SHORT-TERM CHILD-CENTERED PLAY THERAPY TRAINING WITH SCHOOL COUNSELORS AND TEACHERS IN ISRAEL

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This study was designed to determine the effectiveness of short-term child-centered play therapy training with school counselor and teachers in Israel. A short-term child-centered play therapy course is an intervention that focuses on changing trainees attitudes and beliefs towards children while teaching them child-centered play therapy theory and skills.

The experimental group, consisting of 18 volunteer school counselors and teachers in Israel received a total of 15 hours of child-centered play therapy didactic training with a variety of learning experiences. The control group consisted of 15 volunteer school counselors and teachers in Israel. The control group did not receive any training. All participants completed the Play Therapy Attitude-Knowledge-Skill Survey (PTAKSS) before and after the training as a means of measuring change in attitude, knowledge and skill. A second purpose of this study was to compare the effectiveness of short-term child-centered play therapy training with a comparison group semester long child-centered play therapy training course at the University of North Texas.

An analysis of covariance revealed statistically significant positive increase in Knowledge subscale as compared to the control group. However the differences between the experimental and the control group were not significant on the participant's total score on the PTAKSS, their attitudes and beliefs towards children or their skill level.

A t-test revealed no significant difference between the experimental and comparison groups on the skill subscale of the PTKASS. Results indicated that there was a significant

difference between the experimental and the comparison groups on the Total score, Attitude and Knowledge subscales of the PTAKSS.

This study supports the use of short-term play therapy training as an effective training model for increasing the trainee's knowledge of child-centered play therapy. It does not support the use of short-term play therapy training as an effective training model for increasing the trainee's attitudes towards children or increasing their confidence in applying play therapy skills.

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CHAPTER I

INTRODUCTION

Johnson (1994) reported that many children all over the world are in need of mental health services, but because children are powerless, other groups typically receive more attention and the mental health services needed. Children experience multiple stressors during their growth and development, which may increase their need for mental health services (Wagner, 1994). Tuma (cited in Wagner, 1994) stated that approximately 15 to 19 % of U.S children and youth need mental health treatment. Although there has been an increase in professional awareness of children's needs in the past two decades and a corresponding increase in mental health programs available to children (Cohen, 1995; Lovacs & Lohr, 1995; Stern & Newland, 1994; Wagner, 1994), most children with emotional and/or behavioral problems still do not receive the appropriate treatment to fit their needs, and some do not receive any kind of mental health treatment (Collins & Collins, 1994).

In addition to normal stressors, e.g., separation from parents, potty training, age appropriate anxieties, etc., today's children are exposed to war, terror, poverty, and other family disruptions. In the last 20 years, play therapy has become one of the most important therapeutic methods practiced by a variety of mental health professionals in the USA (Kranz, Lund, & Kottman, 1996; Kranz, Kottman, & Lund, 1998; Landreth, Homeyer, Bratton, & Kale, 1995; Phillips & Landreth, 1995, 1998). There is a growing body of professionals who are interested in play therapy and see it as an important and crucial therapeutic method for helping children (Frey, 1994; Schaefer & Carey, 1994; Schaefer & O'Connor, 1983). A 1999 survey by the Center for Play Therapy at the University of North Texas found that 83 universities in the US offer one or more courses in play therapy as a component of counselor education or educational psychology

programs (Center for Play Therapy, 2000). However, according to Tanner and Mathis (1995) and Bratton, Landreth and Homeyer (1993), there are not enough trained play therapists to meet the increasing demand.

Child-centered play therapy is the most widely practiced play therapy model with children under the age of ten, and it has also been shown to be successful with children between the ages of ten and fourteen (Landreth & Sweeney, 1997). Phillips and Landreth (1995) conducted a national survey of play therapists and reported that 25 % of play therapists that responded to the survey use the child-centered play therapy approach.

Working with children in a professional setting requires the practitioner to obtain special knowledge, skills, and beliefs about children (Guerney, 1983; Kaczmarek & Wagner, 1994; Kranz & Lund, 1994; Landreth, 2002). According to Phillips and Landreth (1995), there are few play therapists that are trained in play therapy on a graduate level. Kranz, Lund & Kottman (1996) recognized the importance of advanced training and supervised experiences for those who practice play therapy. The Association for Play Therapy, an international organization, has published specific criteria for becoming both a registered play therapist and a play therapy supervisor (APT Newsletter, 1992). Play therapy training and supervision which meet these criteria enable the play therapist to be a better mental health provider for children while ensuring the play therapist's professional and personal growth (Kranz & Lund, 1994; Landreth, 2002).

Israel, one of the smallest countries in the Middle East, is surrounded by hostile neighboring countries and constantly faces the horrors of war and terrorism. The population in Israel is 6 million and 2.7 million are children under the age of 12. (Israel census, 2000) Since

the founding of the country in 1948, children in Israel have experienced a prolonged state of fear and anxiety as a result of war, the threat of war, and terrorism.

The population in Israel currently faces constant attacks from suicidal bombers who carry out their actions in shopping malls, restaurants, buses, and even in schools. The population in Israel is constantly preparing for the possibility of an attack by one or more of the Arab countries around them. This situation causes anxiety and fear in children who may feel that they or their family members are in danger.

While adults may express their experiences and reactions to events such as bombings via conscious thoughts and speech, it is much more difficult for young children to express their feelings in words. Children may experience more anxiety than adults in an insecure environment produced by war. Therefore, it is important to provide children the opportunity to express feelings in the midst of a sense of danger. In times of high stress, as in the case of war, anxious children who do not feel safe to express feelings in words may use play to clarify the situation and explore feelings. Children often use play to act out what both their inner world of self and the outer world of people and things mean to them.

As is the case for other parents, Israeli parents typically play with their children. They may spend hours each days taking care of their child's needs. However, in stressful times of war, they may be focused on their own issues of fear and sorrow and may not be available to attend to their child's emotional needs. In many cases, the school system is the only available resource to meet children's emotional needs. Unfortunately, very few professionals in schools and agencies in Israel are trained in utilizing play therapy methods of treatment to help children and their families. In Israel there are only three universities, which offer play therapy information as a small component of their psychology courses. Therefore, the Israeli elementary school system

has yet to encourage school counselors to obtain play therapy training and provide play therapy sessions to the children they serve.

Purpose of the Study

This study was designed to determine the effects of child-centered play therapy training on school counselors and teachers who work with children in Israel. The purpose of this study was to determine the effects of child-centered play therapy training in (a) improving positive attitudes and beliefs toward children, (b) improving child-centered play therapy knowledge, and (c) improving confidence in applying child centered play therapy skills.

A second purpose of this study was to compare the effectiveness of child-centered play therapy training with trainees at the University of North Texas (Kao and Landreth 1996) and the effectiveness of child-centered play therapy training with school counselors who work with children in Israel.

A third purpose of this study was to document the effectiveness of play therapy in elementary schools in Israel.

Review of Related Literature

The Purpose of Play

Play is universal. It occurs in the absence of anxiety and after the child has become familiar with an object through exploration. Play is an inherent way in which a child communicates with the world (Axline, 1969). It is the core, natural activity during childhood and may take place at all times in all places (Landreth, 2002).

Garvey (1977) stated that play is pleasurable and enjoyable. Play is internally motivated, not externally motivated. Play is concerned with generating stimulation and is governed by the needs and wishes of the child. Erikson (1940) stated that children use play “to make up for

defeats, suffering and frustrations" (pp.45). Specific play episodes have specific meaning to the child.

"Language, as valuable and helpful as it can be, is still of paltry use to children who have neither the ability nor the vocabulary to put feelings into words. Children play out past experiences and present problems. They put problems outside of themselves and are able to see more of their anxieties and tensions" (Cass, 1973). During and after war, the anxious child who does not feel safe to express feelings in words might use play to clarify the situation and explore feelings. Thus, play assumes a critical role in the child's life. The child would not otherwise achieve release, since an attempt at emotional release in reality would most likely produce intense anxiety (Hartley, Frank & Goldenson, 1952).

Play reflects the child's need to experience and express feelings related to external events. Through the use of dolls, for example, anxiety or conflicts can be played out in a way that helps the child deal with emotions. Clay can help children gain mastery over their world as the child pounds, stamps, and integrates his or her own reactions and emotions through this process. The play therapy setting provides a secure, predictable and safe environment for the child to express feelings, reduce anxiety, to show fear, and to play out his or her needs. The child may not be able to find places other than the playroom where traumatic experiences are handled with total empathy, sympathy, and acceptance from an adult. There are no suggestions, criticisms, instructions, or questions by the therapist regarding the play of the child (Axline, 1969).

Since children under the age of 12 find it difficult to express their feelings in words, they use play to process and deal with their experiences. Unlike adults who can think and reason abstractly, children rely on play to work through their feelings and problems rather than talking

(Axline, 1969; Landreth 2002; Piaget, 1962). Play may become fantasy and/or a wish-fulfilling situation that allows instinctual discharge that normally would not be allowed within the framework of reality (Sandler & Nagera, 1963, Schaefer & O'Connor, 1983). Play creates an outlet for children's feelings, expends their energy, allows for the reduction of their frustrations, and facilitates the realization of their goals (Landreth, 2002).

Symbolic Play

Play allows children the opportunity to symbolically "work through" situations that are unmanageable or threatening in reality. The meaning is derived from a child's personal history, the situation that confronts the child, and the child's individual ways of reacting and expressing oneself. The child uses play to translate impulses, feelings and fantasies into action (Hartley, Frank, & Goldenson, 1952). Through self-directed play experiences, the child can explore feelings and thoughts. Each child may choose to use the different objects in the playroom and engage them in a personal, self-healing process and with different symbolism (Gable, Oster, & Pfeffer, 1988; Landreth, 2002). The child-centered play therapist accepts the child's play symbolism as it is. The play therapist represses his or her own need to fit the child's play into the society's labeling system (Moustakas, 1953), and, thus, frees the child to express feelings and ideas (Ross, 1972). Regarding the effectiveness of symbolic play, Axline (1969) wrote, " By playing out these feelings he brings them to the surface, gets them out in the open, faces them, learns to control them, or abandon them. When he has achieved emotional relaxation, he begins to realize the power within himself to be an individual in his own right, to think for himself, to make his own decisions, to become psychologically more mature, and by so doing, realize self-hood" (p.16). The child, when provided with a secure relationship that includes the freedom to express his or her own thoughts, feelings and experiences, will create a personal path. When that

choice is respected and the child is allowed to work through chosen feelings and experiences, the child will be able to achieve insight (Axline, 1969; Landreth, 2002; Moustakas, 1953; Schaefer & O'Connor, 1983).

Child-Centered Play Therapy

Person-centered therapy, a therapeutic approach developed by Carl Rogers (1951), is now referred to as child-centered play therapy when working with children (Landreth, 1993). Virginia Axline saw the Rogerian approach as one that would work with children as well as adults. She translated Roger's philosophy and approach and modified it to the specific needs of children (Guerney, 2001). Child-centered play therapy "is based upon the assumption that the individual has within himself, not only the ability to solve his own problems satisfactorily, but also this growth impulse that makes mature behavior more satisfying than immature behavior" (Axline, 1947, p. 15). In this approach, the therapist is concerned more about the child than the problem. The focus of the therapist is on building a relationship with the child in order to help the child generate the process of change. In child-centered play therapy, the therapist does not interpret the child's behavior, but, instead, focuses on the relationship with the child as the catalyst of growth (Landreth, 1993).

Child-centered play therapy is a unique way of being with children. It is based on a philosophy and not on a series of techniques (Landreth & Sweeny, 1997). It is a complete therapeutic system based on the therapist's deep beliefs about children and their innate ability to change and to grow (Landreth, 1993). Axline's (1947) eight basic principles serve as a guide for therapeutic contract between the child and the therapist. These principles, in revised and extended form by Landreth (2002), are:

1. The play therapist is genuinely interested in the child and develops a warm, caring relationship.
2. The play therapist experiences unqualified acceptance of the child and does not wish that the child were different in some way.
3. The play therapist creates a feeling of safety and permissiveness in the relationship so the child feels free to explore and express him-or herself completely.
4. The play therapist is always sensitive to the child's feelings and gently reflects those feelings in such a manner that the child develops self-understanding.
5. The play therapist believes deeply in the child's capacity to act responsibly, unwaveringly respects the child's ability to solve personal problems, and allows the child to do so.
6. The play therapist trusts the child's inner direction, allows the child to lead in all areas of the relationship, and resists any urge to direct the child's play or conversation.
7. The play therapist appreciates the gradual nature of the therapeutic process and does not attempt to hurry the process.
8. The play therapist establishes only those therapeutic limits that help the child accept personal and appropriate relationship responsibility. (pp. 73-74)

The child-therapist relationship is the main component in the therapeutic process. The therapist provides the child with a safe place and a sense of complete acceptance, granting the child permission to feel and to behave within the limits of the playroom (Axline, 1947; Gerney, 1983; Landreth, 2002).

The Child-Centered Play Therapist

The play therapist works as a direct therapeutic service provider to children. Entering the

playroom, the play therapist immediately begins to establish a therapeutic relationship with the child. In child-centered play therapy the child-therapist relationship plays a significant role. It "...is the deciding factor in the success or failure of the therapy" (Axline, 1947, p. 74). Therefore, the development of relationship-building skills by the therapist is a crucial responsibility. Without appropriate skills, the therapist may be unaware of the impact of the relationship on the child, and may damage the therapeutic process or the child (Kranz, 1978). These relationship skills include basic attitude, empathic responses, and structuring skills (Kao, 1996).

"The three basic attitudes in child-centered play therapy are faith acceptance, and respect" (Moustakas, 1953, p. 2). Faith in the child is based on feelings rather than on the therapist's cognitions. The therapist should feel and express a sincere belief in the child. By conveying faith, the child may experience the same feeling and as a result, may begin to believe in him/herself. Acceptance of the child occurs when the therapist accepts the child as the child is, without any conditions. The therapist should accept the child's feelings, individual meaning, and perceptions. Respect is conveyed to the child by the way the therapist greets the child, follows the child's lead during play, and shows understanding of the child's feelings (Moustakas, 1953).

Empathic responses require active listening and are the key element in conveying to the child four important messages: 1) that the therapist is here in the playroom with the child; 2) that the therapist hears what the child says; 3) that the therapist understands; and 4) that the therapist cares for the child (Landreth, 2002). As the child receives these messages, the child becomes more open to the relationship with the therapist, feels safe enough to explore self, and can choose to change and grow.

In child-centered play therapy, structuring is limited to therapeutic limit setting and to the "providing of information or the arranging of the environment to facilitate situation-appropriate

responses from the child" (Guerney, 1983, p. 37). For example, structuring may include how long the session will last, when the session will end, how often the child and therapist will meet, what the child can do in the playroom, and what the therapist will do during the session (Guerney, 1983).

Limit setting in the playroom serves different purposes, which Landreth and Sweeney (1997) summarized as follows. Limits

1. define the boundaries of the therapeutic relationship
2. provide security and safety for the child, both physically and emotionally
3. demonstrate the therapist's intent to provide safety for the child
4. anchor the session to reality
5. allow the therapist maintain a positive and accepting attitude toward the child
6. allow the child to express negative feelings without causing harm or subsequent fear of retaliation
7. offer stability and consistency
8. promote and enhance the child's sense of self-responsibility and self-control
9. protect the play therapy room
10. provide for the maintenance of legal, ethical and professional standards. (p. 24)

Limit setting is not introduced in the session until necessary. Landreth (2002) recommended the following three-step format:

Step 1: A- acknowledge the child's feelings, wishes, and wants.

Step 2: C- communicate the limit.

Step 3: T- target acceptable alternatives (p. 261).

The play therapist needs to enter the playroom relaxed and able to leave personal issues outside the playroom. After establishing the relationship with the child, the play therapist should strive to maintain the relationship and convey sincere concern for the child's growth. The play therapist must really know children and must like them in order to work with them (Axline, 1947). The play therapist must also possess self-understanding and the ability to accept both the strong and weak components of his or her personality (Landreth, 2002). Self-knowledge on the part of the play therapist will enable the therapist to enter into a deeper relationship with the child and fully utilize his or her professional and personal skills (Moustakas, 1959).

Training of Play Therapists

For the play therapist to be considered a competent mental health professional, it is crucial to be properly trained and have a supervised clinical experience (Landreth & Wright, 1997). According to Moustakas (1958), the first step in play therapy training is teaching the play therapist the principles and the philosophy of play therapy. Landreth and Wright (1997) indicated, "the best method of initial training is a didactic presentation, such as is used in most introductory play therapy courses" (p.45). Bratton, Landreth and Homeyer (1993) stated that prior to being supervised in the play session, the play therapist should have a cognitive understanding of play therapy principles. Before directly applying the play therapy principles in a clinical setting, the students must understand them both theoretically and experientially (Landreth & Wright, 1997). Moustakas (1958) stated that the beginning play therapist should be allowed to develop his or her own style, make mistakes, and progress at his or her own pace, without being rushed by a supervisor or the play therapist over-enthusiasm.

The child-centered play therapist's behaviors in the playroom include: tracking the child's behavior, reflection of content, reflection of the child's feelings, returning responsibility

to the child, and therapeutic limit setting (Landreth, 2002). Through supervised experiences, the play therapy trainee learns to translate the unique factors of child-centered play therapy into verbal and nonverbal responses in the playroom (Tanner & Mathis, 1995). The play therapy trainee learns to speak and listen effectively, to cope with silent moments, and to focus on significant themes (Kranz, 1978).

Kao (1996) investigated the effects of child-centered play therapy training on graduate students majoring in child counseling. The experimental group consisted of 39 students enrolled in semester long (15 weeks) Introduction to Play Therapy courses. The control group consisted of 29 students. Using the Play Therapy Attitude, Knowledge Skill Survey (PTAKSS), Kao measured three aspects of the child-centered play therapy training: (a) the attitudes regarding essential beliefs and interaction patterns, (b) the knowledge of what should be known, and (c) the level of confidence in applying play therapy skills (Kao, 1996, pp.37). She reported a significant improvement in trainee's attitudes and beliefs toward children and an increase in child-centered play therapy knowledge and skills as compared to the control group.

Homeyer and Rae (1998) also used the PTAKSS to study the effectiveness of the length of play therapy training for master level graduate students. They compared the effectiveness of a 3-week mini session training (38 hours) with 12 participants; a regular 5-week summer session training (40 hours) with 8 participants; and a regular 15-week semester training (45 hours) with 9 participants. All versions of the training were an Introduction to Play Therapy graduate course. Homeyer and Rae (1998) reported that in all varied of course length there is a significant improvement in trainee's attitudes and beliefs toward children and an increase in child-centered play therapy knowledge and skills. Although studies have indicated that there are positive results in using play therapy training to train graduate students or parents, the effect of different training

Play Therapy models on trainees has received little attention.

Play Therapy Training Models

One of the earliest play therapy training models was described by Guerney in 1978. Guerney taught masters and doctoral level students play therapy skills in three consecutive semesters. During the first semester, Guerney focused on child-centered theory and play therapy skills utilizing peer supervision, experienced supervisors, and self-supervision. In the second semester, play therapy trainees supervised undergraduate play therapy students. In the last semester, the trainees led a filial therapy group.

Landreth's model (2002) provides trainees with a variety of learning experiences including: didactic lectures comprised of play therapy principles, critiques of facilitative responses, self-directed reading, writing exploration and research papers in related play therapy areas, role playing with the instructor and with peers, discussions, instructor's or other advanced students' video demonstrations, observation of experienced play therapists in the playroom through one way mirror, arranged play sessions, and a micro play therapy practicum supervised by experienced play therapy students. Landreth's syllabus (2003) specifies the following course objectives: (a) obtain an understanding of the major theories of play therapy, (b) develop a philosophy of the approach to play therapy that is effective, (c) develop an awareness of the child's world as viewed by the child, (d) help the student communicate effectively with children, (e) help students understand children, and their behavior, (f) enhance the student's tolerance level toward others, and (g) promote the student's self-exploration and self-understanding.

In 1992, Landreth established the Play Therapy Intensive Supervision/ Training Model (PT-ISTM). This model consists of 27 hours of intensive play therapy training in three consecutive days. The format is based on an intensive workshop and is designed to provide the

play therapist a unique experience under professional supervision. The play therapists are divided into small groups with the ratio of one supervisor to three trainees. Bratton, Landreth, and Homeyer (1994) studied Landreth's supervision model with 12 play therapists and 4 trained play therapy supervisors. During the intensive training they provided play therapy trainees with a variety of learning experiences, including live supervision of individual and group play therapy sessions, observation and immediate feedback from supervisor and peers, critique of trainee's videotaped sessions, and intensive training in play therapy skills. They found positive changes in the play therapist's self-awareness, growth in their play therapy skills, and understanding of the play therapy process.

Homeyer and Rea (1998) stated that it is essential play therapy trainees take a university introductory play therapy course in order to develop a strong cognitive and philosophical base.

Play Therapy in Elementary Schools

"The elementary school counselor uses play therapy with children because play is the child's symbolic language of self expression, and for children to play out their experiences and feelings is the most natural, dynamic, and self-healing process in which children can engage" (Landreth, 1993, p. 17). Landreth (1987) stated that the elementary school counselor uses play as a counseling tool and as a media to meet the child's different needs. Axline (1947) suggested that teachers could learn to reflect a child's feelings and convey the message, "Here is a person who understands you and understand your feelings." Ross (1972) believed that play therapy provides a great opportunity for teachers to have a more meaningful relationship with children and stated, "Through adoption of therapeutic techniques the teacher may achieve an emotional climate which encourages communication between adults and children" (p. 17). Landreth (1993) recommends child-centered play therapy by school counselors in the elementary schools for

children experiencing different personal issues such as learning disabilities, divorce, lack of self-control, depression, abuse, and more. Kranz (1972) stated that teachers and school counselors are in some cases the only professionals who interact with school children. Kranz (1972) conducted research on the effectiveness of training teachers to utilize play therapy in their schools in two elementary schools in California. The teachers were taught a play therapy theoretical course prior to their actual play therapy experience with the child of focus. All of the teachers reported positive experiences in working with children at school. As a result, Kranz recommended continuing and expanding the play therapy practicum with school counselors and teachers.

A study conducted by Schiffer (1960) in New York City focused on the effectiveness of seminar training on teachers and school counselors as leaders of child-centered playgroups. Schiffer found that the participants developed a deeper interest in the study of children's behavior and progress over the course of the school year. The teachers also reported better functioning of the children in their classrooms.

Crow (1990) found that first grade students who participated in play therapy had higher self-concepts than first grade students who were not exposed to play therapy. McGuire (2000) observed positive trends in children's behavior, self-concept and self-control after participating in a child-centered group play therapy sessions in a school setting. Rennie (2000) reported that children with adjustment problems at school exhibited a significant reduction in external behavior problems after participating in group play therapy sessions. Myric and Haldin (1991) presented a case study with a first grade boy and said that after play process the child's engagement in disruptive behavior decreased and the child's teacher, principal, and the teacher aid's positive perception of the boy's behavior increased.

Kottman and Johanson (1993) stated that the powerful healing process of play therapy

could help children who may never receive mental health services other than through the school system. **“**School counselors are in an ideal position to work with teachers to increase their understanding of the children in their classrooms and to help support changes children are making in play therapy” (Kottman & Johanson, 1993, p. 44). According to Campbell (1993), in order to use play, school counselors do not need to become registered play therapists. Their constant participation in play therapy workshops and updating in play therapy skills can help them use play as a counseling tool in their work with school children.

CHAPTER II

METHODS AND PROCEDURES

This chapter presents the methods and procedures for the data collected in this study. Also included are the definition of terms, hypotheses, limitation of the study, instrument utilized for collection of data, a discussion of the selection of subjects, data collection and treatment and an explanation of the data analysis procedures.

Definition of Terms

Attitude "is a basic belief about and a way of being with children" (Kao, 1996, p.38). For the purpose of this study, play therapist attitude was operationally defined as the counselors' and teachers' scores on the Attitude subscale of the Play Therapy Attitude-Knowledge-Skills Survey.

Knowledge "refers to fundamental knowledge of child-centered play therapy, including a view of children, the counseling approach with children, and important child-centered play therapy concepts and terms" (Kao, 1996, p.38). For the purpose of this study, play therapist knowledge was operationally defined as the counselors' and teachers' score on the Knowledge subscale of the Play Therapy Attitude-Knowledge-Skills Survey.

Child-Centered Play Therapy Training "is a teaching model that utilizes the person-centered theory in conceptualization and teaching play therapy" (Kao, 1996, p. 38). For the purpose of this study, child-centered play therapy training was a two- day training workshop in Israel taught by the researcher.

Play therapy was defined as "a dynamic interpersonal relationship between a child (or person of any age) and a therapist trained in play therapy procedures, who provides selected play materials, and facilitates the development of a safe relationship for the child (or person of any age) to fully express and explore self (feelings, thoughts, experiences, and behaviors) through play, the child's

natural medium of communication, for optimal growth and development" (Landreth, 2002, p.16). Play therapists in training were school counselors and elementary school teachers who worked with children in Israel or planned to work with children in a play therapy context in the future. Skills "refers to the ability of the play therapist to transfer play therapy knowledge into skills as well as confidence in applying those skills" (Kao, 1996, p.38). For the purpose of this study, play therapist skills was operationally defined as the counselors' and teachers' scores on the Skill subscale of the Play Therapy Attitude-Knowledge-Skills Survey

Hypotheses

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

1. Participants in the short-term play therapy training group will attain a significantly higher mean total score on the Play Therapy Attitude-Knowledge-Skills Survey (PTAKSS) posttest than will the control group.
    a. Participants in the short-term play therapy training group will attain a significantly higher mean score on the Play Therapy Attitude subscale of the PTAKSS posttest than will the control group.
    b. Participants in the short-term play therapy training group will attain a significantly higher mean score on the Play Therapy Knowledge subscale of the PTAKSS posttest than will the control group.
    c. Participants in the short-term play therapy training group will attain a significantly higher mean score on the Play Therapy Skill subscale of the PTAKSS posttest than will the control group.
2. There will be no significant difference in the mean total score on the PTAKSS between participants who received short-term play therapy training and participants who received

semester long play therapy training.

3. There will be no significant difference in mean score on the Play Therapy Attitude subscale of the PTAKSS between participants who received short-term play therapy training and participants who received semester long play therapy training.
4. There will be no significant difference in mean score on the Play Therapy Knowledge subscale of the PTAKSS between participants who received short-term play therapy training and participants who received semester long play therapy training.
5. There will be no significant difference in mean score on the Play Therapy Skill subscale of the PTAKSS between participants who received short-term play therapy training and participants who received semester long play therapy training.

Limitations

This study has the following limitations:

1. Subject selection was limited to volunteers from the Haifa metroplex in Israel and this produced a small experimental group.
2. This study relied on volunteer sampling. Due to the small population of school counselors in this area and the purpose of the study, random selection was not possible and the subjects in the experimental and control group were not balanced for age, sex, race, number of courses in play therapy, or prior experience.
3. The subjects in the experimental group took a pretest one month prior to receiving the play therapy training. During the month prior to training and after the participants completed the PTAKSS, there was a possibility that the participants searched for information about play therapy. This might cause biased results. In addition, subjects may have become sensitized to the test.

4. Since the native language in Israel is Hebrew, translation of a few of the English words on the PTAKSS form into Hebrew was necessary. The validity of the translated version was not tested.

Instrument

The Play Therapy Attitude Knowledge Skills Survey (PTAKSS), (see Appendix A) is a self-administered written test developed by Garry Landreth and Shu-Chen Kao (Kao,1996). Test items were based on two main child-centered play therapy texts: *Play Therapy* (Axline, 1947) and *Play Therapy: The Art of the Relationship* (Landreth, 1991). "Three areas were defined by considering the important objectives of child-centered play therapy training for beginning level students. Items in the attitude subscale refer to essential beliefs and interaction patterns that trainees are expected to obtain from child-centered play therapy training. Items in the knowledge subscale refer to what trainees should know as a result of attending the from child-centered play therapy training. Items in the skill subscale evaluate trainees' confidence in applying child-centered play therapy skills" (Kao, 1996 p. 41). Therefore, the PTAKSS consists of the following three subscales: the play therapy attitude subscale, the play therapy knowledge scale, and the play therapy skill scale.

Kao and Landreth (1996) investigated the content validity of the PTAKSS by using a panel of four Ph.D counselor judges who were considered experts in the field of play therapy. A pilot study was conducted by Kao, which indicated that the PTAKSS is a sensitive instrument that can test the effects of child-centered play therapy training on changing the play therapy attitude, knowledge, and skills of beginning play therapy trainees.

The PTAKSS is an 88-item likert scale format on which a rating of five indicates a high agreement or ability, and a rating of one indicates low agreement or ability. The Attitude scale

consists of 33 items, which are item numbers one to 33. The Knowledge scale consists of 21 items, which are item numbers 34 to 54. The Skill scale consists of 34 items, which are item numbers 55 to 88. The PTAKSS has four different scores: the total score, the attitude score, the knowledge score, and the skill score. The scoring for items #5, 11, 13, 14, 17, 20, 22, 23, 26, 28, 29, 31, 33, 34, 35, 36, 37, 38, 39, 42, had to be reverted on the likert scale because the low score for these questions is the preferred answer. The approximate time to administer the test is 20 minutes. Analysis of the content validity, criterion validity, and Cronbach's alpha reliability for the PTAKSS were conducted by Kao and by the researcher to support the use of the PTAKSS. For the reliability coefficient (Cronbach's alpha) for the PTAKSS, Kao's results were attitude scale **.**73, Knowledge scale **.**94, and skill scale **.**99. For the reliability coefficient (Cronbach's alpha) for the PTAKSS, the researcher's results were Total scale .94 (pretest), **.**90 (posttest); Attitude scale **.**95 (pretest), **.**97 (posttest); Knowledge scale **.**53 (pretest), **.**82 (posttest); Skill scale **.**79 (pretest), **.**83 (posttest).

Selection of Subjects

Volunteer subjects were school counselors and teachers who were selected from a large metroplex of the north Israel school district. The participants were required to meet the following criterion in order to be eligible for participation: (a) must have graduated from a counseling or education-related university program, (b) must currently work with children, (c) must agree to participate in 15 hours of play therapy training, (d) must be willing to sign a consent to participate form, and (e) must complete a pre and posttesting instrument.

The researcher contacted the educational training administrator in Haifa (located in the northern part of Israel) to assist in advertising the play therapy training for school counselors and teachers. A flyer (Appendix A) was sent to counselors and teachers informing them about the

play therapy training and asking for volunteers. Fifteen participants volunteered for the control group and completed the pretest and posttest. Eighteen additional participants volunteered to participate in the training.

The control group of 15 participants consisted of 2 males and 13 females ages 28 to 56. There were 9 counselors with a mean of 8.5 years of experience and 6 teachers with a mean of 17.5 years of experience. The experimental group of 18 participants consisted of 4 males and 14 females ages 28 to 56. There were 16 counselors with a mean of 7.5 years of experience and 2 teachers with a mean of 21 years of experience.

Collection of Data

Volunteer participants were asked to complete the Play Therapy Attitude- Knowledge-Skill Survey. A packet containing a cover letter from the researcher (Appendix B) and the Play Therapy Attitude-Knowledge-Skill Survey (Appendix C) was sent to the educational training administrator of the Haifa and north Israel school district in Haifa. She administered the test to 9 counselors during the school counselor's monthly meeting and sent the test package via mail to 6 teachers who volunteered to participate in the play therapy training. They were asked to mail the test back to the administrator two days after receiving the test. This first testing served as the pretest for the control group. Each participant was assigned a four-digit identification number, the first four digits of the subject's home phone number, to ensure the subject's anonymity.

The 15 volunteer participants were asked to again complete the Play Therapy Attitude-Knowledge-Skill Survey one month after the pretesting and sent it back to the researcher who visited at that time in Israel. This second testing served as the posttest for the control group. The 18 participants who participated in the training completed the pretesting of the Play Therapy Attitude- Knowledge-Skill Survey at the beginning of the two days training. This first testing

served as the pretest for the experimental group. They were asked to again complete the Play Therapy Attitude- Knowledge-Skill Survey at the end of the training. This testing served as the posttest for the experimental group. Each participant was assigned a four-digit identification number, the first four digits of the subject's home phone number, to ensure the subject's anonymity.

Treatment

Eighteen school counselors and teachers participated in 15 hours of comprehensive child-centered play therapy training in a two-day period taught by the researcher according to the model designed by Dr. Garry Landreth for beginning play therapy trainees. Landreth currently teaches a graduate course in Introduction to Play Therapy in the Department of Counseling, Development and Higher Education at the University of North Texas. The training that is a part of this research study is similar in content to parts of Dr. Landreth's course with the exception of the Play Therapy Micro Practicum. The training took place in a hotel in Acho, Israel in the northern part of Israel.

The researcher was a doctoral student in Dr. Landreth's Introduction to Play Therapy course and later audited this course in preparation for this research study. This course provides graduate students with a variety of learning experiences including didactic lectures, discussions, role-playing with the instructor and peers, observations of Landreth's play therapy sessions on videotapes and a mini-practicum in play therapy. The researcher also has completed courses in Filial Therapy, Advanced Play Therapy and Group Play Therapy and has completed a doctoral Practicum in Play Therapy and a doctoral Internship in Play Therapy.

The two-day training course was based on Landreth's (2002) book, *Play Therapy: The Art of the Relationship.* The primary chapters from this book used in this research project were:

(a) Beginning the Relationship: The Child's Hour (pp.173-204); (b) Characteristics of Facilitative Responses (pp. 207-232); (c) Therapeutic Limit Setting (pp.245-272); and (d) The Playroom and Materials (pp.125-146).

The following are parts of Dr. Landreth's Introduction to Play Therapy course outline (Appendix D) used by the researcher in the two-day short-term course in Israel. The major objectives of the training are to provide students an opportunity to understand and demonstrate competencies in:

1. Perceiving the child's word as viewed by the child.
2. Communicating effectively with children at a feeling/emotional level.
3. Understanding the meaning and implications of children's behavior.
4. Establishing a helping/ facilitative relationship with a child in a play therapy experience.
5. Self-exploration, which promotes self-understanding.

Activities schedule- Day 1:

8:30-10:30 Lecture-discussion topics: Rationale for play therapy, understanding the meaning in play, and how children communicate. The child's world: Perception, understanding children, and children's needs.

10:30-11:00 Group work and role-playing focused on being a child and trying to view the experiences through the child's eyes.

11:00-12:00 Lecture-discussion and observation of videotapes of play therapy sessions. Topics: communicating with children, active listening, facilitative words and phrases.

12:00-12:30 Break

12:30-1:00 Group work and role-playing focused on reflective listening.

1:00-2:30 Lecture-discussion and observation of videotapes of play therapy sessions and Dr. Landreth's videotape "Child-Centered Play Therapy." Topics: toys and materials, purpose and objectives, rationale for toy selection, recommended toys and materials, the playroom, and modified school setting.

2:30-3:00 Group work and role-playing focused on reflective listening with the emphasis on feelings.

3:00-4:30 Lecture-discussion and observation of videotapes of play therapy sessions: The play therapy hour; initial contact with a child, potential problems with parents, establishing the relationship, and children's questions.

4:30 Handouts of play therapy journal articles and dismissal.

Activities schedule- Day 2:

8:30-10:30 Lecture-discussion. Topics: limits and handling aggression: rational for setting limits, therapeutic limits, situational limits- room, toys, time, and counselor, and steps in setting limits.

10:30-11:00 Group work and role-playing focused on limit setting.

11:00-12:00 Lecture-discussion and observation of videotapes of play therapy sessions and Dr. Landreth's videotape "Choices Cookies and Kids."

12:00-12:30 Break

12:30-1:00 Group work and role-playing focused on choice giving.

1:00-2:30 Lecture-discussion and observation of videotapes of play therapy sessions. Topics: limit setting and choice giving.

2:30-3:00 Group work and role-playing focused on choice giving and limit setting.

3:00-3:20 Observation of the researcher conducting a live play therapy session with a child.

3:20- 4:00 Discussion, questions and answers related to the observed live session.

4:00 Handouts of play therapy journal articles.

4:00-4:30 posttesting.

At the conclusion of the training, the volunteer subjects were asked to make a commitment to conduct at least 3 play therapy sessions each week for the first 10 weeks of the fall school term with 3 different children referred by teachers in the school where they are employed. These sessions should be 30 minutes long in the school counselor's room or any other adjusted room in the school and the counselors were asked to utilize toys and materials recommended by Landreth (2002).

For supervision purposes, the volunteer subjects were asked to contact the researcher through e-mail or the phone once a week or a minimum of once every two weeks. They were asked to report their progress, write about their concerns, issues in the playroom or ask any question they have regarding their play therapy sessions. The researcher promised to provide them answers, suggestions, ideas, and encourage their effort.

After 10 play therapy sessions the school counselors were instructed to meet with the child's teachers and interview them about the child's changes in behavior and the teacher's evaluation of the effectiveness of play therapy. The school counselors were asked to use the interview questions as a model (see Appendix C) and add to the list his/her own questions. The school counselors were also asked to provide a written evaluation of the use of play therapy in their school.

Analysis of Data

Following the collection of the pretest and the posttest for the control group (one administered a month prior to the training and the other when the participants began the training), and the experimental group, the self-report instruments were scored, double checked and keyed into the computer by the researcher. Pretest and post-test scores were paired according to the four-digit identification number. The data was analyzed by the researcher using SPSS for Windows, Release 6.12 (http://www.spss.com).

An analysis of covariance (ANCOVA) was computed to test the statistical and practical significance of the difference between the experimental group and the control group on the adjusted means for hypotheses 1, 1(a), 1(b), and 1(c) (Hinkle, Wiersma, & Durs, 1994). To establish preliminary conditions for the research, it was necessary to give each participant in both the experimental group and the control group a pretest. The PTAKSS instrument was used as the pretest to determine the existing levels of play therapy attitude, knowledge, and skill levels of the experimental and control groups. For the experimental and control group, the posttest score specified in each of the hypotheses was used as the dependent variable and the pretest score was used as the covariant. ANCOVA was used to adjust the means on the posttest on the basis of the pretest, thus statistically equating the experimental, comparison and control groups.

Scores obtained from the PTAKSS pretest and posttest for the experimental group were analyzed and compared to the experimental group PTAKSS pretest and posttest scores obtained by Kao (1996). In order to determine whether intensive short term child-centered play therapy training with trainees in Israel was an effective intervention, the following data was utilized from Kao's (1996) study for comparative analysis: mean scores on the PTAKSS total, attitude, knowledge and skill subscales.

A t-test was computed to test statistical significance between the short-term and the comparison group. In each case the posttest specified in each of the hypotheses was used as the dependent variable and the pretest as the covariant. Statistical significances between the means were tested at the .05 levels. On the basis of the ANCOVA and the t-test, the hypotheses were either retained or rejected.

CHAPTER III

RESULTS AND DISCUSSION

This chapter presents a description of the statistical and practical analyses performed in the pre and posttest, as well as the specific results of each hypothesis tested in the study. Also included is a discussion of the potential meaning and implications of the findings, and recommendations for future research.

Results

The results of this study are presented in the order the hypotheses were tested. Analyses of covariance were preformed on hypotheses 1 through 1(c). A t-test was computed on hypotheses 2 through 5. A level of significance of .05 was established as the criterion for either retaining on rejecting the hypotheses.

Hypothesis 1

The experimental group will attain a significantly higher mean total score on the Play Therapy Attitude-Knowledge-Skills Survey (PTAKSS) posttest than will the control group.

Table 1 presents the pre and posttest means and standard deviations for the experimental and control groups. Table 2 presents the analysis of covariance data; showing the level of significance of the difference between the experimental and control groups' mean scores.

Table 1 Mean Total Scores on the PTAKSS

	Short-Term Group		Control Group	
	Pretest	Posttest	Pretest	Posttest
Mean	2.81	3.56	3.13	2.99
Standard Deviation	0.21	0.48	0.48	0.36
Total cases	18	18	15	15

Table 2. Analysis of Covariance for the PTAKSS Total

Source of Variation	Sum of Squares	df	Mean Square	F Ratio	Significance of F	Observed Power	Eta Squared
Covariates	0.11	1	0.11	0.57	0.45	0.11	0.019
Main effects	0.49	1	0.49	2.45	0.12	0.874	0.076
Error	6.04	30	0.20				

Table 2 shows the F ratio for the main effects was not statistically significant (p=.12) indicating no change in the experimental group's total score on the PTAKSS. Based on this data, hypotheses 1 was rejected. Table 2 shows the eta squared for the main effects was .076 indicating a medium practical significance as measured by the PTAKSS.

Hypothesis 1 (a)

The experimental group will attain a significantly higher mean score on the Play Therapy Attitude subscale of the PTAKSS posttest than will the control group.

Table 3 presents the pre and posttest means and standard deviations for the experimental and control groups. Table 4 presents the analysis of covariance data; showing the level of

significance of the difference between the experimental and control groups' posttest mean scores.

Table 3. Mean Scores on the PTAKSS Attitude Subscale

	Short-Term Group		Control Group	
	Pretest	Posttest	Pretest	Posttest
Mean	3.40	3.59	3.44	3.53
Standard Deviation	0.20	0.40	0.17	0.16
Total cases	18	18	15	15

Table 4. Analysis of Covariance for the PTAKSS Attitude Subscale

Source of Variation	Sum of Squares	Df	Mean Square	F Ratio	Significance of F	Observed Power	Eta Squared
Covariates	0.29	1	0.29	2.83	0.10	0.37	0.86
Main effects	0.16	1	0.16	1.56	0.22	0.37	0.05
Error	3.12	30	0.10				

Table 4 shows the F ratio for the main effects was not statistically significant (p=.22) indicating no change in the experimental group's play therapy attitude as measured by the PTAKSS. Based on this data, hypotheses 1 (a) was rejected. Table 4 shows the Eta Squared for the main effects was .05 indicating a medium practical significance as measured by the Play Therapy Attitude subscale on the PTAKSS.

Hypothesis 1 (b)

The experimental group will attain a significantly higher mean score on the Play Therapy Knowledge subscale of the PTAKSS posttest than will the control group.

Table 5 presents the pre and posttest means and standard deviations for the experimental and control groups. Table 6 presents the analysis of covariance data; showing the level of significance of the difference between the experimental and control groups' posttest mean scores.

Table 5. Mean Scores on the PTAKSS Knowledge Subscale

	Short-Term Group		Control Group	
	Pretest	Posttest	Pretest	Posttest
Mean	2.90	3.67	3.05	2.95
Standard Deviation	0.28	0.52	0.51	0.46
Total cases	18	18	15	15

Table 6. Analysis of Covariance for the PTAKSS Knowledge Subscale

Source of Variation	Sum of Squares	Df	Mean Square	F Ratio	Significance of F	Observed Power	Eta Squared
Covariates	0.04	1	0.04	0.19	0.66	0.07	0.006
Main effects	1.16	1	1.16	4.64	0.03	0.55	0.13
Error	7.49	30	0.25				

Table 6 shows the F ratio for the main effects was statistically significant (p=.03), indicating an increase in the experimental group's play therapy knowledge as measured by the

PTAKSS. Based on this data, hypotheses 1 (b) was retained. Table 6 shows the Eta Squared for the main effects was .13, indicating a large practical significance as measured by Play Therapy Knowledge subscale on the PTAKSS.

Hypothesis 1 (c)

The experimental group will attain a significantly higher mean score on the Play Therapy Skills subscale of the PTAKSS posttest than will the control group.

Table 7 presents the pre and posttest means and standard deviations for the experimental and control groups. Table 8 presents the analysis of covariance data; showing the level of significance of the difference between the experimental and control groups' posttest mean scores.

Table 7. Mean Scores on the PTAKSS Skills Subscale

	Short-Term Group		Control Group	
	Pretest	Posttest	Pretest	Posttest
Mean	2.19	3.47	2.88	2.44
Standard Deviation	0.36	0.78	0.96	0.61
Total cases	18	18	15	15

Table 8. Analysis of Covariance for the PTAKSS Skills Subscale

Source of Variation	Sum of Squares	Df	Mean Square	F Ratio	Significance of F	Observed Power	Eta Squared
Covariates	0.52	1	0.52	0.98	0.32	0.61	0.03
Main effects	0.41	1	0.41	0.77	0.38	0.13	0.02
Error	16.04	30	0.35				

Table 8 shows the F ratio for the main effects was not statistically significant (p=.38), indicating no change in the experimental group's play therapy skills as measured by the PTAKSS. Based on this data, hypotheses 1 (c) was rejected. Table 8 shows the Eta Squared for the main effects was .02, indicating a small practical significance as

Hypothesis 2

There will be no significant difference in the total mean score on the PTAKSS between participants who received short-term play therapy training and participants who received semester long play therapy training.

Table 9 presents the pre and posttest means and standard deviations for the short term and comparison experimental groups. Table 10 presents the t-test analysis of data, showing the level of significance of the difference between the short term and the comparison groups' posttest mean scores.

Table 9. Mean Total Scores on the PTAKSS

	Short-Term Group		Control Group	
	Pretest	Posttest	Pretest	Posttest
Mean	2.81	3.56	3.11	4.04
Standard Deviation	0.21	0.48	0.30	0.22
Total cases	18	18	37	37

Table 10. T-test for Equality of Means on the Total Scores of the PTAKSS

Group	N	Mean	Standard Deviation	T	df	p
Short-term	18	3.56	0.48	7.89	0.53	0.01
Comparison	37	4.04	0.22			

Kao's data indicated that the mean total score for the semester long play therapy training group was 4.04 while in this study the total mean score was 3.56 for the short-term play therapy training group. A critical value of 2.7 or higher shows that the t-test results are significance. The t-test analysis results for the Total score are: t = 7.89, indicating that there is a statistical significance between the groups in favor of the semester long group. Based on this data, hypothesis 2 was rejected.

Hypothesis 3

There will be no significant difference in mean score on the Attitude subtest on the PTAKSS between participants who received short-term play therapy training and participants who received semester long play therapy training.

Table 11 presents the pre and posttest means and standard deviations for the short term and comparison experimental groups. Table 12 presents the t-test analysis of data; showing the level of significance of the difference between the short term and the comparison groups' posttest mean scores.

Table 11. Mean Scores on the PTAKSS Attitude Subscale

	Short-Term Group		Control Group	
	Pretest	Posttest	Pretest	Posttest
Mean	3.40	3.59	3.37	3.92
Standard Deviation	0.20	0.40	0.21	0.28
Total cases	18	18	37	37

Table 12. T-test for Equality of Means on the Attitude Subscale

Group	N	Mean	Standard Deviation	T	df	p
Short-term	18	3.59	0.40	3.16	0.53	0.01
Comparison	37	3.92	0.28			

Kao's data indicated the Attitude mean score for the semester long play therapy training group was 3.92 while in this study the Attitude mean score was 3.59 for the short-term play therapy training group. A critical value of 2.7 or higher shows that the t-test results are significance. The t-test analysis results for the Attitude subscale are: t = 3.16, indicating that there is a statistical significance between the groups in favor of the semester long group. Based on this data, hypothesis 3 was rejected.

Hypothesis 4

There will be no significant difference in mean score on the Knowledge subtest on the PTAKSS between participants who received short-term play therapy training and participants who received semester long play therapy training.

Table 13 presents the pre and posttest means and standard deviations for the short term and comparison experimental groups. Table 14 presents the t-test analysis of data; showing the level of significance of the difference between the short term and the comparison groups' posttest mean scores.

Table 13. Mean Scores on the PTAKSS Knowledge Subscale

	Short-Term Group		Control Group	
	Pretest	Posttest	Pretest	Posttest
Mean	2.90	3.67	3.28	4.30
Standard Deviation	0.28	0.52	0.35	0.29
Total cases	18	18	37	37

Table 14. T-test for Equality of Means on the Knowledge Subscale

Group	N	Mean	Standard Deviation	T	df	p
Short-term	18	3.67	0.52	4.80	0.53	0.01
Comparison	37	4.30	0.29			

Kao's data indicated knowledge mean score for the semester long play therapy training group was 4.30 while in this study the knowledge mean score was 3.67 for the short-term play therapy training group. A critical value of 2.7 or higher shows that the t-test results are significance. The t-test analysis results for the Knowledge subtest are: $t = 4.80$, indicating that there is a statistical significance between the groups in favor of the semester long group. Based on this data, hypothesis 4 was rejected.

Hypothesis 5

There will be no significant difference in mean score on the Skill subtest on the PTAKSS between participants who received short-term play therapy training and participants who received semester long play therapy training.

Table 15 presents the pre and posttest means and standard deviations for the short term and comparison experimental groups. Table 16 presents the t-test analysis of data; showing the level of significance of the difference between the short term and the comparison groups' posttest mean scores.

Table 15. Mean Scores on the PTAKSS Skills Subscale

	Short-Term Group		Control Group	
	Pretest	Posttest	Pretest	Posttest
Mean	2.10	3.47	2.76	3.98
Standard Deviation	0.36	0.78	0.64	0.35
Total cases	18	18	37	37

Table 16. T-test for Equality of Means on the Skills Subscale

Group	N	Mean	Standard Deviation	T	df	p
Short-term	18	3.47	0.78	2.64	0.53	0.01
Comparison	37	3.98	0.35			

Kao's data indicated that the skill mean score for the semester long play therapy training group was 3.98 while in this study the skill mean score was 3.47 for the short-term play therapy training group. A critical value of 2.7 or higher shows that the t-test results are significance. The

t-test analysis results are: t = 2.64, indicating that there is no statistical significance between the groups. Based on this data, hypothesis 5 was retained.

Discussion

The results from this study indicate that some areas of the play therapy training were effective. The short-term play therapy training was mainly effective in increasing the Israeli trainees' knowledge of child-centered play therapy. Statistically significant results were found on hypothesis 1(b) in this study, indicating an increase in the experimental group's play therapy knowledge as measured by the PTAKSS.

There was no significant difference between Kao's results, which examined the confidence level in applying play therapy skills of graduate students in long-term training, and the results of this study, which examined the confidence level in applying play therapy skills of Israeli counselors and teachers in short-term intensive training. This may be interpreted to mean that play therapy trainees felt equally as confident in applying their play therapy skills after long-term training as they do after short-term training.

For the short-term play therapy training group, hypotheses 1, 1(a), 1(c), results indicated a positive directional change. However the differences between the experimental and the control group ware not significant on the participant's total score on the PTAKSS, their attitudes and beliefs towards children or their skill level.

Because statistical results are so heavily influenced by sample size and the sample size in this research was small (18 participants), practical significant analysis results were also reported. "Although large practical effects do not assure clinically significant effects, nevertheless, large effects are more likely to be clinically significant than small ones" (Thompson, 2002 p.67). Medium practical significant results were found on hypotheses 1, and 1(a). A large practical

significant result was found on hypothesis 1(b) indicating the participant's Knowledge of play therapy increased. Small practical significant results were found on hypothesis 1(c). Hypotheses 2, 3 and 4 were rejected, indicating that there was a significant difference between Kao's results, and this research on the Total score, Attitude, and Skill subscales of the PTAKSS.

Participants in the experimental group showed no statistically significant change (p =**.** 22) and a medium practical significance (**.**05) in their play therapy attitude as indicated by the PTAKSS Attitude subscale. This may be interpreted to mean that, after intensive training, these participants' beliefs about children did not change. A positive change in student attitude may be affected by the student's self-understanding and self-acceptance, which are important factors in the process of becoming an effective play therapist (Landreth, 2002). Landreth (2002) stated, "the attitude of the play therapist sets the tone of the play therapy session and quickly permeates the entire experience" (pp.108).

It is important to consider the fact that Israel is an immigrant society. Many different cultures in the world are superimposed upon the Israeli culture. Jewish immigrants from all over the world travel to Israel to infuse Israeli culture with their original culture. The blend to being a "sabra" (an Israeli born in Israel, speaks Hebrew, and behaves according to the Israeli culture) happens only after several generations. As a result of this diversity, there are several Israeli subcultures that differ dramatically from each other, particularly in the patterns of relationships between teachers, school counselors, and children. Understanding the Israeli culture and mindset may assist in understanding the results of the lack of significant change in the participant's attitude as measured by the PTAKSS.

In the Israeli culture, self-introspection, self-exploration, and self-understanding are not encouraged or valued as they are in the United States. Israelis are less likely to open up their

feelings in a short-term setting as perhaps American's are. This could be one factor affecting the results on the attitude scale. The medium practical significance on this scale indicates that the results may be only partially relevant in the application of these research results to any clinical situation. In comparing the sort-term with the long-term groups on the Attitude subscale of the PTAKSS, results showed a statistically significant difference between the two studies. This may be interpreted to mean that there is a notable difference between the effects of short and long-term play therapy training on how the trainee views the child. The long-term study showed more positive effect on the trainee's view of the child than did the training.

The PTAKSS also measures the professional and personal changes of beginning level participants trained in child-centered play therapy. The results of this study indicate participants may experience significant change in professional and personal growth as a result of a long-term play therapy course, but not from a short-term play therapy course. It seems that during the training, the trainee is not able to go through the process of professional and personal change that is needed from a beginning level participant. This may indicate that the course length is a significant factor in the trainee's personal change and that more training time may be needed to effect that change.

Another possibility for the lack of significant results on the Attitude subscale may be due to the challenge the trainer faced in translating the course material into Hebrew, specifically the child-centered play therapy language. In many instances direct translation from English to Hebrew altered the meaning and intention of the play therapy language. For example, in the process of teaching the counselors and teachers to set limits, the trainer used the format recommended by Landreth (2002), which involves first acknowledging the child's feeling or wish, communicating the limit, and then targeting alternatives. Limit setting addresses the

immediate reality of the situation and indirectly calls attention to the child's behavior through statements such as "You would like to paint on the wall, but the wall is not for painting on," as opposed to, "Don't paint the wall." The child's feeling or desire is the focus of the first part of limit-setting, not the child's behavior. The recipient or object of the behavior is the focus of the second part of the limit-setting statement.

This way of communicating the limit in a passive voice is not common in the Hebrew language. In Hebrew it is not common to say, "The wall is not for writing on," or "I am not for shooting." Instead, it is more common to use direct language such as, "You cannot paint on the wall," or "Don't shoot me." This style changes the meaning of the sentence; instead of giving the child a general rule, the child is given a direction or a specific rule. At the same time, direct language may stir up feelings of defensiveness because the child's behavior is the focus of the interaction rather than the wish and the potential alternatives. In order to deal with this cultural difference, the trainer emphasized the importance of the first part of the limit setting, (acknowledgment of the child wish and feelings,) before communicating the limit.

Several additional challenges became apparent as play therapy words and concepts were translated into Hebrew. Reconstruction of the active voice of the Hebrew language into statements of reflections of feelings proved to be quite difficult. In the Israeli culture, when people talk to each other, they are often very direct, open, and use a lot of body language. It is very common for Israeli teachers or school counselors to ask children very direct questions, to give commands, or to use language that may sound rude to other cultures. For example, an American teacher could say to a child, "I am sorry but it's late. You might need to reschedule." An Israeli teacher might just say, "It's late. Come another day." This is a subtle, but meaningful difference.

The feelings vocabulary seems more limited in Hebrew. There seem to be fewer words to describe different feelings in the Hebrew language compared to the English language. It was a challenge to help the teachers and the school counselors use a variety of words to describe similar feelings in order to broaden their feelings vocabulary.

Participants in the experimental group showed a statistically significant positive increase ($p = .03$) and a large practical significance (.13) in their play therapy knowledge as indicated by scores on the PTAKSS Knowledge subscale. This may be interpreted to mean that, after short-term intensive play therapy training, these participants became more knowledgeable about child-centered play therapy and were able to learn information and gain knowledge about child-centered play therapy as opposed to the participants who did not receive the training.

Some possible explanations for the training factors that contributed to the trainee's increased knowledge in play therapy might be:

1. Intensive training lectures and discussions that focused especially on how children view the world, basic knowledge of child-centered play therapy concepts, and how to establish a good relationship with children in a safe and accepting environment.
2. Reading the child-centered play therapy article: *Child Centered Play Therapy* (Landreth, 1993).
3. Observing the *Choices, cookies, and kids* videotape by Dr. Landreth.
4. Observing the videotape *Child-Centered Play Therapy* by Dr. Landreth.
5. Observing the instructor conducting a real play therapy session in the class with a child.

Landreth and Wright (1997) indicated, "the best method of initial training is a didactic presentation, such as is used in most introductory play therapy courses" (p.45). Bratton,

Landreth and Homeyer (1993) stated that prior to being supervised in the play session, the play therapist should have a cognitive understanding of play therapy principles. The results of this study seem to indicate that these participants, through a didactic presentation, learned and understood the play therapy principles.

On the Knowledge subscale of the PTKASS there was no statistically significant difference between the two studies. This may be interpreted to mean that there are no differences between the effects of short or long-term training on how trainees gain child-centered play therapy knowledge. It may also mean that, after intensive training, the Israeli participants became more knowledgeable of basic concepts in play therapy, as did the American participants. The similar results of these two studies indicate the effectiveness of both long and short play therapy training on the trainees. This may indicate that course length is not a significant factor in gaining knowledge of child-centered play therapy. The possible reason there was no difference between short term and long term training is because the concepts of child-centered play therapy are easy to grasp and somewhat fundamental as opposed to other types of psychotherapeutic training. This conclusion supports Homeyer and Rea's (1998) research about the impact of semester length on play therapy training, which was that there was no difference between short and long term training as measured by the PTKASS. It also supports the use of Bratton, Landreth and Homeyer's (1993) intensive three-day play therapy supervision/training model.

Participants in the experimental group showed no statistically significant change ($p = .38$) and a small practical significance (.02) in their play therapy skills as indicated by the PTAKSS Skills subscale. This may be interpreted to mean that, after intensive training, these participants did not become more confident and comfortable with the play therapy interaction skills, and that more training time may have been needed. This may indicate that training courses

should include more play therapy videotapes, observations, and a supervised mini practicum where participants have the opportunity to practice the new skills once or twice before applying them in a school or clinical setting.

During and after the training, several participants indicated they profited from the training experience. Typical responses were similar to the following:“ This is the first time that I have finished an intensive seminar and felt that I know so much about the subject.” “ Leaving this intensive play therapy course, I feel comfortable applying these skills with my students at school.” “I can’t wait for the school year to start so I can start working with my students in play therapy.” “ I am not going to wait until the school year to start, I am going to start applying these skills with my own children right now.” “I am sorry I did not know the limit setting skill when my children were young… I believe that my relationship with them would be so much better today if I had the training when they were young… the good part is that I am going to use it with my grandchildren.” Many of the participants asked to participate in the second course to be offered the following summer. Some school counselors asked to have an intensive play therapy course offered for their school teachers.

At the conclusion of the training, the participants were asked to make a commitment to conduct at least 3 play therapy sessions each week for the first 10 weeks of the fall school term with 3 different children. Unfortunately, only one of the participants followed the requested procedure and conducted additional play therapy sessions in her school. She conducted play therapy sessions with 2 children. This counselor e-mailed the researcher every other week with her concerns, questions, and difficulties in the playroom. The researcher provided her answers, suggestions, ideas, and encouraged her efforts. The counselor met with the children’s teachers and talked over the phone with the children’s parents, who both reported positive changes in

behavior. The children's parents and teachers reported a decrease in aggressive behaviors and improvement in the children's self-confidence. In addition, the teachers reported positive attitudes regarding the effectiveness of play therapy. When the researcher contacted the other participants, most of them said that they did not have e-mail access or did not know how to use e-mail. They reported that phone calls were expensive and expressed difficulty communicating in English via e-mail. This may be interpreted to mean that, due to the expensive long distance phone calls, difficulty accessing e-mail, and the language barrier, participants found it difficult to follow through with the final part of the research. This may indicate that longer training sessions are needed so the trainer and the participants will be in direct weekly contact.

Summary

There was a statistically significant difference between the two studies on the PTKASS Total Score, as well as on the Attitude, and Skill subscales of the PTKASS. This may be interpreted to mean that there are differences between the short and the long-term training on the trainee's personal and professional change. It may also mean that, after intensive training, the Israeli participants did not become more confident and comfortable with the new play therapy skills, as did the American participants.

As shown in tables 13 and 14, there was no statistical difference between the two studies on the Knowledge subscale of the PTKASS. This may be interpreted to mean that there are no differences between the short and the long-term training on trainee's ability to learn basic play therapy concepts. The similar results of these two studies in the trainees' ability to acquire child-centered play therapy knowledge indicates the effectiveness of both long and short-term play therapy training on the trainees.

Since the population in Israel currently faces constant attacks from suicidal bombers who carry out their actions in shopping malls, restaurants, buses, and even in schools, there is a pressing need for immediate mental health training for children who may feel that they or their family members are in danger.

Children may experience more anxiety than adults in an insecure environment produced by acts of terrorism. Therefore, it is important to provide the children in Israel the opportunity to express their feelings in the midst of threats of danger. In times of high stress, anxious children who do not feel safe to express feelings in words may use play to clarify the situation and explore feelings. In many cases, the school system is the only available resource to meet children's emotional needs. Unfortunately, very few professionals in schools and agencies in Israel are trained in utilizing play therapy methods of treatment to help children and their families. For the play therapist to be considered a competent mental health professional, it is crucial to be properly trained and have a supervised clinical experience (Landreth & Wright, 1997). Therefore, it is important that the Israeli elementary school system encourages teachers and school counselors to obtain play therapy training and provide play therapy sessions to the children they serve.

As shown in this study, a short-term play therapy training program may not be effective in changing Israeli counselors and teacher's attitudes toward children, or their levels of confidence in applying play therapy skills. However, there is a great need for play therapy training to help mental health professionals assist children in dealing with present and potential terrorist activities. Results of this study may suggest that the use of long-term training models would yield greater effects than short-term training models. Several factors may have contributed to the lack of statistical significance demonstrated within this study. These factors include: a) a

small sample size; b) cultural differences; and c) the trainer had limited child-centered play therapy teaching experience.

Recommendations

Based on the results of this research the following recommendations are offered:

1. The Attitude-Knowledge-Skills test questions 11, and 14 should be converted in order to provide the proper weighting for each item.
2. A follow-up study is needed to investigate the effects of the child-centered play therapy training on the trainees.
3. A follow up study is needed to investigate the effectiveness of short-term child-centered play therapy training on children.
4. Similar research is needed to compare the effect of other play therapy models.
5. Longer periods of play therapy training are recommended in Israel with more play therapy experience and practice added to the training.
6. This study should be replicated with a more experienced trainer.

APPENDICES

Appendix A: Play Therapy Attitude-Knowledge-Skills Survey

Code: _____ (Please give the last 4 digits of your home phone)

Play Therapy Attitude-Knowledge-Skills Survey

This survey is designed to provide the play therapy trainer information regarding the attitude, knowledge and skills of a group of trainees. **It is not a test**. No grade will be given as a result of completing this survey. Please read each statement/question carefully. From the available choices, circle the **one** that best fits your reaction to each statement/question.

Thank you for your cooperation.

1. Gender
    - Male
    - Female
2. Age _____
3. University courses taken in play therapy (circle one and give title of course)
    - 0 _____
    - 1 _____
    - 2 _____
    - 3 _____
    - More than 3 _____
4. Play therapy workshop attended (circle number and give title of workshop)
    - 0 days
    - 1 day _____
    - 2-3 days _____
    - 4-6 days _____

- 7-10 days _____
- More than 10 days _____

5. Clinical experience in play therapy
    - None
    - Under 1 year
    - 2 year
    - 2 years
    - 3 years
    - More than 3 years
6. Supervised experienced in play therapy

    _____

7. Years of experience as elementary school counselor
8. Work experience with children
    - None
    - School teacher: Number of years: _____
    - Child Care: Number of years: _____
    - Other (please specify) _____ Number of years_____
    - Currently work as a school counselor
    - Yes _____
    - No _____

On the following statements, please indicate your response with each statement in the following manner:

1 – Never

2 – Seldom

3 – Sometimes

4 – Often

5 – Always

		Never				Always
1.	I enjoy being child-like sometimes	1	2	3	4	5
2.	I am accepting of the child part of myself	1	2	3	4	5
3.	I enter new relationships with children with confidence and relaxation	1	2	3	4	5
4.	I am a warm and friendly person to children	1	2	3	4	5
5.	I usually provide too many answers to children	1	2	3	4	5
6.	I have a high tolerance for ambiguity	1	2	3	4	5
7.	I am vulnerable and make mistakes at times	1	2	3	4	5
8.	I know myself and accept myself as who I am	1	2	3	4	5
9.	I have a sense that children trust me	1	2	3	4	5
10.	I appreciate my childhood	1	2	3	4	5

On the following statements, please indicate your agreement or disagreement with each statement in the following manner:

1 – Strongly Disagree

2 – Disagree

3 – Undecided

4 – Agree

5 – Strongly Agree

		Strongly Disagree				Strongly Agree
11.	Children's behavior is usually unpredictable	1	2	3	4	5
12.	The underlying motivation of children's behavior can be understood	1	2	3	4	5
13.	Children are basically miniature adults	1	2	3	4	5
14.	Children are irresponsible	1	2	3	4	5
15.	Children possess a tremendous capacity to overcome obstacles and circumstances in their lives	1	2	3	4	5
16.	Children's behavior is usually explainable	1	2	3	4	5
17.	Since children are in the process of developing, they do not usually experience the depth of emotional pain adults are capable of experiencing	1	2	3	4	5
18.	Children are capable of positive self-direction if given an opportunity to do so	1	2	3	4	5

		Strongly Disagree				Strongly Agree
19.	How things seem to children is more important than what has actually happened	1	2	3	4	5
20.	Children's behavior needs to be molded and directed for optimal growth and adjustment	1	2	3	4	5
21.	Children's behavior is usually understandable	1	2	3	4	5
22.	Children can be helped to grow and mature faster	1	2	3	4	5
23.	Children usually need considerable structure and direction since they are still learning and developing	1	2	3	4	5
24.	Children are capable of figuring things out	1	2	3	4	5
25.	Children are resourceful	1	2	3	4	5
26.	Children are unkind	1	2	3	4	5
27.	Children tend to make the right decision	1	2	3	4	5
28.	Children need a capable adult to point them in the right direction	1	2	3	4	5
29.	Children think before they act	1	2	3	4	5
30.	Children are capable of insight into their own behaviors	1	2	3	4	5
31.	Children are unfeeling	1	2	3	4	5
32.	Children can be trusted	1	2	3	4	5
33.	Children will out grow most of their problems	1	2	3	4	5

		Strongly Disagree				Strongly Agree
34.	Most children are able to express their feelings, frustrations, and personal problems though verbal expression	1	2	3	4	5
35.	Adjusted and maladjusted children express similar types of negative attitudes	1	2	3	4	5
36.	Most children need direction from a counselor to work out solutions to their own problems in a counseling relationship	1	2	3	4	5
37.	Typically, an adult must intervene physically or directly to stop most children's aggressive and/or destructive behavior	1	2	3	4	5
38.	Children communicate in much the same way as adults	1	2	3	4	5
39.	Adult counselors and play therapists use similar techniques	1	2	3	4	5
40.	Children's natural medium of communication is play and activity	1	2	3	4	5
41.	How the therapist feels about the child is more important than what the therapist knows about the child	1	2	3	4	5
42.	Children do not have emotional disturbance problems. They just lack education and training	1	2	3	4	5

On the following statements, please indicate your agreement or disagreement with each statement in the following manner:

1 – None

2 – Very Limited

3 – Limited

4 – Good

5 – Very Good

		None				Very Good
43.	In general, how would you rate your knowledge of play therapy as an approach for counseling with children?	1	2	3	4	5
44.	How would you rate your understanding of the reasons for selecting and excluding toys and materials in play therapy?	1	2	3	4	5
45.	How would you rate your awareness of your own feelings when you are relating to children?	1	2	3	4	5
46.	In general, how would you rate your knowledge of how children communicate?	1	2	3	4	5
47.	In general, how would you rate your knowledge of identifying areas where limits should be set?	1	2	3	4	5

		None				Very Good
At the present time, how would you rate your own understanding of the following terms						
48.	"Play theme"	1	2	3	4	5
49.	"Tracking"	1	2	3	4	5
50.	"Returning responsibility"	1	2	3	4	5
51.	"Therapeutic limit setting"	1	2	3	4	5
52.	"Choice giving"	1	2	3	4	5
53.	"Play materials"	1	2	3	4	5
54.	"Play therapy"	1	2	3	4	5
55.	How would you rate your ability to conduct a play therapy session with a child?	1	2	3	4	5
56.	How would you rate your ability to effectively assess the mental health needs of a child?	1	2	3	4	5
57.	How well would you rate your ability to distinguish differences in counseling adults and children?	1	2	3	4	5
58.	How would you rate your ability to identify the strengths and weaknesses of verbal therapy in terms of their use with different age children?	1	2	3	4	5
59.	How would you rate your overall ability to relate to children?	1	2	3	4	5
60.	How would you rate your ability to achieve the frame of reference of a child?	1	2	3	4	5

		None				Very Good
61.	In general, how would you rate yourself in terms of being able to effectively deal with a silent child in play therapy?	1	2	3	4	5
62.	How would you rate yourself in terms of being able to effectively deal with an aggressive child in play therapy?	1	2	3	4	5
63.	How would you rate yourself in terms of being able to effectively deal with a reluctant anxious child in play therapy?	1	2	3	4	5
64.	How well would you rate your ability to discuss the issue of confidentiality with parents?	1	2	3	4	5
65.	How would you rate your ability to help parents understand their children?	1	2	3	4	5
66.	In general, how would you rate your ability to accurately articulate a child's problem?	1	2	3	4	5
67.	How would you rate your ability to critique a play therapy session?	1	2	3	4	5
68.	How well do you think you could identify play themes in a play therapy situation?	1	2	3	4	5
69.	In general, how would you rate your skill level in terms of being able to provide appropriate counseling services to children?	1	2	3	4	5
70.	How would you rate your ability to effectively consult with another mental health professional concerning the mental health needs of a child?	1	2	3	4	5
71.	Rate your ability to communicate to a child your understanding of the child's feelings and play activity in play therapy	1	2	3	4	5

		None				Very Good
72.	Rate your ability to select appropriate toys for play therapy	1	2	3	4	5
73.	Rate your ability to identify children's emotions in play therapy	1	2	3	4	5
74.	Rate your ability to structure the play therapy relationship	1	2	3	4	5
75.	Rate your ability to understand symbolic play in play therapy	1	2	3	4	5
76.	Rate your ability to understand the meaning of children's questions	1	2	3	4	5
77.	Rate your ability to communicate the steps in therapeutic limit setting	1	2	3	4	5
78.	Rate your ability to set limits on children's behavior in play therapy	1	2	3	4	5
79.	Rate your ability to establish a facilitative relationship with a child	1	2	3	4	5
80.	Rate your ability to build children's self esteem without causing dependency in play therapy	1	2	3	4	5
81.	Rate your ability to track a child's behaviors in play therapy	1	2	3	4	5
82.	Rate your ability to reflect children's feelings in play therapy	1	2	3	4	5
83.	Rate your ability to reflect the content of children's play in play therapy	1	2	3	4	5
84.	Rate your ability to facilitate children's spontaneity and creativity in play therapy	1	2	3	4	5
85.	Rate your ability to facilitate decision making and responsibility by children in play therapy	1	2	3	4	5
86.	Rate your ability to verbally match the effective and activity pace of a child in play therapy	1	2	3	4	5

		None				Very Good
87.	Rate your ability to be succinct and specific in communicating with children in play therapy	1	2	3	4	5
88.	Rate your ability for self-supervision of counseling relationships with children	1	2	3	4	5

Appendix B: Cover Letter

August 27, 2002

Dear Participant,

My name is Suzi Kagan. I am conducting a research project for my doctoral dissertation that is designed to study how play therapy training influences school counselors. This study consists of one instrument, the Play Therapy Attitude-Knowledge-Skills Survey. You will complete the questionnaire of Play Therapy Attitude-Knowledge-Skills Survey three times. The first time will be one month prior to the training course, the second time at the beginning of the training course, and the third time at the end of the training course. Each time will take approximately 30 to 40 minutes to complete.

Please remember:

- Your participation in this study is voluntary.
- Your decision whether or not to participate will in no way affect you standing in this class.
- All of your information will remain confidential.
- Please do not sign your name on the instrument.
- Please give the last 4 digit of your home phone number as an identifying code.
- You may withdraw at any time without affecting your class standing.

If you choose to do so, please:

1. Complete the questionnaire--- I would very much appreciate your participation in answering ALL of the questions, but you may skip any question, which you feel uncomfortable in answering.
2. Give the questionnaire directly to the researcher.

At the conclusion of the study, a summary of group results will be made available to all interested participants. Should you have any question or desire further information, please feel free to call me at 001-940-565-2066, or in Israel: 03-732-0683. You may also contact my advisor Dr. Landreth in the Counseling Education department at the University of North Texas 001-940-565-2910.

THANK YOU IN ADVANCED FOR YOUR TIME AND PARTICIPATION.

This project has been reviewed and approved by the UNT Committee for the Protection of Human Subject

Appendix C: Teacher's Interview

Code: _____ (Please give the last 4 digits of your home phone)

Teacher's Interview

The teacher's last 4 digit home number _____

The child's first name_____

Please answer the following questions. You may add your comments, the teacher's comments or any other question you may think is relevant.

1. What were the reasons you chose to send this child to play therapy?

   _____

   _____

2. Have you seen any changes in the child's behavior? Give at least two examples_____

   _____

3. Have you seen any changes in the child's social interactions? Give at least two examples_____

   _____

4. Have you seen any changes in the child's ability to express his/ her feelings? Give at least two _____

   _____

5. Would you recommend other children in your class to attend play therapy?_____
6. What would the reasons be for your referrals?_____

   _____

7. Do you have any questions or comments about the process your student experienced in play therapy?_____

_____

THANK YOU FOR YOUR COOPERATION,

SUZI KAGAN

Appendix D: Treatment Course Outline, Introduction to Play Therapy

This course focuses on enhancing the counseling relationship with children by using play media to facilitate expression, self-understanding, and personal growth and development. Observation of actual play session and role-playing in play therapy are integral parts if the training. The major objectives of the training are to provide students an opportunity to understand and demonstrate competencies in:

1. Perceiving the child's word as viewed by the child.
2. Communicating effectively with children at a feeling/emotional level.
3. Understanding the meaning and implications of children's behavior.
4. Establishing a helping/ facilitative relationship with a child in play therapy experience.
5. Self-exploration, which promotes self-understanding.

Activities

1. Lecture-discussion
2. Group work
3. Role-playing.
4. Observation of actual play therapy videotape session
5. Handouts of articles in play therapy

Course Outline

I. Rationale for Play Therapy

   A. Play and meaning

   B. How children communicate

   C. Differential uses on play

II. The Child's World

A. Perception

B. Understanding children

C. Children's needs

III. Toys and Materials

A. Purpose and objectives

B. Rational for toy selection

C. Recommended toys and materials

D. Play room

E. Modified setting

F. How children use items in play therapy and meaning

IV. Communicating With Children

A. Active listening

B. Facilitative words and phrases

C. Happening in the playroom

D. Role play

V. Limits and Handling Aggression

A. Rational for setting limits

B. Therapeutic limits

C. Situational limits

1. Room

2. Toys

3. Time

4. Counselor

D. Steps in setting limits

E. Role play

V I. The Play Therapy Hour

A. Initial contact

B. Potential problems with parents

C. Establishing the relationship

D. Children’s questions

E. Role play

F. Video tape

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