findings indicate a significant decrease in the experimental group children's post-test scores on the Delinquent Behavior subscale of the CBCL-Parent Report.

For the Demandingness subscale of the PSI, the pre-test and post-test paired
differences mean of 1.3333 with a standard deviation of 2.4103 resulted in a \( t \) score \( (t = 2.142) \) significant at the .050 level. These findings indicate a significant decrease in the experimental group children's post-test scores on the Demandingness Subscale of the PSI.

For the Health subscale of the PSI, the pre-test and post-test paired differences mean of -1.8667 with a standard deviation of 3.1137 resulted in a \( t \) score \( (t = -2.322) \) significant at the .036 level. These findings indicate a significant increase in the experimental group children's post-test scores on the Health Subscale of the PSI.

For the Depression Subscale on the PSI, the pre-test and post-test paired differences mean of -2.0000 with a standard deviation of 3.7417 resulted in a \( t \) score \( (t = -2.070) \) significant at the .057 level. These findings indicate a significant increase in the experimental group children's post-test scores on the Depression subscale of the PSI.

For Life Stress Scale of the PSI, the pre-test and post-test paired differences mean of 4.1333 with a standard deviation of 4.7188 resulted in a \( t \) score \( (t = 3.392) \) significant at the .004 level. These findings indicate a significant decrease in the experimental group children's post-test scores on the Life Stress scale of the PSI.

Discussion

The results of this study along with teachers' comments and the facilitator's observations provide information regarding the adjustment of kindergarten children who received 10 weekly play sessions facilitated by fifth grade students trained in child-centered play therapy procedures and skills. Of the eleven hypotheses, none were retained. However, several measures showed positive trends even though not at the .05 level of significance. Interpretation of the findings are provided in the following section.
Self Concept/Self Perception

As revealed in Tables 4 and 5, the scores of children in the experimental group show a positive trend in self concept as measured by the Joseph Pre-School and Primary Self-Concept Screening Test (JPPSST) although not at the .05 significance level. This slight increase in score suggests that the play sessions did begin to help children improve their self concepts. It should be noted that Table 5 reveals an extremely low power of .058 which means that if there was significant change there would only be a 5.8% chance of finding it. Hence, actual change as measured by this instrument and all others in the study may be masked due to the low power caused by the small sample size.

As indicated by the data in Tables 7 and 8, the children in the experimental group showed a decrease in their self perception as measured by the Haak Sentence Completion (HSC) while the children in the control group showed an increase in their self perception. Although the scores on the HSC seem to contradict the scores on the JPPSST, the “perception of others” dimension in the HSC based on questions such as “my classmates think I am ________” should be considered. The decrease in the HSC self perception scores may possibly be explained by children in the experimental group having an increase in self awareness and thus obtaining a more accurate perception of others viewing them as having “problems.” This supposition is supported by a response on the sentence completion by a girl in the experimental group. When asked, “my father thinks I am ________,” the girl said “ugly.” When the researcher followed up on this response by asking the girl “what do you think you are,” the girl said “pretty.” Another possible explanation for the decrease in the HSC self perception scores is the kindergarten children’s cognitive
limitations in understanding the questions may have skewed the data. For example, when “Scarlet” was given the prompt, “My teacher thinks I am ______, she responded “Scarlet.”

Clinical significance of positive change in the experimental children’s self concept and self perception was observed by the researcher during the play sessions in the following areas.

Self Acceptance Increased

An increase in self acceptance of children in the experimental group was demonstrated throughout the play sessions. For example, when “Stacey” hid under a desk in the corner of the play area for the first five minutes of a session, her fifth grade facilitator patiently waited and tracked her behavior. In her own time, “Stacey” came out from under the desk, played with the toys, faced the fifth grade facilitator, and initiated conversation. The fifth grade student’s patient response communicated to “Stacey” that all parts of herself, even the reluctant, scared parts, are totally accepted.

The development of self acceptance was also facilitated when “Oscar” who had a history of aggression threatened to knock off his fifth grade facilitator’s glasses. After his facilitator set a therapeutic limit, “Oscar” responded by hiding for four minutes. As the fifth grade facilitator patiently reflected, “Oscar” began playing with the toys in a calm manner, finding that he was totally accepted even when he displayed aggressive behavior.

Throughout the play sessions, kindergarten children received frequent reflections of their feelings such as happy, proud, sad, mad, and scared from their fifth grade facilitators. These reflections increased the kindergarten children’s awareness and
acceptance of their feelings and of self.

**Self Esteem and Self Confidence Increased**

Increased self esteem and self confidence were frequently observed by the researcher throughout the play sessions. For example, “Leo” who delighted in mastering the challenge of hitting his target with the dart gun exclaimed with new found pride “I got it twenty-four times!” “Carol” whose teacher described her as “a very young five year old” built a Play Doh snowman by herself. When her fifth grade facilitator exclaimed “You did it!” “Carol” beamed with pride and self confidence.

An increase in self reliance and self empowerment in children during the play sessions was frequently observed. For example, “Jean” asked for some handcuff keys from her fifth grade facilitator who responded “I know you’d like some but today there are not any.” Unsatisfied, “Jean” came to the researcher who directed her back to her area. Perplexed, “Jean” relied on her own creativity and figured out how to open the handcuffs without the keys. Hence, she experienced self empowerment from her increased self reliance.

Teachers also reported increases in self esteem of children who received play sessions. At the beginning of the year, a kindergarten teacher reported “Julia” as being “easily hurt when criticized” but after Julia received 10 weeks of play sessions, the teacher indicated she “shows more self-esteem.”

**Problematic Behaviors of Children**

As indicated by the data in Tables 10 and 11, the experimental group did experience a slight reduction of their total behavior problems as measured by the CBCL.
Teacher Report while the control group experienced a slight increase in their total behavior problems. However, the results were not significant at the .05 level. This finding suggests that a continuation of play sessions for children in the experimental group may have resulted in significant change in their overall behavior as measured by the CBCL-Teacher Report.

Tables 13 and 14 show both the experimental and control groups increased in internalizing behavior problems as measured by the CBCL-Teacher Report, although the experimental group increased more than the control group. However, this finding was not at the .05 significance level. A positive trend in the experimental group’s decrease of externalizing behavior problems as measured by the CBCL-Teacher Report is revealed in Tables 16 and 17. This finding also suggests that a continuation of play sessions may have resulted in significant change in the experimental group’s externalizing behavior based on teacher perception. A continuation of play sessions to further facilitate positive behavior change is affirmed by LeBlanc’s (1998) meta analysis which found that optimal change in children occurs after thirty play therapy sessions.

This supposition that play sessions helped change kindergarten children’s externalizing behavior is further supported by comments from the kindergarten teachers. A month after the play sessions ended, kindergarten teachers reported a marked increase in externalizing behavior problems of children who had received play sessions. The kindergarten teachers stated that the play sessions seemed to maintain the children’s behavior but now that they were not receiving the play sessions, the children were “getting worse.” For example, several teachers reported that children were displaying more
aggression such as hitting other children whereas they had not done so when they were receiving play sessions.

These observations by teachers are consistent with Heller, Baker, Henker, and Hinshaw's (1996) finding that severe externalizing behavior problems in preschoolers continue to be severe in the first grade. Results from this current study suggests that play sessions over a longer period of time may be a preventative factor for the development of more extreme externalizing behavior problems in children who start out with behavior problems.

The CBCL-Parent Report scores presented in Tables 19 through 26 reveal that both experimental group children and control group children experienced a reduction in their total behavior problems, internalizing behavior problems, and externalizing behavior problems. For total behavior problems and internalizing behavior problems, children in the control group showed slightly more reduction than did children in the experimental group. However, for externalizing behavior problems, the experimental group showed slightly more reduction as measured by the CBCL-Parent Report than did the control group. This finding is verified by significant t-test results on the Externalizing Behavior scale of the CBCL-Parent Report. Hence, parents perceived a decrease in externalizing behavior problems for children in the experimental group. Based on the overall findings on the CBCL-Parent Report, the emergence of a positive trend in the reduction of problematic behaviors in children who received play sessions with fifth grade students is revealed.

Positive trends in the children who received play sessions were also verified through statistically significant change on some of the CBCL subscale scores. As indicated
by the results on the Somatic Complaints subscale CBCL–Teacher Report, the experimental group demonstrated significantly more improvement than the control group through a decrease in somatic complaints such as “tired,” “has aches,” or “has nausea.” This finding suggests that the understanding, attentive relationship the kindergarten children in the experimental group experienced with the fifth grade children decreased the need for kindergarten children to seek attention from their teachers through somatic complaints.

The Delinquent Behavior subscale CBCL–Parent Report scores, based on both MANOVA of gain scores analysis and $t$-test results, indicate the parents of children in the experimental group perceived a decrease in the delinquent behavior of their children while parents of children in the control group perceived only a slight decrease of delinquent behavior of their children. Demandingness subscale scores on the PSI also decreased as indicated by significant $t$-test results, indicating parents experienced less stress related to their child’s demandingness. Reduction in delinquent behavior and demandingness may be a result of the kindergarten children in the experimental group receiving so much individual positive attention in the play sessions that they did not need to seek negative attention from their parents at home.

Positive trends in the behavior of children who received play sessions were observed by the researchers in the following areas.

**Self Control Increased**

An increase in kindergarten children’s self control was frequently demonstrated during the play sessions. For example, “Christopher” who aggressively hit the punching
doll on numerous occasions and often required therapeutic limit setting, accidentally hit his fifth grade facilitator on the head. “Christopher” immediately stopped and said, “Sorry, Ashley.” This pause for apology indicated “Christopher” had exercised self control by maintaining his aggression within appropriate limits.

“Garry” who often required therapeutic limit setting was provoked by another child in an adjoining session. “Garry” responded “I’m going to shoot you.” However, when the fifth grade facilitator set the limit, “Garry” exercised self control and shot the punching doll instead of the boy who provoked him.

Teachers also verified the increase in self control of kindergarten children who experienced the play sessions. For example, at the beginning of the school year, a kindergarten teacher described “Sue” as “very young, restless, and talks too much.” After the play sessions, the teacher reported that “Sue” was displaying more self control in the classroom. Another kindergarten teacher described “Dave” as “can be stubborn, argues a lot; disturbs others; talks too much; hot temper” before the play sessions but after the play sessions described him as “a lot less argument and much more cooperation.” Before the play sessions, “Mike” had “little self control; can’t pay attention; fidgets; impulsive; and talks too much.” After the play sessions, “Mike’s” teacher reported he displayed “more self control and can pay better attention.”

**Aggression Decreased/Creativity Increased**

Notable decreases in aggression and increases in creativity were observed by the researcher throughout the project. For example, “Philip” spent the first several sessions in aggressive and active play behaviors of shooting the dart gun and hitting the punching
doll. By the last several sessions, he began more creative activities such as making a Play Doh face on the bowling ball and drawing. "Keith" who displayed aggressive behavior throughout the ten weeks decreased his aggressive intensity and duration in the later sessions and increased his creative play such as coloring, playing with Play Doh, and depicting scenes with the doll house.

Teachers also reported improvement in children who had previously shown aggressive behavior. At the beginning of the year, "Derek" was described as "defiant; disrespectful; aggressive; restless; argues a lot; not liked by others; and talks too much." After the play sessions, "Derek’s" teacher stated he is "much better; follows my directions; gets along with others; and doesn’t hurt others."

**Withdrawn Behavior Decreased**

Remarkable progress was observed in the play session behavior of "Christine," a shy, withdrawn kindergarten girl who was selectively mute and often displayed a frown. During the first two sessions, she played in total silence with only the animals as her fifth grade facilitator patiently tracked her behavior. In the third session, "Christine" expanded her play behavior by making the zebra and giraffe hit the face of the blow up punching doll. In the fourth session, she increased her verbalizations by making animal sounds such as hissing and mooing. She expressed aggression in the fifth session by having the domestic animals smash the alligator’s head as the fifth grade facilitator appropriately responded, "It’s mad." In the sixth session, "Christine" continued verbalization of animal noises, expressed anger by throwing animals against the wall, and demonstrated an increase in pleasure as indicted by numerous smiles. Expansion of the use of toys was
change in the kindergarten children. Benefits of the kindergarten child and fifth grade student’s relationship were identified by the school counselor as: (a) the fifth grade student was a positive role model in the school environment, (b) a sense of belonging was created for kindergarten children who frequently experienced peer exclusion due to their adjustment difficulties, and (c) the needed one on one attention was given by the attentive, caring fifth grade student. Teachers also reported that the positive relationship was one of the main benefits of the play sessions. “My students looked forward to their time with the fifth grade students. It gave them individualized time that is needed. It gave them the opportunity to work through some problems.”

The power of the positive relationship was confirmed by the researcher’s continual observation of kindergarten students exuding excitement when called for their play sessions. With a broad smile and energetic voice, they would exclaim, “I get to go again!!! Yea!!!” as they walked down the hall with a bounce in their step looking for their assigned fifth grade facilitator.

Throughout the play sessions, positive relationship development was readily observed. For example, “Elizabeth” asked her fifth grade facilitator during the fourth play session, “Are you my best friend?” “Susanna” exclaimed to her fifth grade facilitator during the third play session, “Know what I’m going to draw on top of this heart? You!” During the fifth session, “Ray,” an active and restless kindergarten boy, sat down and made a tea party for his fifth grade facilitator. At the end of the project, when the researcher reflected to “John” who was frequently disruptive in the classroom and play session that he will miss his fifth grade partner, John replied with a heavy sigh “Yeah,
"Esther" is a good girl." These positive relationships appeared to be a meaningful experience and to inspire positive behavior change within the kindergarten children who received play sessions.

**Parenting Stress**

As indicated by the data in Tables 28 through 32, the parents of children in the experimental group experienced an increase in their total parenting stress and in the "Parent Domain" as measured by the Parenting Stress Index (PSI) while the parents of children in the control group decreased in these areas. Tables 34 and 35 reveal the parents of children in both the experimental and control groups decreased in parenting stress as measured by the PSI "Child Domain." The difference between the "Parent Domain" scores and the "Child Domain" scores indicates that at post-testing parents of children in the experimental group experienced more stress in relation to their own issues such as health and spouse and less stress in relation to their child's issues such as distractibility/hyperactivity and demandingness. This finding suggests that parents with children in the experimental group experienced less difficulty with their children but more difficulty with their own personal concerns, thereby increasing their overall parenting stress.

The analysis of PSI subscales revealed specific areas of personal stress for parents of children in the experimental group. Significant findings on the Health subscale of the PSI indicated the parents of children in the experimental group experienced more stress related to health concerns in themselves at post-testing than did parents of children in the control group. In addition, significant findings on the Spouse subscale of the PSI revealed
the parents of children in the experimental group reported more stress related to their spouse than did the control group. Reports of depression also significantly increased in parents with children in the experimental group, based on *t*-test results of the Depression subscale of the PSI.

These PSI subscale findings may illuminate the lack of significant change in the Total PSI scores of parents with children in the experimental group. Personal health concerns, marital concerns, and depression in these parents may have resulted in a pervasive negative perception which limited their reporting of decreases in stress on the PSI scales. Parenting stress related to health concerns, spouse concerns, and depression may have also limited the recognition of positive behavioral change as measured by the CBCL-Parent Report for children in the experimental group. This supposition is supported by Heller, Baker, Henker, and Hinshaw's (1996) finding that “parenting stress contributed to the prediction of the child’s subsequent externalizing behavior” and “further impaired the quality of parent-child interactions” (p. 385). Hence, parenting stress may have impeded the finding of significant change in children in the experimental group.

**Limitations**

Although some positive trends were revealed in this study, the lack of statistical findings on the hypotheses may have been confounded by the following limitations.

**Small Sample Size**

Due to the small sample size of this research study (experimental group *n* = 15; control group *n* = 14), an extremely low power resulted. For example, on the CBCL-Teacher Report and CBCL-Parent Report the power ranged from .060 to .163 and thus
there was only a 16% chance of finding significance if it was present. The appropriate power of .80 which would adequately reveal significant findings could be obtained through a larger sample size.

Teacher and Parent Input

Due to the nature of the study, teachers and parents did not receive feedback of children’s progress to ensure that change could be attributed to play sessions with the fifth grade students rather than to improvement in teacher or parent interventions. The lack of input to teachers and parents may have prevented their ability to reinforce positive change and hindered their perceptions of the children’s progress. Thus, their responses on the CBCL-Teacher Report, CBCL-Parent Report, and PSI may not have reflected the true change that may have occurred in the kindergarten children who received play sessions.

Limited Relationship Period

Although the small sample size of this research project did seem to limit significant findings, research studies which have trained parents in child-centered play therapy procedures have produced significant results even with a small experimental group size below 15 (Chau, 1996; Kale, 1997; Yuen, 1997). This difference in significant findings suggests that parents who were trained in filial therapy may have been more effective in their play sessions due to their preexisting relationship, their personal investment with their own children, the intervention into their own family dynamics, and the influence on the parents’ perceptions of their children. The short term relationship between the fifth grade students and the kindergarten children which existed for only 10 weeks may have limited significant findings. Hence, to develop an invested, long term relationship which will yield
more effective results, this model of utilizing fifth grade students as facilitators may need to build in twice as many play sessions as originally planned.

**Cognitive Limitations**

Cognitive limitations of fifth grade students may have also been a factor in preventing statistical findings similar to other research studies which trained adults in play therapy procedures. Evidence of limited problem solving skills, ability to discern appropriate interactions, and ability to apply skills in novel situations was observed during the play sessions. For example, fifth grade students were taught to return responsibility and facilitate creativity by responding to a child’s question such as “what is this toy?” with “whatever you want it to be.” When one kindergarten girl tried to get to know her fifth grade facilitator better by asking “what bus do you ride?”, the fifth grade facilitator responded “whatever bus you want me to ride.” This fifth grade student’s inability to discriminate an appropriate response revealed her concrete operational thinking. Since adults have formal operational thinking, they may more readily implement play therapy procedures and thus promote children’s change in a shorter period of time than the fifth grade students.

**Extreme Need of Experimental Group**

The experimental group had more severe symptoms at pretesting than did the control group based on comparisons of pretest means on the total behavior scores of the CBCL-Teacher Report, total behavior scores and externalizing behavior scores of the CBCL-Parent Report, and total scores and Child Domain scores on the PSI. The experimental group may have had a disproportion of severe symptoms because parents
who had more concerns about their children's behavior may have turned in their permission slips first and thus their children were placed in the experimental group. The severity of the experimental group's need was verified by the school counselor who commented that the children in the experimental group were the children with the most behavioral concerns. Since the experimental group had such extreme needs, they may have needed more time for change to occur as indicated by LeBlanc (1998) who found that optimal change in children occurs after 30 play therapy sessions. Thus, the brief intervention of 10 weeks may have been too short to detect significant change.

Implications

Although the hypotheses of this study were not statistically significant, positive trends in kindergarten children's self concept and behavior were observed. These positive trends as well as the observations by the researcher, school counselor, and teachers support the continued implementation of play sessions between kindergarten children who have adjustment problems and fifth grade students who have been trained in child-centered play therapy procedures and skills. Kindergarten children who experience social, emotional, and behavioral problems need appropriate intervention to be successful in school. This study has been a beginning in demonstrating that play sessions with trained fifth grade students can make a positive difference in the self concept and behavior of kindergarten children. Further research is necessary to determine if the intervention results in statistically significant changes in the self concept and behavior of kindergarten children.

Along with positive changes in kindergarten children, several other benefits occurred as a result of implementing this project. Fifth grade students were observed to be
more self confident throughout the project. One fifth grade student stated “I use to let my friend boss me around but now I set limits with her.” Other fifth grade students reported using child-centered play therapy skills at home, “I use these things with my little sister and she behaves better.” One fifth grade boy’s parent who is a school principle said, “My mom is impressed with all that I’m learning and says she wished she had learned it at my age.”

The school counselor also received benefits. His resources and time were maximized since this project provided therapeutic intervention for 15 referred kindergarten children and positive communication skills for 15 fifth grade leaders. With an investment of just four hours a week (1 hour to train fifth grade students, 2 hours to supervise sessions, and 1 hour for coordination or preparation time), 30 students received therapeutic services. Clearly, implementation of this project is well worth the school counselor’s time.

Kindergarten teachers were relieved that students with adjustment difficulties were receiving the one on one attention that they needed. Decrease of teacher stress was reported by the school counselor who stated the play sessions gave extra attention to troubled children which helped teachers not to feel so overwhelmed. In addition, according to the school counselor, teachers developed a sense of hope which inspired them to look for positive changes in the children who received play sessions.

In addition, a greater sense of school community was developed through this project. Fifth grade students and kindergarten students increased their social interaction with each other. For example, kindergarten students would exclaim to their fifth grade
facilitator, “I saw you on the bus today.” Fifth grade teachers and kindergarten teachers increased their collaboration as well.

Parents of the kindergarten children in the experimental group were also relieved that their children were receiving additional attention at school. Many parents reported that their children “loved” going to their play time. Other parents commented that their children needed “all the help they could get.”

This project has resulted in positive trends in increasing kindergarten children’s self concept and decreasing their behavior problems as well as numerous benefits to fifth grade students who receive the training, teachers, school counselors, and parents. Therefore, continuation of this project is warranted.

Recommendations

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

1. Conduct a replication of this study using a larger sample size and extend the number of play sessions for more than 10 sessions, perhaps two sessions per week for one semester or once-a-week for the duration of the year. This frequency would address the kindergarten students’ limited time perception and could facilitate a deeper committed, invested relationship between the fifth grade student and the kindergarten student.

2. Give weekly feedback of general progress and give training in basic play therapy skills to teachers and to parents. Informing teachers and parents of general progress could help them be aware of children’s positive growth and training in basic play therapy skills could reinforce effective strategies in the classroom and home, thereby facilitating even more positive change in the kindergarten children.
3. Adapt the child-centered play therapy training model by (a) providing three to four training sessions a week for 5 weeks, (b) allowing twice as much time for role playing, and (c) giving concrete examples to accommodate the fifth grade students’ cognitive limitations.

4. Adapt the fifth grade students’ role so that they are “allowed to play” as long as the kindergarten child is in the lead. This adaptation will meet the fifth grade student’s need to “play” while still keeping the attention on the kindergarten child.

5. School counselors should focus on providing services to children with the most severe need to prevent the escalation of their behavior problems.

Concluding Remarks

This project was the first in the country to attempt to address kindergarten children’s adjustment problems through play sessions with fifth grade students trained in child-centered play therapy procedures and skills. The positive trends, although limited, in kindergarten children’s self concept and behavior as well as observations of the power of the therapeutic relationship compel the continued implementation of this project. The information presented in the recommendations will add to the future success of this project.
APPENDIX A

AXLINE’S EIGHT BASIC PRINCIPLES
AXLINE'S EIGHT BASIC PRINCIPLES  
(of Non-Directive Play Therapy)

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.

APPENDIX B

CHILDREN’S PROBLEMS ADDRESSED IN PLAY THERAPY
<table>
<thead>
<tr>
<th>Problem</th>
<th>References</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS in the Family</td>
<td>Reid (1991)</td>
</tr>
<tr>
<td>Amputation of child’s leg</td>
<td>Korth (1993)</td>
</tr>
<tr>
<td>Depressed and suicidal</td>
<td>Stiles (1990)</td>
</tr>
<tr>
<td>Domestic violence</td>
<td>Webb (1991)</td>
</tr>
<tr>
<td>Dying Child</td>
<td>Gray (1989)</td>
</tr>
<tr>
<td>Emotional Disturbance</td>
<td>Perry (1988), Schiffer (1957)</td>
</tr>
<tr>
<td>Fear and anxiety</td>
<td>Alexander (1964), Milos &amp; Reiss (1982)</td>
</tr>
<tr>
<td>Grief</td>
<td>Carey (1990), LeVieux (1994)</td>
</tr>
<tr>
<td>Homelessness</td>
<td>Hunter (1993)</td>
</tr>
<tr>
<td>Incest</td>
<td>Goodwin (1989)</td>
</tr>
<tr>
<td>Learning Difficulties</td>
<td>Bixler (1945), Siegel (1970)</td>
</tr>
<tr>
<td>MPD in family</td>
<td>Benjamin (1993)</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------------------</td>
<td>------------------------------</td>
</tr>
</tbody>
</table>

Note: Many of these cases as well as other cases are summarized in Landreth, Homeyer, Glover, and Sweeney's (1996) *Play Therapy Interventions with Children's Problems*. 
APPENDIX C

HAAK SENTENCE COMPLETION
SENTENCE COMPLETION QUESTIONNAIRE
For Kindergarten Adjustment Program

Child’s Name: ____________________________ Date: ________________

Administrator’s Name: ____________________________

Scale 1 - Perception of Self and Others

1. Most grown people are ________________________________

2. The people in my class think I am ________________________________

3. My mother thinks I am ________________________________

4. My teacher thinks I am ________________________________

5. My father thinks I am ________________________________

6. My mother makes me feel ________________________________

7. Most policemen are ________________________________

8. My friends think I am ________________________________

Scale 2 - Task Performance and Achievement

9. When my father gives me lots of work, I ________________________________

10. When I see somebody else do something really good in school, I ________________________________

11. When no one can help me but myself, I ________________________________

12. When my teacher tells me to do something, I ________________________________

13. When my teacher corrects me, I ________________________________

14. When I don’t know what the book says, I ________________________________

15. When there is hard school work to do, I ________________________________
APPENDIX D

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:

G. Parents divorce
H. Death in the family
I. Family Move
J. 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, or 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 E

FILIAL PROBLEM CHECKLIST
INSTRUCTIONS

The following list describes a wide variety of problems children often have. Please underline any item which you feel applies to your own child. Then, to the right of each item you underline, indicate how serious a problem you feel this is by placing a 1, 2, or 3 in the blank provided:

A 1 means "This item is true for my child, but is not really a problem.

A 2 means "This item is true for my child, and it is a mild problem.

A 3 means "This item is true for my child, and it is a severe problem.

EXAMPLE

If you underlined item 20, and you did not think it was really a problem, then you would place a 1 in the blank to the right, like this:

20) Bites nails  1

Or, if you underlined the same item, but felt it was a serious problem, then you would place a 3 in the blank to the right, like this:

20) Bites nails  3

If you have any problems completing this list, please do not hesitate to call for assistance.
A 1 means "This item is true for my child, but is not really a problem.

A 2 means "This item is true for my child, and it is a mild problem."

A 3 means "This item is true for my child, and it is a severe problem."

<table>
<thead>
<tr>
<th>(5-24)</th>
<th>(25-43)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Eats too little</td>
<td>21. Picks nose</td>
</tr>
<tr>
<td>2. Not eating the right food</td>
<td>22. Always late, dawdles</td>
</tr>
<tr>
<td>3. Wets bed at night</td>
<td>23. Difficulty falling asleep or sleeping</td>
</tr>
<tr>
<td>4. Gets lower grades in school than should</td>
<td>24. Troubled restless sleep</td>
</tr>
<tr>
<td>5. Does not talk plainly, poor pronunciation</td>
<td>25. Slow in reading</td>
</tr>
<tr>
<td>7. Too few friends</td>
<td>27. Does not pay attention to teacher</td>
</tr>
<tr>
<td>8. Feels inferior to other children</td>
<td>28. Restless in class</td>
</tr>
<tr>
<td>9. Picked on by children</td>
<td>29. Headaches for no physical reason</td>
</tr>
<tr>
<td>10. Has no self-confidence</td>
<td>30. Stomach cramps, aches</td>
</tr>
<tr>
<td>11. Nervous, tense</td>
<td>31. Feels different from other children</td>
</tr>
<tr>
<td>12. Sad, unhappy too often</td>
<td>32. Easily led</td>
</tr>
<tr>
<td>13. Cries too easily</td>
<td>33. Left out by children of own age</td>
</tr>
<tr>
<td>14. Feels helpless</td>
<td>34. Never chosen as a leader</td>
</tr>
<tr>
<td>15. Blames self too much</td>
<td>35. Is self-conscious about own body</td>
</tr>
<tr>
<td>16. Gets into trouble</td>
<td>36. &quot;Big-shot&quot;</td>
</tr>
<tr>
<td>17. Destroys property of others</td>
<td>37. Gets angry too easily</td>
</tr>
<tr>
<td>18. Steals</td>
<td>38. Fear of darkness</td>
</tr>
<tr>
<td>19. Lies</td>
<td>39. Panics when afraid</td>
</tr>
<tr>
<td>20. Bites nails</td>
<td></td>
</tr>
</tbody>
</table>
Your Child's Name: ______________________

**A 1 means** "This item is true for my child, but is not really a problem.

**A 2 means** "This item is true for my child, and it is a mild problem."

**A 3 means** "This item is true for my child, and it is a severe problem."

<table>
<thead>
<tr>
<th>Item</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>40. Too easily discouraged</td>
<td>44</td>
</tr>
<tr>
<td>41. Breaks promises</td>
<td>44-64</td>
</tr>
<tr>
<td>42. Thumb sucking</td>
<td>44-64</td>
</tr>
<tr>
<td>43. Bad table manners</td>
<td>44-64</td>
</tr>
<tr>
<td>44. Untidy</td>
<td>44-64</td>
</tr>
<tr>
<td>45. Has bad dreams</td>
<td>44-64</td>
</tr>
<tr>
<td>46. Afraid to speak up in class</td>
<td>44-64</td>
</tr>
<tr>
<td>47. Fights too much with children</td>
<td>44-64</td>
</tr>
<tr>
<td>48. Blows his or her top</td>
<td>44-64</td>
</tr>
<tr>
<td>49. Sulks, pouts</td>
<td>44-64</td>
</tr>
<tr>
<td>50. Gripes too much</td>
<td>44-64</td>
</tr>
<tr>
<td>51. Fear-ridden child</td>
<td>44-64</td>
</tr>
<tr>
<td>52. Unusual fears</td>
<td>44-64</td>
</tr>
<tr>
<td>53. Does not do chores</td>
<td>44-64</td>
</tr>
<tr>
<td>54. Takes advantage of people</td>
<td>44-64</td>
</tr>
<tr>
<td>55. Disobeys parents</td>
<td>44-64</td>
</tr>
<tr>
<td>56. Not close to parents</td>
<td>44-64</td>
</tr>
<tr>
<td>57. Scratches self a lot</td>
<td>44-64</td>
</tr>
<tr>
<td>58. Swears, uses dirty language</td>
<td>44-64</td>
</tr>
<tr>
<td>59. Unable to keep to a time schedule</td>
<td>44-64</td>
</tr>
<tr>
<td>60. Uses hands in poorly</td>
<td>44-64</td>
</tr>
<tr>
<td>61. Restless, can't stay in one place</td>
<td>1-4</td>
</tr>
<tr>
<td>62. Non-athletic</td>
<td>1-4</td>
</tr>
<tr>
<td>63. Does not like to go to school</td>
<td>1-4</td>
</tr>
<tr>
<td>64. Does not spend enough time in study</td>
<td>1-4</td>
</tr>
<tr>
<td>65. Not interested in books</td>
<td>1-4</td>
</tr>
<tr>
<td>66. Always wants revenge</td>
<td>1-4</td>
</tr>
<tr>
<td>67. Irritable child</td>
<td>1-4</td>
</tr>
<tr>
<td>68. Teases excessively</td>
<td>1-4</td>
</tr>
<tr>
<td>69. Daydreams a lot</td>
<td>1-4</td>
</tr>
<tr>
<td>70. Gets too excited</td>
<td>1-4</td>
</tr>
<tr>
<td>71. Does not try to correct bad habits</td>
<td>1-4</td>
</tr>
<tr>
<td>72. Too stubborn with parents</td>
<td>1-4</td>
</tr>
<tr>
<td>73. Continued demanding of gifts, new things</td>
<td>1-4</td>
</tr>
<tr>
<td>74. Wants too much attention from parents</td>
<td>1-4</td>
</tr>
<tr>
<td>75. Careless in own appearance</td>
<td>1-4</td>
</tr>
<tr>
<td>76. Careless with clothes &amp; belongings</td>
<td>1-4</td>
</tr>
<tr>
<td>77. Selfish, won't share</td>
<td>1-4</td>
</tr>
<tr>
<td>78. Does not complete work</td>
<td>1-4</td>
</tr>
<tr>
<td>79. Poor memory</td>
<td>1-4</td>
</tr>
</tbody>
</table>
Your Child's Name: __________________________

A 1 means "This item is true for my child, but is not really a problem.
A 2 means "This item is true for my child, and it is a mild problem."
A 3 means "This item is true for my child, and it is a severe problem."

(24-40) (41-52)

80. Unsere of self in school  
81. Has had a number of accidents  
82. Plays too much with younger children  
83. Bossy with brothers and/or sisters  
84. Jealous of brothers and/or sisters  
85. Preoccupied with own thoughts  
86. Loses temper  
87. Is erratic, unpredictable  
88. No control over emotions  
89. Fights back, talks back to elders.  
90. Too dependent upon Mother, Father  
91. Inconsiderate of parents  
92. Bumps into furniture, trips, etc.  
93. Watches TV all the time  
94. Trouble adjusting to a new school  
95. Tries to get attention in class  
96. Fights brother(s) and/or sister(s)  
97. Gets people angry, provokes  
98. Loses own possessions frequently  
99. Gets completely out of control  
100. Oversensitive to criticism from parents  
101. Behind other children on dressing  
102. Feels bad about own physical appearance  
103. Elimination problems (e.g. diarrhea, constipation, gas, holds urine, etc.)  
104. Dangerous habits (describe)  
105. Sex-related problems (e.g. "peeps", exposes self, etc.)  
106. Physical tension problems (e.g. hives, ulcers, colitis, sweats, nausea, dizziness, etc.)  
107. Excessively passive, meek  
108. Body movement problems (e.g. clumsy in using legs, jumpy, has no energy, head banging, paralyzed, rocks all the time, etc.)
APPENDIX F

PLAY THERAPY INFORMATION AND CONSENT FORM
Dear Parent,

You 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 sessions 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 your 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 the 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 or Legal Guardian

Signature of Kindergarten Child
Date

Printed Name of Kindergarten Child
Age

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 H

MANOVA PRETEST SCORES
### MANOVA PRETEST

<table>
<thead>
<tr>
<th>Group</th>
<th>Group</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Global Self Concept Score Joseph</td>
<td>Exper.</td>
<td>24.4000</td>
<td>4.7929</td>
</tr>
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REFERENCES


Clement, P., & Milne, D. C. (1967). Group play therapy and tangible reinforcers used to modify the behavior of 8 year old boys. *Behavior Research & Theory, 5*, 301-312.


