AN EARLY MENTAL HEALTH INTERVENTION FOR DISADVANTAGED PRESCHOOL CHILDREN WITH BEHAVIOR PROBLEMS: THE EFFECTIVENESS OF TRAINING HEAD START TEACHERS IN CHILD TEACHER RELATIONSHIP TRAINING (CTRT)

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This study examined the effectiveness of training Head Start teachers and aides in child teacher relationship training (CTRT). CTRT is based on child parent relationship therapy (CPRT) (Landreth & Bratton, 2006), a filial therapy model based on the principles of child-centered play therapy, and was adapted for the classroom. In this quasi-experimental design, 12 teacher/aide pairs \((n = 24)\) were assigned to the experimental \((n = 12)\) or active control group \((n = 12)\). Children who scored in the Borderline or Clinical range on at least one scale of the Child Behavior Checklist-Caregiver/Teacher Report Form (C-TRF) at pretest qualified for the study \((n = 54)\).

Nine hypotheses were analyzed using a two factor repeated measures multivariate analysis to determine if the CTRT group and the active control group performed differently across time according to pre-, mid-, and posttest results of the C-TRF. Additionally, effect sizes were calculated to determine practical significance. Five hypotheses were retained at the .05 level of significance. Post hoc analysis was conducted to analyze the effects of the two phases of treatment.

Results indicated that children in the experimental group made statistically significant improvements in externalizing problems \((p = .003)\). Children of focus made statistically significant improvements in externalizing \((p = .003)\) and total behavior \((p = .01)\) problems. Results are particularly significant for the non-children of focus, who only received the in-classroom intervention. The non-children of focus made statistically significant improvements in externalizing behavior problems \((p = .04)\) and practical significance was large. Results indicate that a school based intervention such as CTRT is a viable treatment option for many children with externalizing behavior problems.
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CHAPTER 1
INTRODUCTION

Increases in violence and suicide among U.S. youth have focused greater attention on the dire consequences of not addressing the mental health needs of children. The most recent U.S. Surgeon General’s report on the status of children’s mental health described the lack of appropriate mental health services for children, especially for the most disadvantaged families, as a national “crisis” (United States Public Health Service, 2001). The report further emphasized that “growing numbers of children are suffering needlessly, because their emotional, behavioral, and developmental needs are not being met” (p. 3). The report also identified several contributing factors: a shortage of mental health professionals specially trained to work with children; a lack of accessible services; and most importantly, the need for early intervention, specifically involving caregivers in the delivery of services (United States Public Health Service, 2001).

Dedicated researchers in the field of mental health and early childhood have increased the knowledge of the external risk factors that negatively impact the development of young children, including poverty, domestic violence, alcohol, drugs, and homelessness (Duncan, Brooks-Gunn, & Klebanov, 1995; Knitzer, 2000;). These risk factors have been positively correlated with increases in academic, social, and mental health problems, including school dropout, delinquency, violence, and suicide (United States Public Health Service, 2001). A synthesis of the literature overwhelmingly supports early intervention as a preventive measure for these problems, especially for young children growing up in disadvantaged homes with multiple risk factors (Thompson & Happoid, 2001; Yokshikawa & Knitzer, 1997). Head Start, the nation’s largest early intervention and prevention program for disadvantaged families, was designed not
only to address the cognitive development of at-risk children, but was also intended to provide early identification and intervention for children exhibiting emotional and behavioral difficulties (Serna, Nielsen, Mattern, & Forness, 2003).

However, authors have challenged the effectiveness of Head Start in addressing the mental health needs of disadvantaged children, citing the fact that far too many Head Start graduates continue to struggle socially and emotionally as they grow and develop (V.E. Lee, Brooks-Gunn, Schnur, & Liaw, 1990; Lopez, Tarullo, Forness, & Boyce, 2000). Others have suggested that because Head Start focuses primarily on academic readiness, the statistics on the number of children reported to suffer from emotional problems are underestimated (Forness et al., 1998); therefore, mental health problems may be under-addressed through Head Start initiatives. In a recent task force report on Head Start and Mental Health, Head Start teachers and administrators reported noticeable increases in aggressive and “out-of-control” behavior problems that can threaten safety and learning in the classroom, and they also noted a lack of specific training for teachers in how to respond to the often significant mental health needs of this population (Yokshikawa & Knitzer, 1997).

Although most experts agree that disadvantaged children can benefit from an early mental health intervention program, scant research targets the best method of delivery. One point agreed upon is that families of at-risk, disadvantaged children, many of whom are minorities, are unlikely to seek traditional mental health services for a variety of reasons, including lack of resources and lack of accessibility. Experts in the field have focused on the importance of a systemic approach in addressing the mental health needs of preschool children based on the view that a young child’s primary relationships (parents, grandparents, and in many cases, teachers) are critical to their development and mental health (B.G. Guerney, 1966; B.G. Guerney &
Children who have had few stable, positive relationships in early childhood are significantly more at risk for life-long adverse consequences such as poor school performance, inability to manage anger as reflected by higher rates of delinquency and violence, a higher proportion of placement in special education, and school dropout (Knitzer, 2000; Perry, 2001). For many disadvantaged preschool children, teachers provide an opportunity for a more consistent, nurturing relationship than their parents may be able to provide. As a full day program, many children in Head Start spend more waking hours with their teacher than with their parents, pointing to the importance and potential influence of the child-teacher relationship. Early childhood experts agree that young children base their sense of competence and self-worth and their view of others and the world around them on the quality of the significant adult relationships in their lives (Klein, 2002; Thompson & Happoid, 2002). Due to the significant amount of time Head Start children spend in the school setting, their teachers have a potentially strong influence on their social, emotional, and intellectual development (Donahue, 2002). Therefore, it is critical to provide teachers with the knowledge and skills necessary to enhance all areas of a child’s development (Thompson & Happoid, 2002; Yoshikawa & Knitzer, 1997).

Leading authorities have argued that while Head Start teachers play a significant caregiving role in the lives of young children---a role that is particularly vital to the healthy emotional, social, and cognitive development of children identified as at risk---they lack the necessary training to respond effectively to the considerable emotional and behavioral needs of these children (Donahue, 2002; Yoshikawa & Knitzer, 1997). Research supports the fact that when teachers receive additional training in this area they feel more empowered to respond to difficult and emotionally charged children and report less general stress in the classroom.
(Donahue, 2002; Yoshikawa & Knitzer, 1997). Donahue (2002) emphasized that training teachers in mental health strategies had the added benefit of addressing the needs of all the children in the classroom, not only the children with severe behavioral difficulties.

Play therapy has gained widespread acceptance as a developmentally-responsive mental health treatment for young children exhibiting emotional and behavioral problems (Bratton & Ray, 2000; Landreth, 1991/2002). Because young children have difficulty expressing their emotional needs, play therapists use toys and play materials to help children communicate their needs in a developmentally sensitive and concrete manner. A recent meta-analysis of over 5 decades of play therapy outcome research revealed a large treatment effect (ES = .80) and concluded that play therapy was an effective treatment across a variety of presenting issues (Bratton, Ray, Rhine, & Jones, 2005). The meta-analysis further revealed that humanistic approaches to play therapy, primarily child-centered play therapy and nondirective play therapy, demonstrated an even larger treatment effect (ES=.92). Bratton et al. (2005) further analyzed play therapy approaches involving paraprofessionals (parents and other significant adults in children’s lives, such as teachers), and found an effect size of ES = 1.05. The authors concluded that filial therapy (play therapy involving a child’s parent or teacher) was an effective modality for intervening in young children’s problems and provided the added benefit of potentially preventing the onset of more costly and serious problems across the lifespan.

Filial therapy, grounded in the principles and procedures of child-centered play therapy (CCPT), was developed in the 1960s by Bernard and Louise Guerney based upon the belief that a parent/caregiver potentially holds more emotional significance to a child than a therapist does. The term, filial therapy, was first coined by Bernard Guerney (1964) to reflect the importance of the parent-child bond to the success of this new intervention. The Guerneys’ revolutionary
approach to child therapy was founded on the novel belief that parents could be trained to be effective therapeutic agents in their children’s lives. They further theorized that training parents in basic child-centered play therapy skills to be used in structured, weekly parent-child play sessions could effectively reduce children’s behavioral problems. Early research by the Guerney’s and their protégées demonstrated that parents were capable of learning essential child-centered play therapy (CCPT) skills and were effective therapeutic agents with their children (B. Guerney & Stover, 1971; Stover & Guerney, 1967; Oxman, 1972). Based on a similar premise of teachers’ emotional significance to children, Andronico and Guerney (1969b) first suggested training teachers in filial therapy methods. B. G. Guerney & Flumen (1970) further researched this premise and found that teachers were capable of learning the skills and implementing them in play sessions with their students.

Based on the Guerneys’ philosophy of filial therapy, Landreth (1991/2002) developed a more time-limited and structured 10-session filial therapy model. Landreth and Bratton (2005) formalized this model with a textbook, Child Parent Relationship Therapy (CPRT): A 10-Session Filial Therapy Model. The CPRT protocol was manualized by Bratton, Landreth, Kellam, and Blackard (2006), allowing for replication of the model. CPRT has been widely researched, with 33 studies and more than 900 subjects. In the previously mentioned meta-analysis completed by Bratton et al. (2005), 26 of 93 studies used filial therapy methodology and demonstrated a treatment effect of $ES = 1.15$. Landreth and Bratton (2005) further analyzed only those studies that utilized the CPRT model. In order to ensure treatment integrity, only researchers who were directly trained in this model and supervised by Landreth or Bratton were included in the analysis. Statistical analysis revealed a very large treatment effect size of 1.25 for the CPRT model (Landreth & Bratton, 2006).
The CPRT model has also been successfully extended for use with in-service teachers (D. M. Smith & Landreth, 2004), mentors (Jones, Rhine, & Bratton, 2002), and pre-service teachers (Brown, 2003; Crane & Brown, 2003). D. M. Smith and Landreth (2004) examined the effectiveness of the 10-session CPRT model with 24 teachers of hard of hearing and deaf preschool children. Compared to a no-treatment control group, the 12 teachers in the experimental group significantly improved their empathic interactions with students. Children whose teachers received CPRT training exhibited fewer overall behavior problems compared to control group children. In an innovative study by Jones, Rhine, and Bratton (2002), the effects of CPRT training with 31 high school mentors was investigated to determine the impact on the behavior of 4- and 5-year olds referred for school adjustment problems. According to parent report, the 16 children receiving weekly one-on-one play sessions with their CPRT mentor demonstrated a significant reduction in problem behaviors when compared to the 15 children whose mentors received training in the comparison treatment, a manualized peer helper program. Further results indicated that CPRT trained mentors demonstrated a statistically significant increase in their empathetic interactions with children over the comparison group mentors. In similar studies, Brown (2003) and Crane and Brown (2003) investigated the effects of CPRT with undergraduate students enrolled in human services classes. Both studies revealed that students receiving the CPRT intervention demonstrated statistically significant gains in empathic interactions with children, as well as in their attitudes, knowledge, and skills related to play therapy. Using an approach based on principles and procedures similar to CPRT, White, Flynt and Draper (1997), White, Flynt, and Jones (1999), Draper, White, O’Shaughnessy, Flynt and Jones (2001) and Post, McAllister, Sheely, Hess, and Flowers (2004) expanded filial training to help teachers generalize therapeutic skills to the classroom, again with promising outcomes.
While the strength of these studies is limited by the absence of random assignment and control groups, the preliminary results are encouraging, revealing increases in teachers’ empathic interactions with students, decreases in child behavior problems, and improvement in early literacy skills. Clearly, these findings support the potential impact of training teachers in CPRT skills to enhance the teacher-child relationship and to remediate the problematic behaviors of young children. These studies lay a solid foundation for further research on the use of the CPRT model with teachers. Research is needed to determine the most appropriate training protocol and delivery system to enable teachers to effectively meet the social-emotional and behavioral needs of their young charges, particularly those most at-risk for achieving academic and personal success.

Statement of the Problem

Disadvantaged, at-risk children are enrolled in Head Start programs to prepare them for school in order to give them an advantage equal to that of children from middle and upper economic families. Head Start teachers have reported an increase in problem behaviors in the classroom as well as frustration in their lack of training to handle these difficult behaviors (Yokshikawa & Knitzer, 1997). The literature indicates that student-teacher relationships of preschool children play a significant role in their future academic and personal success (Hamre & Pianta, 2001). By providing teachers with the necessary skills to respond to students’ emotional and behavioral needs, as well as their academic needs, teachers are empowered to address the needs of the whole child. This is especially important for disadvantaged, at-risk children who are in danger of more academic and emotional problems as they grow and develop (Yokshikawa & Knitzer, 1997). Although Head Start literature acknowledges the importance of
early mental health services for the children served by this program, there is virtually no research that examines the impact of an infused mental health program designed to train Head Start teachers in therapeutic skills to use with children in their classrooms (Yoshikawa & Knitzer, 1997).

Review of Related Literature

The review of the literature concentrates on the following elements: (a) the Head Start program and issues related to the mental health needs of this program; (b) the importance of the teacher and child relationship; and (c) rationale for using play therapy and filial therapy.

Head Start Program

Head Start, begun in 1965, was designed to break the cycle of poverty in American families. The initiative provides preschool children of low-income families with a comprehensive program designed to address their emotional, social, health, nutritional, and psychological needs. In order to qualify for Head Start, children must be at least three years of age and family income must fall below the poverty line as defined by the office of Management and Budget (Head Start Act, 1981). According to the Administration for Children and Families (2004) the majority of children enrolled in Head Start are ethnic minorities: Hispanic, 31.2%; Black American, 31.1%; and Caucasian, 26.9%, with Native American, Asian, Pacific Islander, and multiracial children making up 10.8%. Many of the children enrolled in Head Start are also labeled with a disability; 12.7% of children enrolled in the 2003-2004 school year were identified as such. Children growing up in economically disadvantaged families are at risk for a multitude of difficulties later in life, including academic failure, social-emotional difficulties,
violence, and mental illness and therefore, need for an early intervention to address these risks (Duncan et al., 1995).

During the preschool years, low-income children, when compared to their peers, display higher levels of dysregulated behavior (Miller, Gouley, Seifer, Dickstein, & Shields, 2004). They seem to have a more difficult time adjusting to the expectations of the preschool classroom and have a higher risk for later difficulties in school. Consequently, these children should be targeted in prevention and intervention efforts (Miller et al., 2004). Results indicate the need for Head Start teachers to be trained in recognizing and addressing the emotional needs of Head Start students in order to increase future academic success.

Researchers in early childhood education have suggested a higher rate of maladjusted behavior in children enrolled in Head Start than that reported by the National Head Start Program (Tankersley & Kamps, 1996; Webster-Stratton & Hammond, 1998). The cause may be the program’s focus on the cognitive and academic development of the students, ignoring the emotional development and difficulties of many children enrolled in Head Start (Forness et al., 1998). In focusing so much on the academic and cognitive progress of children, administrators are missing a critical element of school readiness and emotional development.

Additionally, Head Start staff report an increase in children exhibiting aggression, withdrawal, or general “out-of-control” behaviors that threaten the classroom environment. Community and family stressors such as drugs and alcohol, violence, financial strain, and depression and other mental illnesses prevalent among Head Start families impact not only the students and their social-emotional development but also the parents and their ability to participate in Head Start parenting programs as well as, their ability to be good parents (Yoshikawa & Knitzer, 1997). In a synthesis of the literature Thompson and Happoid (2001)
stated that kindergarten teachers reported that it is not children’s lack of cognitive abilities that cause the most difficult challenges in the classroom; rather, it is children lacking the motivational and social-emotional qualities necessary for school readiness.

*Rationale for early mental health intervention.* Serna et al. (2003) suggested that because Head Start is the earliest form of intervention provided nationwide for children, the primary goal should lie in the development of social-emotional skills rather than a strict focus on academic skills. Social-emotional development strongly impacts a child’s school readiness, the primary goal of Head Start. Thompson and Happoid (2001) identified three qualities in young children that are necessary for school success: intellectual skills, motivation to learn, and social-emotional development. The best learning occurs under the guidance of an adult teacher balanced by the influence of peers. Therefore, children must be able to understand the feelings and views of others, cooperate with others, and experience self-control, both emotionally and behaviorally (Thompson & Happoid, 2001). A child’s emotional regulation proves critical to the development of learning. Children must feel in control of their emotions in order to share a book with another child, to block out the outside stimuli to pay attention to the task at hand, and to feel good about school and be motivated to learn (Raver & Zigler, 2004; Thompson & Happoid, 2001). Several leading authorities in children’s mental health have emphasized the strong tie between how children feel about themselves and their ability to think and learn (Faber & Mazlish, 1995; Ginott, 1972; Nelsen, Lott, & Glenn, 2000).

Yoshikawa and Knitzer (1997) concluded that the literature supports the importance of early intervention as a preventive measure against later problems such as school dropout and delinquency. Preschool children are at a critical developmental level for intervention. Thompson and Happoid (2001) determined through a synthesis of the literature that the most significant
advances in psychological understanding of others occurs between the ages of 3 and 4 years. They also concluded that an early intervention program with supportive relationships and appropriate practices will benefit disadvantaged children significantly more than children from middle-income families. The preventative focus of Head Start provides disadvantaged, at-risk children with the type of emotionally supportive environment that will facilitate their optimal social-emotional growth. Knitzer (2000) proposed that when children are provided a supportive and encouraging environment, they are better able to understand their own feelings as well as those of others.

*Head Start’s difficulty in addressing mental health concerns.* The Head Start Performance Standards of 1996 outlined the program’s focus on mental health: work collaboratively with parents, secure services of mental health professionals, and have regularly scheduled onsite visits with mental health professionals. Critics consider these guidelines vague, consequently allowing for loose interpretation by Head Start program directors (Lara, McCabe, & Brooks-Gunn, 2000). According to the standards, mental health professionals provide effective identification and intervention in family and staff concerns regarding a student’s mental health. In 1999, however, 50% of the Head Start programs reported having a mental health professional available less than 6 hours a week (Lopez et al., 2000). Although the Head Start Standards appear to emphasize the importance of addressing the social-emotional needs of these children, these discouraging statistics indicate that in practice the mental health needs of Head Start’s children are not being met in this current system.

*Importance of the Teacher-Child Relationship*

Relationships between children and significant adults in their lives are critical to the
social-emotional development of children (Pianta, 1999). Inadequate attachment with a significant adult in early childhood can cause notable difficulties as children develop as well as put them at risk for a host of other difficulties. A young child may form a strong connection with a nurturing teacher who provides interest in the child’s emotional needs (Perry, 2001). Teachers of young children provide many of the same nurturing tasks that parents provide and function as attachment figures (Howes & Bowman, 2002). The high degree of relational processes occurring in the classroom as part of the learning environment makes early childhood education unique. As a result, the teacher-child relationship is even more critical during this time (Pianta, 1999). Solid relationships may increase children’s work ethic; just as teachers tend to put more effort into children with whom they have a strong relationship, children are likely to work more for teachers they feel connected to as well (Hamre & Pianta, 2001).

Birch and Ladd (1997) investigated three features of a teacher-child relationship: closeness, conflict, and dependency and how each related to school adjustment in young children. Closeness relates to the extent to which the child feels connected to the teacher. Open communication and warmth constitute important attributes in the relationship a child experiences with his or her teacher. Students who sense closeness with their teacher feel more secure in the classroom and therefore may be more willing to take risks and in turn be more successful in the classroom, both academically and emotionally. Dependency refers to the extent to which the child clings to the teacher, the extent to which the child depends on the teacher to feel supported. Inappropriate dependency may hinder the child’s development and willingness to explore the learning environment. There is, however, a distinction between a child’s dependency on a teacher and a child who has a close, secure relationship with the teacher. A close, secure relationship enables a child to be appropriately dependent on the teacher for help and
independent enough to take risks in the environment. Closeness may increase as a child develops while dependence decreases. Children who feel close, secure, and attached are more likely to be appropriately autonomous. Young children who are autonomous are able to take risks, explore their environment, and feel secure as they experience new things, all of which contribute to the learning process (Birch & Ladd, 1997).

A conflicted teacher-child relationship can be detrimental to children as this relationship may impact their present and future views of school. Characteristics of conflictual teacher-child relationships include one that lacks rapport and has harsh interactions. Children do not view this relationship as a source of support and therefore have a more difficult time feeling comfortable in the learning environment. Children who are in conflict with their teacher may withdraw, feel alienated, and have a generally negative attitude about school (Birch & Ladd, 1997).

Birch and Ladd (1997) followed 206 kindergarten children and their 16 teachers as part of a longitudinal correlational study evaluating the impact of the teacher-child relationship on the child’s adjustment to school. Results indicated a correlation between students whose teachers perceived them to be dependent to the child’s poor academic performance, school attitude, and school involvement. A connection was also found in children whose teacher rated their relationship as conflictual and the children’s tendency to avoid the classroom environment, to be less cooperative, and to be less self-directed. Finally, a correlate was found in children whose teacher characterized their relationship as close; the children saw the teacher as a source of support and consequently were more willing to engage in learning activities. These students were also viewed as having a more positive attitude toward school and were seen as more open about their feelings and attitudes with the teacher, thus allowing the teacher to guide and explore feelings with them. Therefore, there seems to be a strong correlation between the teacher-child
relationship and academic performance. Children who have a close relationship with their teacher may become more self-directed and autonomous in the classroom due to their perspective of the supportive environment and the teacher’s ability to guide and encourage them (Birch & Ladd, 1997).

Hamre and Pianta (2001) followed 179 children in kindergarten through eighth grades to examine the extent to which their kindergarten teachers’ perception of the teacher-child relationship predicted several school outcomes including academic achievement and behavior problems. The kindergarten teachers were given two different assessments to complete on each child. The Teacher-Child Rating Scale is a rating scale of children’s classroom behavior, and the Student-Teacher Relationship Scale evaluates teachers’ perceptions of their relationship with a specific student. At kindergarten entry children were given the vocabulary subtest of the Stanford-Binet Intelligence Scale-Revised, Fourth Edition, to assess cognitive ability. Each year grades were collected, and teachers’ reports of work habits as indicated on the students’ report card and each students’ disciplinary record as maintained by the school were collected. The Iowa Test of Basic Skills was also given each year to students in the school system.

Pearson product-moment correlation was calculated to determine the bivariate associations between the kindergarten teacher’s ratings of the teacher-child relationship and the child’s behavioral and academic performance through the eighth grade (Hamre & Pianta, 2001). A significant correlation was found between the teachers’ perception of high conflict and the poor academic outcomes for boys throughout their schooling from first through eighth grade ($p < .01$). A significant correlation was also found in boys and girls who had a highly conflictual relationship with their kindergarten teachers; they tended to have fewer positive work-habit marks in elementary school ($p < .01$) and more discipline infractions in upper elementary school.
These correlations remained significant for boys through middle school \((p < .01)\). Girls whose relationship with the teacher was characterized as close tended to have significantly more positive work-habit marks in lower elementary school \((p < .01)\) as well as fewer disciplinary problems in upper elementary school \((p < .05)\). A significant correlation was not found in boys who had a close relationship with the kindergarten teacher and their disciplinary infractions in elementary or middle school. These results indicate that a strong predictor of behavior in children is the quality of the teacher-child relationship early in the child’s academic career (Hamre & Pianta, 2001).

A hierarchical regression model was used to determine whether there was a relationship between a negative teacher-child relationship and the child’s academic performance in school (Hamre & Pianta, 2001). Relational Negativity, a composite of the Conflict and Dependency subtests of the Student Teacher Relationship Scale (STRS), accounted for a significant amount of variance \((p < .01)\) in predicting language arts and math grades in lower elementary school. However, this relationship did not continue into upper elementary or middle school. Relational Negativity also accounted for a significant portion of the variance in Iowa Test of Basic Skills scores in lower elementary school \((p < .05)\). There were no significant associations between teacher-rated behavior problems and academic performance, indicating that it was the negativity in the teacher-child relationship that impacted the child’s academic performance. These results also suggest that children who were characterized as having behavioral difficulties in kindergarten but were able to develop a positive relationship with their teacher were more likely to avoid future behavioral problems than were children whose relationship with their teacher was rated as highly negative. These results indicate the importance of investing in the development of
the teacher-child relationship, because the quality of this relationship seems to have unique
influence on both the academic and behavioral success of students (Hamre & Pianta, 2001).

Hughes, Cavell, and Jackson (1999) investigated the contribution of the quality of the
teacher-child relationship to changes in the child’s level of aggression. Teachers participating in
the study were asked to nominate children in their class whom they considered aggressive; 61
third-grade children participated in the study. The Child Behavior Checklist-Teacher Report
Form (CBCL-TRF) was used as a screening tool to determine the child’s level of aggression.
Children participating in the study scored above the 84th percentile on the Aggression Scale of
this instrument. Teachers also completed the Teacher Reinforcing Scale (TRS) on each child to
determine the extent to which the child is reinforcing to the teacher in the relationship. The
children participating in the study completed the Network of Relationships Inventory to assess
the extent to which they felt supported by their teacher. Children also completed the Social
Support Appraisals Scale, which assesses the extent to which children feel well liked by their
teacher. Peer-rated aggression was also taken into consideration; these data were collected
through an interview-type experience in which children were asked to choose children to play the
part of aggressive children in a dramatic play. Parents of the participants completed the Parental
Acceptance-Rejection Questionnaire, which measures the parents’ perception of their childhood
relationships with their mothers.

A series of hierarchical multiple regression analyses was conducted to investigate if the
quality of the teacher-child relationship accounted for the child’s levels of aggression (Hughes et
al., 1999). Results indicated that the scores on the Teacher Relationship Scale from the fall and
spring of the first year of study predicted the second year’s scores on Aggression of the Teacher
Report Form ($p < .05$). There was a significant correlation between the results of the Teacher
Report Form of Aggression from Fall year 2 and the scores on the Teacher Relationship Scale from Fall year 1 ($p < .05$). The children’s report of relationship quality in year 1 also predicted the Teacher Report Form of Aggression in year 2 ($p < .05$). Children whose parents rated high on the Parental Acceptance-Rejection Questionnaire were analyzed separately from children whose parents rated low on this questionnaire. The children whose parents’ scores were high had a significant correlation between the Teacher Relationship Scale and the peer-rated aggression ($p < .05$). Children in the low group of this questionnaire did not have a significant correlation between these two factors. Thus, it seems that the children who were considered more at risk for relationship and attachment difficulties benefited more from a high-quality teacher-child relationship. These results indicate a correlation between the quality of the child-teacher relationship and the child’s behavior; however, they do not indicate a causal relationship. The results of this study indicate the importance of the quality of the teacher-child relationship as it relates to the child’s future aggressive tendencies. This study demonstrates the importance of developing a strong positive teacher-child relationship, especially for students who may be at-risk for more significant behavior difficulties such as aggression (Hughes et al., 1999).

*Teachers as Therapeutic Agents*

Young children develop a sense of self, other people, and the world around them based on the significant adult relationships in their lives, such as parents, caregivers, and teachers. A young child’s ability to regulate self-control in respect to strong emotional reactions heavily relies on the response of the caregiver, who provides necessary soothing and encouragement (Thompson & Happoid, 2001). Because of the significance of the teacher-child relationship, it only makes sense to train teachers to respond more therapeutically to the emotional reactions of
the children in their classes. With the at-risk nature of the students in the Head Start Programs and the shortage of funding for mental health professionals, there is potential for significant benefit in giving additional training to these teachers (Yoshikawa & Knitzer, 1997).

According to Yoshikawa and Knitzer (1997), the key to addressing the mental health needs of children in Head Start programs is a comprehensive approach. They concluded that working with teachers, parents, and children seems to be most successful. Collaborative programs have affected a variety of child and family issues such as antisocial behaviors and delinquency. Therefore, strengthening the mental health support for children, parents, and staff enhances the intensity of support for children, consequently increasing its potential impact.

In order for schools to provide a comprehensive approach to the emotional and cognitive development of children, collaboration between mental health professionals and educators is critical. A collaborative approach enables the mental health professional to respond to the needs of all children in the early childhood center, not only the children with severe behavioral difficulties. Teachers provided with additional training in addressing children’s emotional needs are empowered and feel they can work with more difficult and emotionally charged children (Yoshikawa & Knitzer, 1997). This additional training should include training teachers in developmentally responsive methods such as reflecting children’s feelings, both positive and negative (Donahue, 2001). Most adults do not attend to or reflect children’s feelings, thinking that addressing those feelings, especially the more negative feelings, will cause the child to become out of control. However, children are more likely to become out of control when their feelings are not acknowledged and discussed. Children are calmed as they feel understood when they are given the opportunity to express themselves to an adult who listens and cares for them (Donahue, 2001). Often, adults do not understand the child’s feelings and emotional needs.
because of the adult’s tendency to rely on verbal communication when a child’s natural mode of communication is through play (Landreth, 2002).

**Rationale for Utilizing Play Therapy**

Scholars generally view play as the universal language of children; it is natural, spontaneous, and meaningful (Landreth, 2002). Play therapy allows children an opportunity to express themselves fully, to play out their feelings and experiences just as adults in therapy talk out their feelings and problems (Axline, 1947). The historic case of Little Hans with Freud in 1909 broke ground by utilizing play to help the boy overcome his phobia. Freud instructed Hans’s father about how to respond to him based on remarks his father made about Hans’s play (Landreth, 2002). Following Freud’s lead, Hermine Hug-Hellmuth first used play with children as a form of therapy in 1920 (Gil, 1991). Hug-Hellmuth was one of the first to focus on the meaning and healing powers of play for children and therefore its importance in analysis (Landreth, 2002). Melanie Klein and Anna Freud followed her lead some 10 years later, perfecting the use of psychoanalytic play therapy. Klein and Freud wrote extensively about their use of play in therapy with children. Klein utilized play as a substitute for the child’s verbalizations; Klein believed that toys and play were a child’s language; and Freud utilized toys to build a secure, comfortable relationship, relying more on the child’s verbal skills to communicate (Esman, 1983).

Developmentally young children do not possess the cognitive abilities to think abstractly and reason as do adults; thus, play provides a concrete means of expression. Play is a child’s natural language; it comes easily and fluidly, just as words come for adults. Play provides an avenue for children to express their thoughts and feelings completely and make sense of the
world around them. In play, children can transfer thoughts, feelings, and experiences onto the toys rather than onto other people (Landreth, 2002).

Child-centered play therapy is rooted in the early work of Carl Rogers (1951), who focused on the importance of the relationship in person-centered therapy. Landreth (2002) attributed Virginia Axline (1947) as the forerunner of child-centered play therapy by expanding Rogers’s basic principles of person-centered therapy. The focus of this theoretical model is in being with the child, not doing for the child. Axline’s (1947) foundations of play therapy included the importance of the therapist believing that each child has the capacity to solve his/her own problems and that adaptive behavior satisfies more than maladaptive behavior. The therapist then provides total acceptance for the child, just as he/she is, and allows the child to fully be himself/herself without changes. Through the therapist’s acceptance of the child and the child’s emotions, the therapist reflects to the child all that the child expresses to help the child understand his/her experience more fully. This safe environment allows the child to be fully comfortable, to be himself/herself. Axline (1947) stated that the therapist believing in the child’s capacity to heal is critical to the therapeutic relationship. Clark Moustakas (1959) and Garry Landreth (2002) added to Axline’s work and perfected the child-centered play therapy approach which is widely used as an effective modality in working with young children (Landreth, 2002).

Play Therapy in Head Start Programs

There is very little research on conducting play therapy specifically with children in Head Start programs. Of the studies found, filial therapy was the modality of treatment utilized with parents of students enrolled in Head Start rather than individual therapy with children in Head Start programs (Johnson, Bruhn, Winek, Krepps, & Wiley, 1999). A case study
demonstrating the effectiveness of filial therapy with a parent and child enrolled in Head Start was reported, with the parent stating that she had begun to have more fun with her son again. New limit-setting skills were reported as most helpful to the parent because she was able to take more of a leadership role rather than a power and control role as a parent and her son was monitoring his own behavior more and throwing fewer temper tantrums (Johnson et al., 1999).

**History of Filial Therapy**

Filial therapy was developed by Bernard Guerney in the 1960s to enhance the parent-child relationship. Louise Guerney later joined her husband in the research of filial therapy. The Guerneys trained parents in basic child-centered play therapy skills to be utilized in play times with their children each week. Parents participated in a group format that included didactic instruction, demonstrations, role-playing, at-home play sessions, and supervision. Filial group sessions for parents occurred once a week for 2 hours for approximately 1 year, sometimes as long as 2 years. Parents conducted play sessions at the clinic and eventually transitioned to having play sessions at home once the therapist believed they were ready (B.G. Guerney, 1964).

_Rationale for filial therapy._ Filial therapy focuses on the parent-child relationship, teaching and supervising parents in basic child-centered play therapy skills to be utilized during weekly special play times at home with their child (Landreth, 2002). Parents are trained to be therapeutic agents for their child in place of the therapist. The parent-child relationship has more emotional significance to the child than a relationship with a play therapist and consequently meets the child’s emotional needs in a more meaningful way. The child’s in the presence of the parent has more power and more meaning than in the presence of a therapist, who does not have the same caliber of relationship with the child (L. Guerney, 2000). The filial training model
offers unique aspects that set it apart from other parenting models. Parents are provided training and supervision on their filial skills in a small group format. Filial therapy also utilizes the child’s natural mode of communication, play, while teaching the parent to learn the child’s language and to look at things from the child’s perspective, contributing to the parent’s ability to understand the child more completely (B. Guerney et al., 1966).

*Filial therapy research utilizing the Guerney model.* Stover and B. Guerney (1967) and Andronico, Fidler, Guerney, and Guerney (1961) conducted what are considered landmark filial therapy studies designed to determine the effectiveness of parents’ using child-centered play therapy skills in play times with their children labeled as emotionally disturbed. Andronico et al., (1961) determined that filial therapy was effective in reducing children’s physical and behavioral difficulties as well as restoring harmony in the parent-child relationship. Stover and B. Guerney (1969) found that parents were capable of learning the therapeutic skills and were effective in working with their children. To extend that study, B. Guerney and Stover (1971) trained 51 mother-child dyads in filial therapy. Live observations indicated that after 12 to 18 months of therapy, the mothers made statistically significant improvements in their empathetic interactions with their children who had been diagnosed as emotionally disturbed. The children also improved in social adjustment and behavior problems, and for 28 of the children improvement was considered statistically significant. Oxman (1972) extended B. Guerney and Stover’s research by providing a matched sample of 77 mother-child dyads to be the no-treatment control group. Results revealed that, in comparison, the mothers who received filial therapy from the B. B. Guerney and Stover study reported a statistically significant improvement in their children’s behavior over the matched control group as well as significantly more satisfaction with their children. L. Guerney (1975) conducted a longitudinal follow-up study with 42 of the original 51
mothers from B. Guerney and Stover’s (1971) study responding. Continued improvement 1 to 3 years after treatment was reported by 76% of the mothers while 86% reported that their children’s initial improvement had maintained over the 1 to 3 years post treatment. Sywulak (1977) used the Guerneys’ methodology in training and supervision of 32 parents (19 mothers and 13 fathers) of 19 children who were clinic referred and acted as their own control group. Parents conducted play sessions with their children and after 2 months and 4 months of treatment, data were gathered, with results revealing a statistically significant improvement in parental acceptance and child adjustment. Children who were considered withdrawn made faster improvements than children considered aggressive. Sensue (1981) conducted a follow-up study 3 years after the initial training and formed a matched no-treatment comparison group of parents whose children were not referred for therapy. Results revealed that the filial-trained parents \( n = 25 \) attained statically significant improvements in parental acceptance as well as in the parents’ perception of their children’s adjustment when compared to the comparison group at the 6-month and 3-year follow-up. At follow-up the children who had been labeled as maladjusted and whose parents had received filial therapy training were found to be as adjusted as the children in the comparison group who had never been referred to therapy for behavioral problems.

*Landreth 10-session filial therapy model: Child parent relationship therapy (CPRT).* Based on the Guerneys’ previous work in filial therapy (1961, 1967, & 1969) Landreth (2002) developed a 10-session model that utilized didactic teaching, group process, demonstrations, role-playing, at-home sessions, and videotaped or live supervision. This model was formalized and is now titled child parent relationship therapy (CPRT) (Landreth & Bratton, 2006). In this approach, typically small groups of parents meet weekly for 2 hours to participate in the filial therapy group. Each session parents are taught and practice skills such as reflecting feeling and
tracking that assist in their communication with their children. Principles of filial therapy such as allowing the child to lead, the meaning of play as the child’s primary mode of communication, and belief in the inner person of the child are emphasized. Parents are also taught discipline skills such as limit setting and choice giving, which encourage the child to gain control over his/her own behavior and consequently make his/her own changes. The goal is for the child to learn to trust and utilize his/her internal locus of control; ultimately, this will enable the child to make more appropriate decisions throughout life. After the third session, parents are ready to begin conducting weekly 30 minute special play times at home with their children. Each session, parents bring a videotape of their play session to class, and the filial leader provides supervision to parents, assisting in gaining insight into the child’s world. Due to the didactic and therapeutic nature of filial sessions, parents often learn as much about themselves through their child’s play and the discussions during filial sessions as they learn about their child (Landreth, 2002).

**Efficacy of filial therapy.** There have been a total of 33 studies involving over 900 subjects investigating the effectiveness of all filial therapy studies. Filial therapy has been utilized with a wide variety of populations, and its results are impressive (Bratton et al., 2005) as a viable form of psychotherapy for children. In a recent meta-analysis of play therapy outcome research, including 26 filial therapy studies, Bratton et al. calculated an effect size for the parent-only filial studies, revealing a strong treatment effect of 1.15. The parent-only studies were singled out because the majority of paraprofessional studies involved parents. Bratton and Landreth (2005) further analyzed these data to determine the treatment effect for studies that followed the Landreth 10-session model. In order to maintain treatment protocol the authors included only studies following the 10-session model and conducted by students whom either author had directly supervised. Results of this analysis indicated a large treatment effect (ES =
1.25) for the 10-session model. Clearly, these findings indicate the strength of filial therapy as an effective modality in treating children. There is an extensive body of research studying the effects of filial therapy with specific populations of children and parents. A review of these studies follows.

**Research Support for Child Parent Relationship Therapy-Parent Studies**

The following outcome studies utilized Landreth’s 10-session model to train parents to be the therapeutic avenue of change for their child. The parents participating in these studies attended a 2-hour filial therapy training session each week for 10 weeks and conducted 30-minute play sessions each week with their child after the third week of filial training unless otherwise indicated. In each of these studies the researchers utilized a pretest posttest control group design, unless otherwise specified. Statistical significance and significance are used interchangeably to describe the progress of the over 800 total subjects included in these studies in which the change in the subjects due to treatment was $p < .05$ or better.

Bratton and Landreth (1995) trained 43 single-parent families in a pretest posttest randomized control group design to determine the effectiveness of the Child-Parent-Relationship Therapy (CPRT) model. The single parents identified their young children, ages 3 to 7 years, as having behavioral problems. Trained raters directly observed the 22 parents in the experimental group, who were found to have demonstrated a statistically significant increase in empathetic interactions with their children when compared to the no-treatment control group. Statistically significant changes were reported by the experimental group of parents on all other measures, including increase in parental acceptance, decrease in stress related to parenting, and a decrease in their children’s behavioral problems.
Glazer-Waldman, Zimmerman, Landreth, and Norton (1992) conducted a treatment-group only pretest-posttest design with parents of children who were chronically ill. The researchers trained mothers \((n = 5)\) of children who are chronically ill between the ages of 4 and 8 years of age. Qualitative results indicated that parents believed the filial therapy experience positively impacted their relationship with their children. Quantitative results indicated that the parents were more accurately able to judge their children’s anxiety. Expanding this study, Tew, Landreth, Joiner, and Solt (2002) designed a pretest posttest control group study with 23 parents of children who were chronically ill. When compared to the no-treatment control group, the 12 parents who received the filial therapy training were found to have a statistically significant change on all measures, including a decrease in parenting stress, an increase in acceptance of their children, and a reduction in their children’s behavioral problems.

Parents whose children have specific presenting difficulties have also been researched using filial therapy as the modality of treatment. Kale and Landreth (1999) trained parents of elementary-aged children who had been diagnosed with a learning disability. The 22 parents participating were assigned to either the no-treatment control or the experimental group, based on scheduling and geographic location. Results indicated that the parents in the experimental group reported statistically significant increases in parental acceptance and statistically significant decreases in parenting stress. Parents of children diagnosed with pervasive developmental disorder were studied by Beckloff (1998). The 23 parents who participated in the study were randomly assigned to either the experimental group or the no-treatment control group. Statistically significant increases in parental acceptance in relation to their children’s need for autonomy and independence were reported by the experimental group. Improvements, however not statistically significant, were also made in the parent’s acceptance of their children. The
children also showed marked improvement in the areas of aggressive problems, externalizing problems, and depressive/anxiety symptoms.

N. Smith and Landreth (2003) utilized an intensive filial therapy treatment intervention with mothers who were residing in a domestic violence shelter with their children, who were believed to be witnesses of the domestic violence. The study was a pretest posttest comparison group design in which the treatment was extended to 12 sessions in a 2 to 3 week time period to accommodate the schedule of the shelter. The 11 mothers in the treatment group reported statistically significant reductions in the children’s (ages 4 to 10 years) behavior problems. The children reported a statistically significant increase in their self-concept as compared to the children in the no-treatment group. Parents’ play sessions were rated by trained raters, who found that the parents demonstrated statistically significant increases in parental acceptance and in their empathetic interactions with their children. The authors expanded their study to further examine this intensive treatment by comparing the findings to two earlier studies with matched populations and settings (Kot, Landreth, & Giordano, 1998; Tyndall-Lind, Landreth, & Giordano, 2001). The authors determined that when compared with a no-treatment comparison group, intensive filial therapy with parents was equally as effective as intensive individual play therapy or group play therapy with professional therapists.

Costas and Landreth (1999) trained non-offending parents of sexually abused children, ages 5 to 9 years, in filial therapy. The 26 parents were assigned to the experimental or control group based on their geographic location. When compared to the parents in the control group, parents participating in the filial therapy training group \( n = 14 \) demonstrated statistically significant improvements in their empathic interactions with their children. These parents also reported a significant decrease in parental stress and a significant increase in their acceptance of
their children. Researchers also reported improvement in the children’s behavior problems, anxiety, emotional adjustment, and self-concept. These gains were not significant, however, they demonstrate the implications of filial therapy with children of this population.

Training incarcerated parents in filial therapy has been researched by Landreth and Lobaugh (1998) and Harris and Landreth (1997). Landreth and Lobaugh (1998) randomly assigned 32 fathers of 4- to 9-year-olds who were in a medium-security federal prison to either the no-treatment control \( (n = 16) \) or the experimental group \( (n = 16) \). Fathers conducted weekly play sessions in the prison during the children’s scheduled weekly visit with their fathers. Results determined that the filial-trained fathers significantly increased their acceptance of their children and reported significant decreases in their children’s behavior problems as well as their own stress in relation to parenting when compared to the no-treatment control group. Children in the experimental group also showed a significant increase in self-esteem. Harris and Landreth (1997) studied 22 incarcerated mothers of children 3- to 10- years-old. Researchers adapted Landreth’s (2002) 10-session model to accommodate the average 5-week stay in the county jail of the mothers participating in the filial groups. The mothers assigned to the experimental group \( (n = 12) \) participated in 2-hour filial training sessions twice a week as well as conducted biweekly play sessions with their children, during visitation at the jail for 5 weeks. Results indicated that when compared with the no-treatment nonequivalent control group \( (n = 10) \), the 12 mothers in the experimental group increased their empathic interactions with their children and reported a significant enhancement in parental acceptance as well as a significant decrease in their children’s behavior problems.

Filial therapy with diverse populations using the Landreth 10-session model. Landreth’s 10-session filial therapy model has been utilized in studies with a diverse population of parents,
including Native American, Korean, Israeli, immigrant Chinese, and immigrant Korean parents living in the U.S. Glover and Landreth (2000) studied the effectiveness of filial therapy with Native American parents living on the Flathead Reservation participated in filial therapy. Eleven parents were assigned to the experimental group and 10 to the control group based on geographic location. Parents in the experimental group made significant gains in empathic interactions with their children, and the children whose parents were in the experimental group demonstrated significant increases in desirable play behaviors with their parents when compared to the children in the control group. The measures of parental acceptance, parental stress, and children’s self-concept did not show statistically significant changes; however, improvements were noted in each area. Researchers noted that a limitation of the study may be the compatibility of the Native American culture with the instruments utilized in the study.

In a study by Chau and Landreth (1997), volunteer Chinese parents currently residing in the United States were randomly assigned to a control or experimental group. This filial study investigated the effects of filial therapy on parental empathic interactions, parental acceptance of child, and parental stress. Results indicated that parents in the experimental group obtained a statistically significant change on all measures (Chau & Landreth, 1997). Replicating Chau and Landreth’s study, Yuen, Landreth, and Baggerly (2002) investigated the effects of 10 sessions of filial therapy training on immigrant Chinese parents in Canada, obtaining similar results. The 18 filial-trained parents demonstrated significant change over the control group on all measures. Specifically, the filial-trained parents in both studies demonstrated a significant increase in their level of empathic interactions with their children during parent-child play sessions, a significant increase in their attitude of acceptance toward their children, and a significant reduction in their level of stress related to parenting.
Immigrant Korean parents living in the United States participated in a study investigating the effectiveness of filial therapy with this population. Parents who volunteered for the study were randomly assigned to the experimental ($n = 18$) or control ($n = 18$) group. Results of this study included a statistically significant improvement of the parents’ perceived acceptance of their children and of the parents’ ability to communicate empathy to their children. Parents were also found to demonstrate an improvement in their ability to communicate acceptance, allow the child to lead, and be involved in the child’s play. In the area of parental stress, there was a statistically significant decrease in the parents’ reported overall stress in relation to parenting (M. Lee & Landreth, 2003).

Kidron (2003) investigated intensive filial therapy with 27 native Israeli families. Fourteen parents were assigned to the treatment group, receiving nine filial therapy training sessions and conducted seven filial play sessions in a 5-week period. When compared to the no-treatment control group, parents in the experimental group reported a significant decrease in their children’s externalizing behavior problems. Parental stress was also significantly reduced, along with a significant increase in the parents’ communication of empathy to their children.

_Filial therapy with non-parents as therapeutic agents._ Fifth-grade student mentors were trained utilizing the Landreth 10-session filial therapy model for use in mentoring at-risk kindergarten students. Baggerly and Landreth (2001) measured the change in the kindergarten students. Results were not statistically significant; however, slightly positive trends were found in self-concept, total behavior problems, externalizing behavior problems, delinquent behavior, and demandingness. Teacher reports and research observations indicated an increase in self-esteem, self-confidence, self-control, acceptance, and positive relationships, with a reported decrease in aggression and withdrawn behaviors. In a companion study, Robinson (2001) studied
the empathy level of the fifth graders and found a statistically significant increase in empathetic responses, acceptance, and a willingness to follow the kindergarten students’ lead.

Jones et al. (2002) divided high school students enrolled in a peer assistance and leadership (PALs) class into two groups; one group received training in the Landreth 10-session filial therapy model, and the other group received the traditional PALs curriculum training. To measure the behavioral adjustment of the pre-kindergarten and kindergarten children, a pretest-posttest control group model was utilized. Results indicated that parents of children in the experimental group reported a statistically significant reduction in their total behavior problems and internalizing behavior problems. A positive trend was also reported indicating a decrease of externalizing behavior problems, as reported by the parents. The teachers reported a marked reduction in behavior problems of the children in the experimental group. Direct observation was utilized to evaluate the high school students’ use of empathy during play sessions. A statistically significant increase in empathetic play behaviors and interactions, communication of acceptance, allowing self-direction in children, and attention to and participation in children’s play during play times was found (Jones et al., 2002).

Teachers as therapeutic agents. Andronico and B.G. Guerney (1969a) first recommended using teachers as therapeutic agents. Andronico and Guerney suggested this format in order to utilize the time of the school counselors and psychologists more effectively. This idea also falls directly in line with Andronico and Guerney’s theory of relying on the strength of the relationship in training significant people in children’s lives with more empathetic skills to impact children’s behavior. It takes weeks and sometimes months for therapists to establish a therapeutic relationship with a child; a teacher, however, already has this established relationship due to the extensive time spent with the child each day. Therefore, it makes sense to train
teachers to be effective therapeutic agents with the children in their classrooms (B.G. Guerney & Flumen, 1970). The goal in training teachers is for them to generalize the therapeutic skills into their normal interactions in the classroom, eventually impacting far more children than a therapist ever could (Andronico & B.G. Guerney, 1969b).

B.G. Guerney and Flumen (1970) trained 11 volunteer elementary school teachers in filial therapy theories and skills to conduct play times with one withdrawn student from their classroom. Students in the study \( (n = 15) \) were referred by the teachers due to a lack of interaction with other students and a general unfulfilling approach to school. Students were randomly assigned to the experimental \( (n = 9) \) or no-treatment control group \( (n = 6) \). Teachers participated in training sessions of 1½ hours each week for 20 weeks. After week 6 teachers began 45-minute play sessions with their student, for a total of 14 sessions. The authors provided supervision and additional training during this time as well. The children were observed in their classroom, and their behavior was coded. The authors reported that all nine of the children in the experimental group demonstrated a consistent pattern of increasing assertiveness during the experimental period, while the children in the control group demonstrated no improvement in assertiveness. Categories of assertiveness were observed, and while an increase in teacher student interactions occurred, the most consistent area of change was in student-to-student interactions. The authors suggested that these results indicate that eventually some change in the child’s self-image and self-confidence would also occur.

Brown (2003) provided filial therapy training utilizing the Landreth 10-session model to undergraduate students majoring in early childhood education. Convenience sampling was utilized to assign subjects to either the comparison \( (n = 20) \) or experimental group \( (n = 18) \). Results indicated that when compared to the comparison group, students in the experimental
group obtained statistically significant increases in empathetic behavior during play sessions with children. While not statistically significant, improvements in the students’ communication of acceptance, allowing the child self-direction, and involvement in the child’s play were observed by trained research professionals. Since these results were not self-reported, the results are considered noteworthy even though they lack statistical significance. The experimental group also made significant gains on a measure of play therapy attitudes, knowledge, and skills over the comparison group. In a similar study, Crane and Brown (2003) utilized convenience sampling to assign subjects to the experimental \((n = 10)\) and control \((n = 10)\) groups. Undergraduate human service majors were trained in filial therapy, with researchers finding consistent results. Trained raters found that, in contrast to the comparison group, the experimental group significantly improved their communication of empathy and acceptance and increased their play therapy knowledge and skills.

D. M. Smith and Landreth (2004) adapted the Landreth 10-session filial model to train teachers of deaf and hard of hearing students. When compared to the control group \((n = 12)\) teachers in the experimental group \((n = 12)\) significantly improved their ability to communicate empathy and acceptance, and allowing the child self-direction. Children in the experimental group also scored significantly lower on the total behavior problems subscale, internalizing behaviors, and withdrawn behaviors when compared to the control group. D. M Smith and Landreth (2004) concluded that because of the teachers’ increase in communication of empathy, students’ behavior problems significantly decreased.

Qualitative filial therapy research. Bavin-Hoffman, Jennings, and Landreth (1996) interviewed 20 families who participated in the Landreth 10-session filial therapy model. Parents’ answers to the interview questions fell into four different categories: improved family
functioning, improved parent-child communication, improved partner communication, and improved child behavior in the areas of aggression and self-control. These results are consistent with the ethnographic study conducted by Lahti (1992), who examined the filial therapy process to provide understanding of the effects on the parent, child, and parent-child relationship. Three parents and their three children (ages 7-9) who attended 10 weekly 2-hour filial therapy training sessions participated in the study. Parent changes included increases in confidence and feelings of personal power, awareness of adults and children’s needs, and a reduction in the degree of parental control and responsibility. Stronger parent/child and marital relationships were reported and characterized by improved communication, embracing more realistic expectations, and less friction. The changes in the children included improved communication, increased responsibility for actions, increased feelings of happiness, and decreased withdrawn and aggressive behaviors.

Solis, Myers, and Varjas (2004) utilized Landreth’s 10-session filial therapy model and included training elements from VanFleet’s (2000) filial therapy training handbook designed to evaluate the effectiveness of filial therapy with the African American population. Results of a qualitative case study with an African American mother and her 6-year-old son indicated the parent reported an increase in her awareness of her child’s thoughts and feelings. However, when asked if she observed an increase in empathy toward her child, she replied that she had not. Authors noted that awareness of her child’s thoughts and feelings was a foundational step in becoming more empathetic toward her child.

Kinder training. Kinder training was developed by White et al. (1997), White et al. (1999), and Draper et al. (2001) based on the Guerneys’ filial therapy model and the Adlerian concepts of encouragement and logical consequences integrated into the curriculum. Kinder training is a consultation model involving the school counselor and the teacher in collaboration
in working with the child. This model provides the teacher with a more central role in the intervention, empowering the teacher and releasing some responsibility from the school counselor. The goal of kinder training is to help the teacher and child enhance their relationship by making a connection on an emotional level. This new understanding of each other will change the relationship, the child’s behavior, and the teacher’s behavior inside and outside the classroom (White et al., 1997).

White et al. (1997) reported results of a case study of a 5-year old non-English-speaking girl who was struggling with issues of control and school anxiety. Through the kinder training intervention the teacher reported seeing the child in a different way and valuing her personality more. Because the child’s behavior changed, her perception of the teacher was also changed, resulting in an improvement in the teacher-child relationship. The child’s crying and tantrums in the classroom ceased, and the teacher clearly felt empowered and encouraged by this experience. Four months following the intervention the child continued to function in her classroom without further intervention by the school counselor.

A pilot study of kinder training was conducted by White et al. (1999). Six kindergarten teachers and 1 student from each class identified as having difficulty adjusting to school were involved in the study. The aim of kinder training was to offer teachers some specific skills and strategies that could be utilized in the classroom beyond the special play time. Classroom observations were conducted by researchers to track the teachers’ interactions with the student of focus. Observations were conducted before training and then again 6 weeks after training. Encouraging statements and goal-disclosure statements tripled in the 6-week follow-up. Logical consequences doubled, and ineffective verbal statements decreased by two thirds. The students of focus also improved. Results of the Social Skills Rating System indicated an increase in
appropriate social skills and a decrease in less appropriate social skills. All 6 children demonstrated a decrease in hyperactivity, aggression, depression, and inattention. The children also demonstrated an increase in more socially appropriate behaviors. Researchers also looked at the academic improvements of the 6 students and found that teachers reported students improved in math and language arts skills (White et al., 1999).

Kinder training has also been utilized to investigate the impact on students’ school adjustment (Draper et al., 2001). Kindergarten teachers and classroom aides and first-grade teachers ($n = 14$) and their selected students who exhibited discouraged behavior ($n = 14$) participated in this study. Despite the lack of control group, results indicate good preliminary support for the use of kinder training in the classroom as overall students demonstrated positive changes in the classroom. Although not statistically significant, positive changes were made in the students’ problem behaviors, social skills, openness to experience, and sense of belonging. Early literacy skills were also measured in this investigation, and 10 of the 13 students made improvements. Teachers also made changes. Observations of teacher behavior indicated an increase in the number and kinds of encouraging and effective verbal responses made by teachers to students.

Using a comparison group design to determine teachers’ effectiveness in generalizing play therapy skills into the early childhood classroom, Post et al. (2004) followed an adapted version of the Landreth (2002) 10-session filial therapy model. The 10-sessions of filial training were followed by 13 weeks of group training and supervision to generalize play therapy skills into the classroom. Teachers in the experimental group ($n = 9$) chose 2 children in their classroom who exhibited maladjusted behaviors; one child in each class was placed in the experimental group ($n = 9$) based on early return of the consent forms, and the other child was
placed in the no-treatment control group \((n = 9)\). Results indicated a statistically significant improvement in the children in the experimental group on internalizing problems, overall behavior, and adaptive skills. The effect sizes indicate that the filial interaction accounted for 18 to 20% of the variance in the dependent variables. Results of the parent-completed instruments indicated no statistically significant improvements. When compared to the teachers in the comparison group \((n = 8)\), teachers in the experimental group demonstrated a significant increase in their ability to communicate empathy in the classroom and in the playroom. Of particular interest in this study was the change in the teachers’ perceptions of the children, indicating their ability to see them differently and therefore respond in a more empathetic way, which led to the children’s improved behavior in the classroom.

Hess (2004) conducted a follow-up study 1 year after the training completed by Post et al. (2004) to determine whether the teachers who participated in the training continued to use the skills in the classroom. Teachers in the experimental group \((n = 9)\) were compared to a matched group of untrained teachers \((n = 7)\). Results indicated that 1 year after the initial training the experimental group of teachers’ use of play therapy skills or empathy in the classroom was not statistically significant when compared to the comparison group. However, results indicated a statistically significant difference between the two groups of teachers on the use of play therapy skills and empathetic responses in one-on-one play sessions and in the teachers’ attitudes about children and knowledge of play therapy skills. The teachers in the experimental group also reported that the training was useful, including an improvement in classroom management skills, a change in their perspective on the value of children’s opinions, and an increase in their confidence as teachers.
**Conscious Discipline®**

The Conscious Discipline® system (Loving Guidance, Inc., [www.consciousdiscipline.com](http://www.consciousdiscipline.com)) is a discipline program that attends to classroom management as well as the social-emotional development of young children. Bailey (2000) developed this classroom management program as a relationship-based community model attending to both the child and adult in the relationship. Bailey trains adults to be proactive rather than reactive in working with children while in conflict. When adults are proactive and able to remain in control of their own emotions they are able to use conflict as a teaching moment for the child. Bailey bases her philosophy of classroom discipline from child development and current brain research. Schools are viewed as school families where everyone, children and adults, learn the skills necessary to be successful in life: learning, forming relationships, communicating effectively, being sensitive to others’ needs, and getting along with others.

Conscious Discipline training occurs in a workshop format. Professionals can be trained at a Conscious Discipline workshop in a 7-day or 2-day format or receive training through staff development on their campus. This program allows for one professional to attend an official Conscious Discipline workshop and then take this knowledge and provide training to colleagues. An official certification as a Certified Conscious Discipline Instructor is available; however, it is not required for individuals who provide training for free ([www.beckybailey.com](http://www.beckybailey.com) 2/19/2006). This program also allows for adults to complete a self-study using Bailey’s Conscious Discipline book.

During the level 1 workshop, attendees are taught the seven basic skills of discipline and the seven powers of self-control and how to foster a School Family, which focuses on building character and social skills. The second level of training, Conscious Discipline Part 2, is a smaller
and more intimate training for 4 ½ days that focuses on further development and implementation of Conscious Discipline concepts. This training focuses on the personal growth and development of the attendees with the goal of incorporating Conscious Discipline into their daily lives.

Conscious Discipline focuses on training adults in relationship skills, which is believed to be more meaningful than a traditional compliance model of discipline. Conscious Discipline hopes to change the perspective of adults by encouraging them to focus on controlling and changing themselves. Education in basic brain development and then connecting this knowledge of brain development to learning and behavior is also a focus. The main principle of Conscious Discipline is to work to create safer, more caring, and more responsive environments for children (www.beckybailey.com 2/19/2006).

Teachers are taught skills for self-control allowing teachers to utilize their inner skills and become proactive rather than reactive during difficult moments in the classroom. Bailey (2000) considers self-control not to be the ability to be calm but rather the ability to be empathetic with others, to communicate feelings directly, and to resolve conflicts in constructive ways as well as being a contributing member of the school community. Bailey’s (2000) seven powers of self-control includes the following: the power of perception no one can make you mad without your permission; the power of unity understand that this is a community and everyone is in it together; the power of attention you get the most from what you focus on; the power of free will- the only person you can force to change is yourself; the power of love- look for the best in others; the power of acceptance- accept the moment as it is; and the power of intention- conflict is a teaching opportunity.

Teachers are also taught the seven basic skills of discipline that promote inner peace for children and encourage them to learn, cooperate, and help each other to be more successful. The
seven basic skills of discipline are composure, encouragement, assertiveness, choices, positive intent, empathy, and consequences. These skills are to be utilized by the adults and are therefore modeled for the children (Bailey, 2000).

Bailey’s (2000) Web site (www.beckybailey.com) reports results of completed studies that are encouraging. The research section of Bailey’s Web site reported that classrooms utilizing Conscious Discipline had improvements in children’s behavior including decreases in aggression, hyperactivity, and impulsivity. Impacts on school climate, staff collegiality, and organizational climate, and increases in teaching time were also reported as well as an increase in state test scores. Twelve students in grades K-6th who were referred by their teacher for behavior problems were given the Behavior Assessment Scale for Children as a pretest and posttest of their teachers, implementing Conscious Discipline in their classrooms. Results showed that 9 of the 12 students made improvements in the areas of hyperactivity, aggression, impulsivity, and externalizing problems. It is unclear whether the results reported are statistically significant, and with no reported control group it was difficult to assert that changes in the children are due to the implementation of Conscious Discipline. Bailey also reported that classrooms utilizing Conscious Discipline have fewer acts of aggression when compared to other classrooms at the same school; however, it is unclear if these groups are matched controls. Student scores on statewide achievement tests have also shown improvement after grade levels implemented Conscious Discipline into the classroom (www.beckybailey.com, 7/15/2005).

Improvements in school climate and staff working relationships were reported as a result of a survey given to staff before and after they implemented Conscious Discipline in the classroom. Staff reported an improvement in teacher-student relationships as well as an overall improvement in school climate. Staff was also surveyed regarding their commitment to the
workplace as well as satisfaction in their job; improvements were noted after the implementation of this program. Teachers also reported changes in student behavior such as bullying and cliques in the classroom (www.beckybailey.com, 7/15/2005).

Peer-reviewed published journal articles on Conscious Discipline are limited, and only one was found. Hoffman, Hutchinson, and Reiss (2005) completed a small study ($n = 12$) investigating the impact of Conscious Discipline on children’s behavior. Children ranging in ages from 5 to 19 and in Grades K to 6th were referred to the study by their teachers who considered these children to have behavior problems in the classroom. Twelve teachers participated in the study and completed the Behavioral Assessment Scale for Children- Teacher Rating Scale (BASC-TRS) on 1 child in their class before the Conscious Discipline training in October; pretesting-posttesting was completed at the end of training in April. Children in the control group ($n = 2$) were chosen based on the teachers’ indications that they use Conscious Discipline skills minimally in the classroom. The experimental group of children ($n = 10$) was chosen based on the teachers’ reports of using Conscious Discipline techniques in their classroom.

Results of this study are tentative; however, researchers reported that results of comparative $t$-tests indicate improvement of children in the experimental group on the Externalizing Problems subscale and Behavioral Symptoms Index. Although, not statistically significant these results indicate that further study should be completed on this subject (Hoffman et al., 2005).

Summary of Literature

Head Start is the largest early intervention program, in the United States; for at-risk,
disadvantaged students; however, problems with its lack of adequate attention to mental health continue. Children enrolled in Head Start frequently come from homes with a multitude of problems that can negatively impact the child’s emotional development and attachment to primary caregivers. Teachers in Head Start programs report feeling inadequate regarding how best to help students exhibiting significant emotional and behavioral problems. Often mental health consultants in Head Start programs do not have time to fully attend to all the children in need. A more collaborative approach that utilizes the strong connection between teacher and child to address the emotional needs of young children would help insure a more successful approach to meeting the needs of all students. Training teachers to more appropriately attend to the emotional needs of these students would empower teachers and have a reciprocal effect on both students and teachers by impacting the teacher-child relationship. Due to the significant caregiving role that teachers play in the lives of young children, teachers appear to be ideal candidates to be involved in meeting the mental health needs of their students. Both play therapy and filial therapy provide a developmentally appropriate modality for responding to the social-emotional and behavioral needs of young children. Results of the reviewed literature support the efficacy of filial therapy, and preliminary studies suggest that teachers are capable of learning play therapy skills to use with their students. Training and supervising teachers in basic child-centered play therapy skills through child teacher relationship training (CTRT) offers significant possibilities as an intervention to effectively address the emotional and behavioral needs of disadvantaged preschool children.

 Purpose of the Study

The purpose of this study was to determine the effectiveness of training and supervising
Head Start teachers and classroom aides in child teacher relationship training (CTRT) as a mental health intervention for disadvantaged pre-school children identified with behavioral problems. Specifically, this investigation was designed to determine the impact of teacher training and supervision in CTRT skills on the internalizing, externalizing, and total behavior problems of referred children when compared to the clinical behavioral problems of students whose teachers participated in the active control group.
CHAPTER 2
METHODS AND PROCEDURES

Using a repeated measures active control group design, this quasi-experimental study examined the effects of child teacher relationship training (CTRT) on disadvantaged preschool children enrolled in a Head Start program and identified with behavioral problems. CTRT is based on the principles and procedures of child parent relationship therapy (CPRT, Landreth & Bratton, 2006), a structured, time-limited filial therapy model first introduced by Landreth (1991/2002) based on the principles and procedures of child-centered play therapy (CCPT). Definition of terms, hypotheses, instrumentation, participant selection, details of treatment, data collection, and analysis of data are discussed in this chapter.

Definition of Terms

For the purpose of this study the following terms have been operationally defined as indicated below.

*Child parent relationship therapy (CPRT)*: Parents are taught basic child-centered play therapy (CCPT) principles and skills, including reflective listening, recognizing and responding to children’s feelings, therapeutic limit setting, building children’s self-esteem, and structuring required weekly play sessions with their children using a special kit of selected toys. Parents (teachers) learn how to create a nonjudgemental, understanding, and accepting environment that enhances the parent-child relationship, thus facilitating personal growth and change for both child and parent. CPRT has been successfully adapted for use with other significant adults in children’s lives, i.e. teachers and mentors (Landreth & Bratton, 2006, p.11).

*Child-centered play therapy (CCPT)*: Defined by Landreth (2002) as follows:
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.

Child teacher relationship training (CTRT): CTRT, the experimental treatment, was adapted from CPRT methodology following the protocol and training materials included in the Child Parent Relationship Therapy (CPRT) Treatment Manual (Bratton, Landreth, Kellan, & Blackard, 2006). Minor adaptations were made to accommodate the teacher/child relationship, the classroom situation, and school schedule. In this adapted model teachers were trained and supervised in child parent relationship therapy during two phases of training, CTRT Phase I followed immediately by CTRT Phase II: a) During CTRT Phase I teachers participated in the equivalent of 10 training/supervision sessions following the principles and procedures of CPRT, which included 7 weeks of one-on-one play sessions with a teacher-selected child of focus; and b) During CTRT Phase II teachers participated in 10 weeks of coaching/modeling in their classrooms to incorporate CPRT skills into the classroom situation, along with weekly training/supervision group sessions.

CTRT Phase I: This phase of training included 2 ½ days (approximately 14 hours) of intensive, didactic training in the principles and procedures of CPRT prior to the start of the school year, followed by weekly 1-hour supervision meetings for 7 weeks during which time teachers conducted one-on-one weekly, 30-minute play sessions with their child of focus. The weekly, videotaped 30-minute play sessions provided a controlled setting for the experimental teachers to practice their CTRT skills and receive supervision from the CTRT therapist. To insure successful learning and application of these new skills, teachers were instructed not to practice skills in the less controlled classroom situation, at this time.
CTRT phase II: This phase of training was 10 weeks in length and focused on helping teachers generalize into the classroom CTRT principles and skills covered in Phase I. Weekly supervision meetings during the teachers’ planning period continued throughout this phase of training. The CPRT skills of advanced limit setting and advanced choice giving, along with coaching teachers in the use of CTRT skills with more than one child, were an additional focus of supervision in CTRT Phase II. These skills were implemented in the classroom during CTR time (see definition below). The Child-Teacher Relationship Building Skills- Center Time Observation Form lists the classroom skills teachers were coached on during CTR time and is provided in Appendix B.

Child teacher relationship (CTR) time: This period of time refers to the time teachers implemented CTRT skills in the classroom during CTRT Phase II (10 weeks). CTR time was scheduled during each teacher’s regularly scheduled, daily center time. Head Start classrooms are divided into “centers” including manipulatives, arts and crafts, blocks and building, dramatic play, home center, etc. Center time is traditionally a time of “free play” for children, not a time for formal teaching; therefore, asking the teachers to implement CTRT skills during this time did not take away from the curriculum. A research assistant and I provided in-class coaching 3 times a week for approximately 30 minutes each for a total of 90 minutes of in-class training per week. Training time was divided equally between the teacher and aide in each classroom. CTR time was structured for one teaching partner (teacher or teacher aide) to use CTRT skills to enhance the teacher-child relationship for 15 minutes, while the other teaching partner focused on general classroom management. During the next 15 minutes teaching partners switched roles, thus each teaching partner received approximately 15 minutes of coaching, modeling, and practice 3 times per week.
Child of focus: A child chosen by the teacher with whom to conduct weekly, one-on-one special play times in order to practice CTRT skills. Teachers chose a child whom they perceived as having significant emotional or behavioral problems. All children of focus met the stated criteria to be included in the study.

Non-child of focus: Children who met the stated criteria for inclusion in the study, but were not selected as a child of focus.

At-risk: Children who scored in the borderline or clinical range in at least one scale or subscale of the Child Behavior Checklist- Caregiver-Teacher Report Form (C-TRF). Students who qualify for the Head Start program and live in families with many of the following characteristics: (a) transient living situations, often with frequent changes in caregivers or physical dwellings; (b) low economic status; (c) substance abuse; (d) neighborhood violence; (e) family mental health problems; (f) neglect; (g) abuse; and (h) insecure attachment to caregiver. These characteristics put children at a greater potential to be at-risk for achieving academic and social-emotional successful (Thompson & Happoid, 2001; Yoshikawa & Knitzer, 1997).

Disadvantaged: A student who is classified as economically disadvantaged and meets the qualifications for Head Start, because family income is at or below the poverty line. These students may also have parents who are illiterate or family situations that do not include sufficient opportunities for early educational experiences, thus these children may be educationally disadvantaged as well.

Head Start program: According to the Head Start Act (1981), Head Start is a federally funded early childhood program for children ages 3 to 5 years of age who come from low-income families at or below the poverty line. This program is designed to provide health, education, social services, and parent-community involvement for the children and their families.
*Head Start classroom aides:* Educators hired to assist certified teachers in classroom instruction in Head Start programs.

*Head Start classroom teachers:* Educators who are degreed and certified by the Texas Education Agency in Early Childhood Education.

*Teaching partner:* This phrase refers to either the classroom teacher or aide in a single Head Start classroom.

*Externalizing behavior problems:* Behaviors which are outward manifestations of an inner conflict, such behaviors include attention problems and aggressive behaviors. For the purposes of this study, externalizing problems was operationally defined as the score on the Externalizing Problems Scale on the Child Behavior Checklist/Caregiver-Teacher Report Form (C-TRF) (Achenbach & Rescorla, 2000).

*Internalizing behavior problems:* Behaviors that are internally expressed and are an attempt at coping with internal difficulties, such behaviors include expressions of high anxiety or depression. Many children have difficulty expressing themselves outwardly, causing them to pull away from others and experience difficulties internally. Subscales that are included in this composite score include Emotionally Reactive, Anxious/Depressed, Somatic Complaints, and Withdrawn. For the purposes of this study, internalizing problems was operationally defined as the score on the Internalizing Problems Scale on the Child Behavior Checklist/Caregiver-Teacher Report Form (C-TRF) (Achenbach & Rescorla, 2000).

*Total behavior problems:* Is the sum of scores on all the problem items on the Child Behavior Checklist/Caregiver-Teacher Report Form (C-TRF). For the purposes of this study, total problems was operationally defined as the score on the Total Problems Scale on the Child Behavior Checklist/Caregiver-Teacher Report Form (C-TRF) (Achenbach & Rescorla, 2000).
Research Hypotheses

The following research hypotheses were formulated in order to complete this study.

1. Children in the experimental treatment group will demonstrate a significant decrease in Externalizing Problems, when compared to children in the active control group over time.

2. Children in the experimental treatment group will demonstrate a significant decrease in Internalizing Problems, when compared to children in the active control group over time.

3. Children in the experimental treatment group will demonstrate a significant decrease in Total Problems, when compared to children in the active control group over time.

4. Children of focus in the experimental treatment group will demonstrate a significant decrease in Externalizing Problems, when compared to children of focus in the active control group over time.

5. Children of focus in the experimental treatment group will demonstrate a significant decrease in Internalizing Problems, when compared to children of focus in the active control group over time.

6. Children of focus in the experimental treatment group will demonstrate a significant decrease in Total Behavior Problems, when compared to children of focus in the active control group over time.

7. Non-children of focus in the experimental treatment group will demonstrate a significant decrease in Externalizing Problems, when compared to non-children of focus in the active control group over time.

8. Non-children of focus in the experimental treatment group will demonstrate a significant decrease in internalizing problems, when compared to non-children of focus in the active control group over time.

9. Non-children of focus in the experimental treatment group will demonstrate a significant decrease in Total Behavior Problems, when compared to non-children of focus in the active control group over time.

Instrumentation

The Child Behavior Checklist (CBCL) has a Caregiver-Teacher Report Form (C-TRF) that is designed for the caregiver or teacher of a child ranging in age from 1½ to 5 years old. The C-TRF has 99 specific problem items that respondents’ rate on a scale of 0-2 indicating; not true (0), sometimes true (1), or very true (2). An open-ended item is also included to list other
problems observed by caregivers. The entire assessment takes approximately 15 minutes to complete. Classroom teachers completed the C-TRF on each student in their class participating in the study. There are eight syndrome scales, six DSM-oriented scales and, composite scales on the C-TRF, the Internalizing Problems Scale, the Externalizing Problems Scales as well as the Total Problems Scale, a composite score of the Internalizing and Externalizing Scales were utilized in this study. A reduction in scores indicates improvement in the targeted behavior (Achenbach & Rescorla, 2000).

The C-TRF was normed on a sample of children living in the northeast section of the United States and some children from The Netherlands. Researchers utilized children referred for clinical services and well adjusted children attending preschool who were participating in a long-term national study. The mean score of the test-retest reliability for the C-TRF is strong ($r = .81$). The test-retest reliability for each scale of the C-TRF are as follows: Emotionally Reactive ($r = .72$), Anxious/Depressed ($r = .68$), Somatic Complaints ($r = .91$), Withdrawn ($r = .77$), Attention Problems ($r = .84$), Aggressive Behavior ($r = .89$), Internalizing Problems, ($r = .77$), Externalizing Problems ($r = .89$), and Total Problems ($r = .88$). The test-retest of the DSM-oriented scales is as follows: Affective Problems ($r = .76$), Anxiety Problems ($r = .57$), Pervasive Developmental Problems ($r = .83$), Attention Deficit/Hyperactivity Problems ($r = .79$) and Oppositional defiant Problems ($r = .87$). The content validity of the problem scales was strong, as was supported by the research which determined that almost all items discriminated between referred and nonreferred children. The criterion-related validity of the problem scales was also supported by the differentiation between referred and non-referred children (Achenbach & Rescorla, 2000).

The Internalizing Problems scales are comprised of the following syndrome scales with,
Emotionally Reactive, Anxious/Depressed, Somatic Complaints, and Withdrawn. The Internalizing Problem Scales reflects upon the child’s problems with the self, while the Externalizing Problem Scales represents the child’s conflict with others and others’ expectations of the child’s behavior. The Externalizing Problems scales include Attention Problems and Aggressive Behavior subscales. Due to the strong research base of the C-TRF, this instrument can be used with a variety of populations and therefore adds strength and credibility to this study (Achenbach & Rescorla, 2000).

The C-TRF is frequently utilized in research to evaluate the effects of interventions as it can be administered before, during, and after treatment during an experimental study. Rescorla (2005) supports the use of the C-TRF indicating that this is a strong instrument, normed on a diverse population. The C-TRF has been used in similar play therapy studies to measure the effect of treatment on children’s behavior (Jones, Rhine, & Bratton, 2002; D.M. Smith & Landreth, 2004).

Participant Selection

I approached the principal/director of a Head Start center in the Southwest region of the United States. I discussed with the principal the possible benefits of improving the child-teacher relationship and how this could affect the behavior of the children in the classroom. The principal and all teachers/classroom aides of the Head Start center agreed to participate in the project. Human Subjects Approval from the University of North Texas Internal Review Board (see Appendix A) was obtained before potential child subjects were contacted. I maintained confidentiality of data by coding all instruments in order to protect subjects’ identity and privacy.
Research responsibilities discussed in the American Counseling Association Code of Ethics (1995), section G, were followed, including informed consent and reporting results.

Teacher Subjects

All Head Start classroom teachers \((n = 12)\) and their aides \((n = 12)\) consented to participate in the study \((N = 24)\). Initially, teacher/aide pairs were to be randomly drawn and assigned to either the experimental or active control group. A few weeks prior to group assignment, it came to my attention that three of the participating teachers were required to attend new teacher inservice, thus would be unable to attend the 2 ½ -day intensive CTRT training which was scheduled by necessity during that same time. This situation was out of my control and created a forced assignment of these 3 teachers to the active control group, resulting in a quasi-experimental research design. Of the new teachers, 2 had been working as classroom aides at the school (so were not new to the school), but had recently received teacher certification, thus were considered a “new teacher.” The remaining teachers were randomly drawn to participate in the experimental or active control group. The imbalance of Hispanic children and teachers in the experimental and active control group (see Tables 2 and 3) is due to the fact that the school housed five Bilingual classrooms. Two Bilingual classrooms were involved in forced assignment to the active control group, as the teachers were new to the district, while the remaining three were randomly assigned to the experimental or active control group. Table 1 addresses the amount of teaching experience and education of the participating teachers and classroom aides. Information in Tables 1 and 2 was obtained from a demographic information sheet completed by each teacher.
Table 1
*Education and Certification for Teachers and Aides in the Experimental and Active Control Group*

<table>
<thead>
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<th>Experimental group</th>
<th>Active control group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Teachers</td>
<td>Aides</td>
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<td>Average years teaching in Head Start</td>
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<td>Bilingual Generalist</td>
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</tr>
<tr>
<td>EC-4 Child Development Associate</td>
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<td>4</td>
</tr>
</tbody>
</table>

Table 2 presents the demographic information regarding the teachers and classroom aides in the experimental and active control group.

Table 2
*Demographic Information for Teachers and Classroom Aides in the Experimental and Active Control Group*

<table>
<thead>
<tr>
<th></th>
<th>Experimental group</th>
<th>Active control group</th>
</tr>
</thead>
<tbody>
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<td></td>
<td>Teachers</td>
<td>Aides</td>
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</tr>
</tbody>
</table>
Child Subjects

All children enrolled at the participating Head Start program whose parents provided consent \((n = 159)\) were eligible to participate in the study. Children were selected to participate based on their teachers’ ratings on the C-TRF. Children who scored in the borderline or clinical range on at least one syndrome scale on the C-TRF were selected to participate in the study \((n = 54)\). No subjects were eliminated based on ethnicity or disability. Children’s treatment group assignment was based on their teachers’ assignment to the experimental or active control group.

Table 3 presents the demographic information for children who qualified for the study. As illustrated, the balance of ethnicity, age, and gender is relatively equal between the experimental and control groups. Interestingly, the number of qualifying males and females were more balanced than expected based on current literature in the field of child psychotherapy research that indicated that twice as many males as females were referred for mental health services (Bratton et. al, 2005). The ethnic breakdown for the children who qualified for the study is comparable to the population of children in the participating Head Start program, with 57.5\% \((n = 104)\) Hispanic, 25.4\% \((n = 46)\), Black American, and 16.6\% \((n = 30)\) Caucasian. It is also important to note that all children who qualify for Head Start and thus were involved in this study are considered economically disadvantaged. In order to qualify for the Head Start program parents must provide proof that their family income is at or below the poverty line (Head Start Act, 1981).

For the purpose of the training requirements of this study, child participants were further divided into “children of focus” and “non-children of focus.” Refer to definition of terms and experimental group treatment section in this chapter for further explanation.
Table 3

Demographics Information for Children in the Experimental and Active Control Group

<table>
<thead>
<tr>
<th></th>
<th>Experimental Group</th>
<th>Active Control Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n = 27</td>
<td>n = 27</td>
</tr>
<tr>
<td>Gender</td>
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<tr>
<td>Male</td>
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</tr>
<tr>
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<td>12</td>
<td>10</td>
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<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.0-3.5 years</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>3.6-3.11 years</td>
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<td>6</td>
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<tr>
<td>4.0-4.5 years</td>
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<td>8</td>
</tr>
<tr>
<td>4.6-4.11 years</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>Ethnicity</td>
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<tr>
<td>Hispanic</td>
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<td>18</td>
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<tr>
<td>Black American</td>
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<td>7</td>
</tr>
<tr>
<td>Caucasian</td>
<td>5</td>
<td>2</td>
</tr>
</tbody>
</table>

Note: The experimental group= 2 bilingual classrooms, active control group=3 bilingual classrooms this explains the uneven number of Hispanic children in the active control group.

Treatment

Experimental Group Treatment

The 6 teachers and 6 aides in the experimental group (n = 12) participated in training, supervision, and coaching in child teacher relationship training (CTRT) to learn more effective methods of responding to the emotional and behavioral needs of children. Child teacher relationship training (CTRT) is based on child parent relationship therapy (CPRT) (Landreth & Bratton, 2006), originally proposed by Landreth (1991/2002). The Child Parent Relationship Therapy (CPRT) Treatment Manual (Bratton et al., 2006) was utilized in this study; minor adaptations were made to the structure and curriculum to accommodate the child/teacher relationship, classroom setting, school schedule, and teacher in-service training. 2 ½ days of intensive training (approximately 14 hours) and 1 hour weekly supervision meetings were the format adaptations that were made based on the needs of the school setting. Weekly small group
(n = 6) supervision meetings during the teachers’ 1 hour planning period was consistent throughout both phases of treatment. In this adapted model teachers were trained and supervised in child parent relationship therapy during 2 phases of training, CTRT Phase I followed immediately by CTRT Phase II: a) During CTRT Phase I teachers participated in the equivalent of 10 training/supervision sessions following the principles and procedures of CPRT, which included 7 weeks of one-on-one play sessions with a teacher-selected child of focus; and b) During CTRT Phase II teachers participated in 10 weeks of coaching/modeling in their classrooms to incorporate CPRT skills into the classroom situation, along with weekly training/supervision group sessions. Providing teachers with this structure allowed the teachers to experience success and become comfortable with the skills before they attempted the new skills in the classroom.

CTRT Phase I included intensive skills training and play sessions and supervision. The adapted CPRT Treatment Manual was utilized during this phase to teach specific CPRT skills. The intensive training included: 2 ½ days (approximately 14 hours) of intensive, didactic training in the principles and procedures of CPRT prior to the start of the school year, followed by weekly 1-hour supervision meetings for 7 weeks during which time teachers conducted one-on-one weekly, 30-minute play sessions with their child of focus. The 2 ½ days of intensive training included didactic material equivalent to session 1 to 4 in the CPRT manual (Bratton et al., 2006). Principles and skills including reflective listening, recognizing and responding to children’s feelings, therapeutic limit setting, building children’s self-esteem, and structuring required weekly play sessions with their child of focus are the focus of the CPRT curriculum (Bratton et al., 2006). Teachers’ role played skills and practiced with preschool children who attend the university Lab preschool. During the 1-hour weekly supervision meetings didactic instruction of
the adapted CPRT curriculum (Bratton et al., 2006) continued as well as supervision of the teachers’ videotaped play sessions with their child of focus. Supervision of play sessions focused on the teachers’ ability to implement the therapeutic skills. The weekly, videotaped 30-minute play sessions provided a controlled setting for the experimental teachers to practice their CTRT skills and receive supervision from the CTRT therapist. To insure successful learning and application of these new skills, teachers were instructed not to practice skills in the less controlled classroom situation, at this time which is consistent with the CPRT model (Landreth & Bratton, 2006).

In CTRT Phase II (10-weeks) I began coaching and modeling the CTRT skills in the classroom. Supervision during this phase focused on generalizing CPRT principles and skills (Bratton et al., 2006) presented in Phase I into the classroom. Didactic instruction and role playing in more advanced skills to be used with more than one child was an additional focus of supervision in CTRT Phase II. I modeled these skills in the classroom at this time. The CPRT skills of advanced limit setting and advanced choice giving were also adapted for use in the classroom. The Child-Teacher Relationship Building Skills- Center Time Observation Form lists the classroom skills teachers were coached on during CTR time and is provided in Appendix B. The in-class coaching occurred 3 times a week for 30 minutes each for a total of 90 minutes of in-class training time each week per teaching team. Hour long weekly supervision continued during the 10 weeks of this treatment phase.

Head Start classrooms have a daily center time which became child teacher relationship (CTR) time, for implementing CTRT skills in the classroom. Center time is traditionally a time of “free play” for children, therefore, asking teachers to implement CTRT skills during this time did not take away from the curriculum. This model enabled one teaching partner to focus on
using CTRT skills with a small group of children for 15 minutes while the other teaching partner focused on general classroom management. Teaching partners were encouraged to spend time focusing on different children so that each child in the class received some individual relationship time with one of the teaching partners each week. Teachers were encouraged to keep a weekly checklist of children who participated in CTR time, to ensure equal attention of children. The research assistant and I provided in-class coaching 3 times a week for approximately 30 minutes each for a total of 90 minutes of in-class training per week. Coaching time was equally divided between teaching partners. Coaching in the classroom involved one researcher to sit with the teacher and the small group of students at a center and model for the teacher how to use the CTRT skills in the classroom. During the first few weeks of CTRT Phase II, modeling was more involved, providing an example for teachers. As time continued and teachers became more comfortable and proficient in using the skills the intensity of the modeling decreased as teachers used skills independently. Incorporating CTR time into their regular schedule was a goal for the school administrators, therefore, all children participated in CTR time with the teacher/aide, however data was only collected on children whose parents consented and who qualified for the study.

All training, supervision, and coaching was provided by advanced doctoral counseling students who have extensive experience in play therapy and CPRT. The two doctoral students providing training and supervision have had five advanced doctoral level courses and supervision in play therapy. The primary researcher was a Licensed Professional Counselor, Nationally Certified Counselor, Certified School Counselor, and Registered Play Therapist. The primary researcher also met weekly with Sue Bratton, PhD, LPC, RPT-S, coauthor of *Child Parent Relationship Therapy (CPRT)* (Landreth & Bratton, 2006) to consult on treatment integrity and
curriculum adaptation. A Spanish-speaking advanced doctoral student who also has extensive training in play therapy and CPRT assisted in supervising the bilingual teachers during one-on-one play sessions and generalizing skills into the classroom.

Curriculum utilized during training was *Child Parent Relationship Therapy (CPRT) Treatment Manual* (Bratton et al., 2006), adapted slightly for use with teachers in a classroom setting. The primary investigator was given a pre-publication copy by the lead author for the purposes of this study. Teacher participants were videotaped during practice sessions with children as well as during all one-on-one play sessions with their child of focus to insure adherence to treatment protocol as well as to provide supervision to participants.

**Active Control Group Treatment**

Teachers participating in the active control group (*n* = 12) received training in Conscious Discipline® program (Loving Guidance, Inc., [www.consciousdiscipline.com](http://www.consciousdiscipline.com)). This training was presented by the school’s educational specialist, a Conscious Discipline trainer who has met all qualifications required by Conscious Discipline to provide Conscious Discipline training to others. The educational specialist had a master’s degree in Early Childhood Education and provides all teacher training and support for this Head Start center. Teachers met for training for 1 day prior to school’s starting and then met periodically throughout the study to receive further training and support in implementing Conscious Discipline into their classrooms. Conscious Discipline training includes Conscious Discipline DVDs, readings from *Conscious Discipline: 7 Basic Skills for Brain Smart Classroom Management* (Bailey, 2000), and discussions. This training schedule is typical of what is traditionally received in Conscious Discipline (Bailey, 2000).
Data Collection

After IRB approval was obtained, subjects were recruited during school registration and home visits were made as necessary to obtain informed consent for child subjects (see Appendix A). Due to the high population of Spanish-speaking parents, Spanish-speaking research assistants and translated consent forms (see Appendix A) were utilized as necessary. The C-TRF was completed by teachers for pretesting at the beginning of the school year, and children who scored in the borderline or clinical range in at least one syndrome scale were selected to participate in the study. To insure integrity of data collection, researchers provided substitutes in each classroom, while teachers completed the C-TRF in a room free from distraction. Either myself or my research assistants were present during all data collection to answer any questions and insure consistency in data collection. The C-TRF was collected for midpoint testing at the conclusion of CTRT Phase I. Posttesting occurred at the conclusion of CTRT Phase II.

Analysis of Data

Results obtained from the pretest, midpoint test and posttest of the C-TRF of children who qualified to participate in the study were analyzed in order to examine the effects of the experimental treatment on students’ behavior compared to the active control treatment. To ensure accuracy, both pretest, midpoint testing, and posttest data were scored using computer software scoring for the C-TRF, which requires all data to be entered twice.

SPSS was utilized to analyze data, using a two-factor (treatment group x time) repeated measures multivariate analysis for each dependent variable to determine whether the child teacher relationship training (CTRT) group and the active control group performed differently across time (3 points of measure). Dependent variables included the C-TRF ratings from the
Externalizing, Internalizing, and Total Problem Scales. A reduction in scores on the C-TRF indicated improvement in the targeted behavior. For the analysis of each dependent variable, the C-TRF ratings for the pretest, midpoint-test, and posttest all served as dependent variables in the multivariate test. Wilks’s lambda was utilized to interpret the results. The alpha .05 level of statistical significance was established as the criterion for either accepting or rejecting the hypothesis. Effect sizes were calculated in order to assess the magnitude of the difference between the two groups. Effect sizes were calculated using $\eta^2$ to determine practical significance.
CHAPTER 3
RESULTS AND DISCUSSION

This chapter presents the results, discussion, and limitations of this study, as well as implications for practice and research. The results of the analyses of data are presented in the order of which hypotheses were tested. Post hoc analyses were performed to further analyze findings. The investigator sought consultation through a qualified statistician to ensure the validity and appropriateness of all statistical analyses.

Results

A two-factor (treatment group x time) repeated measures multivariate analysis was computed for each dependent variable to determine whether the child teacher relationship training (CTRT) group and the active control group performed differently across time (3 points of measure). The Caregiver-Teacher Report Form (C-TRF) (Achenbach & Rescorla, 2000) was administered prior to treatment, at the end of CTRT Phase I (pre- to midtest), and at the end of CTRT Phase II (mid- to posttest). Dependent variables included the C-TRF ratings from the Externalizing, Internalizing, and Total Problem Scales. A reduction in scores on the C-TRF indicated improvement in the targeted behavior. For the analysis of each dependent variable, the C-TRF ratings for the pretest, midpoint-test, and posttest served as dependent variables in the multivariate test. Wilks’s lambda was utilized to interpret the results. The alpha .05 level of statistical significance was established as the criterion for either accepting or rejecting the hypothesis. The alpha .10 level was established as a threshold to note positive trends, indicating an improvement in the target behavior for the experimental treatment group when compared to the active control group. Dependent variables were analyzed to screen data for normality,
homogeneity of variance/covariance matrices, and sphericity. All assumptions for a repeated
measures multivariate analysis were met unless otherwise indicated.

Additionally, effect sizes were calculated to explain the practical significance of the
results. For the purpose of this study, partial $\eta^2$ was calculated to assess the magnitude of the
treatment effect. Cohen (1988) defined $\eta^2$ effect sizes as small (0.01 - 0.05), medium (0.06 -
0.13) and large (0.14 - 1.00).

Results for Hypotheses 1 to 3

Table 4 presents the pre-, mid- and posttest means and standard deviations for the
experimental and control group on the Externalizing, Internalizing, and Total Problems Scales of
the C-TRF.

Table 4

<table>
<thead>
<tr>
<th></th>
<th>Experimental group $n = 27$</th>
<th>Active control group $n = 27$</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest  Midpoint  Posttest</td>
<td>Pretest  Midpoint  Posttest</td>
</tr>
<tr>
<td>Externalizing</td>
<td>Mean 62.04  58.89  52.70</td>
<td>Mean 56.04  55.48  53.81</td>
</tr>
<tr>
<td>Problem</td>
<td>SD 11.49  13.60  9.75</td>
<td>SD 9.17  10.08  8.65</td>
</tr>
<tr>
<td>Internalizing</td>
<td>Mean 59.30  56.56  51.70</td>
<td>Mean 54.78  56.67  51.81</td>
</tr>
<tr>
<td>Problems</td>
<td>SD 11.01  10.87  7.44</td>
<td>SD 7.71  8.26  10.47</td>
</tr>
<tr>
<td>Total Behavior</td>
<td>Mean 61.70  58.56  52.33</td>
<td>Mean 56.85  57.15  54.26</td>
</tr>
<tr>
<td>Problems</td>
<td>SD 9.67  12.03  9.03</td>
<td>SD 6.79  7.39  7.49</td>
</tr>
</tbody>
</table>

Note. A decrease in mean scores indicates an improvement in behavior.

Hypothesis 1

Children in the experimental treatment group will demonstrate a significant decrease in
Externalizing Problems, when compared to children in the active control group over time. Table
4 presents the means and standard deviations for the experimental and active control group on
the dependent variable at pre-, mid-, and posttest.
Results of the multivariate analysis of the dependent variable, Externalizing Problems, revealed a statistically significant interaction effect of time (pre-, mid-, posttest) x group membership (experimental/active control), Wilks’s lambda = 0.80, \( F(2, 51) = 6.53, p = .003 \). These results indicate that the children in the CTRT group demonstrated a statistically significant decrease in Externalizing Problems from pre- to mid- to posttreatment, when compared to the active control group. On the basis of these results Hypothesis 1 is retained. Partial \( \eta^2 \) was calculated to determine the magnitude of the treatment effect. Results indicate that the CTRT intervention had a large treatment effect (\( \eta^2 = 0.20 \)) on children’s externalizing behavior problems, when compared to children whose teachers participated in the active control group.

Figure 1 graphically displays the interaction effect of mean group differences for externalizing behavior problems over time.

*Figure 1. Estimated marginal means of Externalizing Problems for total group.*

**Hypothesis 2**

Children in the experimental treatment group will demonstrate a significant decrease in Internalizing Problems, when compared to children in the active control group over time. Table 4
presents the means and standard deviations for the experimental and active control group on the dependent variable at pre-, mid-, and posttest.

Results of the multivariate analysis of the dependent variable, Internalizing Problems, did not reveal a statistically significant interaction effect of time (pre-, mid-, posttest) x group membership (experimental/active control); Wilks’s lambda = 0.90, $F(2, 51) = 2.997, p = .06$. These results indicate that the children in the CTRT group did not demonstrate a statistically significant decrease in Internalizing Problems from pre- to mid- to posttest treatment when compared to the active control group. On the basis of these results, Hypothesis 2 is rejected. However, the results showed a positive trend ($p < .10$), indicating a decrease in the CTRT children’s Internalizing Problems when compared to the active control group. Partial $\eta^2$ was calculated to determine the magnitude of the treatment effect. Results indicate that the CTRT intervention had a moderate treatment effect ($\eta^2 = 0.11$) on children’s internalizing behavior problems when compared to children whose teachers participated in the active control group.

Figure 2 graphically displays the interaction effect of mean group differences for internalizing behavior problems over time.

Figure 2. Estimated marginal means of Internalizing Problems for total group.
Hypothesis 3

Children in the experimental treatment group will demonstrate a significant decrease in Total Problems, when compared to children in the active control group over time. Table 4 presents the means and standard deviations for the experimental and active control group on the dependent variable at pre-, mid-, and posttest.

Results of the multivariate analysis of the dependent variable, Total Problems, revealed a statistically significant interaction effect of time (pre-, mid-, posttest) x group membership (experimental/active control); Wilks’s lambda = 0.83, $F(2, 51) = 5.08$, $p = .01$. These results indicate that the children in the CTRT group demonstrated a statistically significant decrease in Total Problems from pre- to mid- to post- treatment when compared to the active control group. On the basis of these results, Hypothesis 3 is retained. Partial $\eta^2$ was calculated to determine the magnitude of the treatment effect. Results indicate that the CTRT intervention had a large treatment effect ($\eta^2 = 0.17$) on children’s total behavior problems when compared to children whose teachers participated in the active control group.

Figure 3 graphically displays the interaction effect of mean group differences for total behavior problems over time.

![Figure 3. Estimated marginal means of Total Problems for total group.](Image)
Post Hoc Analysis for Hypotheses 1 to 3

Further inspection of the graphs depicted in Figures 1 to 3 revealed what appeared to be differences in the rate of change between the experimental and active control group mean scores after CTRT Phase I (pretest to midtest) and after CTRT Phase II (midtest to posttest). Because the CTRT group training protocol was divided into two phases that corresponded to the data collection points, theoretically it made sense to further examine the differences detected in the graphical displays. Therefore, post hoc analysis on the interaction effects (time x group) was conducted to statistically analyze the effects of treatment for CTRT Phase I (pre to mid) and CTRT Phase II (mid to post) on each of the dependent variables when compared to the active control group.

Post hoc analysis for Externalizing Problems, Hypothesis 1. Table 4 presents the pretest and midtest means and standard deviations for the experimental and active control groups’ ratings on the Externalizing Problems Scale. Results of the multivariate analysis of the dependent variable revealed that the interaction was not statistically significant (time x group) from pre- to midtesting (after completion of CTRT Phase I); Wilks’s lambda = 0.96, $F(1, 52) = 1.99$, $p = .16$. These results indicate that the children in the CTRT group did not demonstrate a statistically significant decrease in Externalizing Problems from pre- to midtesting, when compared to the control group. The practical significance of the effects of the CTRT treatment from pre- to midtesting was small ($\eta^2 = 0.04$).

Table 4 presents the midtest and posttest means and standard deviations for the experimental and active control groups’ ratings on the Externalizing Problems Scale. In looking at the interaction effect of time at the completion of Phase II of treatment (midtest to posttest) x group membership (experimental/active control); Wilks’s lambda = 0.91, $F(1, 52) = 0.00$, $p = .03$. 

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Results revealed a statistically significant interaction effect, indicating that the children in the CTRT group demonstrated a statistically significant decrease in Externalizing Problems from mid- to posttreatment when compared to the active control group. Partial $\eta^2$ was calculated to determine the magnitude of the treatment effect. Results indicate that the CTRT intervention had a medium effect ($\eta^2 = 0.09$) on children’s externalizing behavior problems when compared to children whose teachers participated in the active control group. These results indicate that the greater change occurred during CTRT Phase II, which is when the teachers were being coached in using the skills in the classroom.

*Post hoc of Internalizing Problems, Hypothesis 2.* Table 4 presents the pretest and midtest means and standard deviations for the experimental and active control groups’ ratings on the Internalizing Problems Scale. Results of the multivariate analysis of the dependent variable revealed a statistically significant interaction effect of time (pre- to midtesting) at the conclusion of CTRT Phase I x group membership (experimental/active control); Wilks’s lambda = 0.91, $F(1, 52) = 5.28, p = .03$. These results indicated that the children in the CTRT group demonstrated a statistically significant decrease in Internalizing Problems from pre- to midtesting when compared to the active control group. Partial $\eta^2$ was calculated to determine the magnitude of the treatment effect. Results indicate that the CTRT intervention had a moderate treatment effect ($\eta^2 = .09$) on children’s internalizing behavior problems when compared to children whose teachers participated in the active control group.

Table 4 presents the midtest and posttest means and standard deviations for the experimental and active control groups’ ratings on the Internalizing Problems Scale. In looking at the interaction effect of time at the completion of CTRT Phase II of treatment (midtest to posttest) x group membership (experimental/active control), Box’s M test of equality of
covariance matrices was significant at the .04 level, indicating that Box’s M was violated. However, when sample sizes are equal (see Table 4), the robustness of significance tests is expected. Tabachnick and Fidell (2001) recommend ignoring Box’s M in this situation, because it is considered a highly sensitive test of homogeneity of variance-covariance matrices. However, if sample sizes are not equal and Box’s M is significant at $p < .001$, then robustness cannot be guaranteed. Therefore, Box’s M was ignored for this analysis since experimental and active control groups are equal in number ($n = 27$). Results of the multivariate analysis of the dependent variable, Internalizing Problems, did not reveal a statistically significant interaction effect of time (mid- to posttesting) completion of CTRT Phase II x group membership (experimental/active control) are as follows: Wilks’s lambda = 1.00, $F(1, 52) = 0.00$ $p = 1.00$. These results indicate that the children in the CTRT group did not demonstrate a statistically significant decrease in Internalizing Problems from mid- to posttesting when compared to the active control group. There was no practical significance when partial $\eta^2$ ($\eta^2 = 0.00$) was calculated. These results indicate that the treatment had no significant impact on the subjects during this time period.

Results from the post hoc analysis of the effects of treatment from pre- to mid- as well as mid- to post testing on the dependent variable, Internalizing Problems indicate that the greatest change occurred after CTRT Phase I. Although the children’s behavior continued to make gains at the conclusion of CTRT Phase II the rate of change for the target behavior was similar to the children in the active control group.

Post hoc of Total Problems, Hypothesis 3. Table 4 presents the pretest and midtest means and standard deviations for the experimental and active control groups’ ratings on the Total Problems Scale. Results of the multivariate analysis of the dependent variable did not revealed a statistically significant interaction (time x group) effect from pre to mid testing (after completion
of Phase I CTRT); Wilks’s lambda = 0.94, $F(1, 52) = 3.08, p = .09$. These results indicate that the children in the CTRT group did not demonstrate a statistically significant decrease in Total Problems from pre- to midtesting when compared to the control group; however, the results indicate a positive trend ($p < .10$) in the CTRT children’s total behavior problems when compared to the control group. The practical significance of the effects of CTRT treatment from pre- to midtesting was small ($\eta^2 = .06$).

Table 4 presents the midtest and posttest means and standard deviations for the experimental and active control groups’ ratings on the Total Problems Scale. In looking at the interaction effect of time at the completion of Phase II of treatment (midtest to posttest) x group membership (experimental/active control) Wilks’s lambda = 0.95, $F(1, 52) = 2.90, p = .10$. Statistical significance was not achieved with alpha set at 0.05; however, the results indicate a positive trend ($p < .10$) in the CTRT children’s total behavior problems when compared to the active control group. The practical significance of the effects of the CTRT treatment from pre- to midtesting was small ($\eta^2 = 0.05$). These results do not indicate that the treatment had a significant effect on the total behavior problems on the subjects during this time period.

The change across both phases of CTRT indicated that the change in children’s total problem behaviors were gradual and consistent across time.

*Results for Hypotheses 4 to 6*

Table 5 presents the pre-, mid- and posttest means and standard deviations for the children of focus in the experimental and control group on the Externalizing, Internalizing, and Total Problems Scales of the C-TRF.
Table 5

*Mean Scores for the Children of Focus on the Externalizing, Internalizing, and Total Problems Scale on the Child Behavior Checklist-Caregiver/Teacher Report Form (C-TRF)*

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<th><strong>Active control group n = 12</strong></th>
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<tr>
<td></td>
<td>Pretest</td>
<td>Midpoint</td>
<td>Posttest</td>
</tr>
<tr>
<td>Externalizing Problem</td>
<td>Mean</td>
<td>56.67</td>
<td>52.58</td>
</tr>
<tr>
<td></td>
<td>SD</td>
<td>10.33</td>
<td>10.27</td>
</tr>
<tr>
<td>Internalizing Problems</td>
<td>Mean</td>
<td>57.17</td>
<td>52.42</td>
</tr>
<tr>
<td></td>
<td>SD</td>
<td>8.49</td>
<td>9.84</td>
</tr>
<tr>
<td>Total Behavior Problems</td>
<td>Mean</td>
<td>57.92</td>
<td>52.58</td>
</tr>
<tr>
<td></td>
<td>SD</td>
<td>8.59</td>
<td>10.10</td>
</tr>
</tbody>
</table>

*Note.* A decrease in mean scores indicates an improvement in behavior.

**Hypothesis 4**

Children of focus in the experimental treatment group will demonstrate a significant decrease in Externalizing Problems, when compared to children of focus in the active control group over time. Table 5 presents the means and standard deviations for the experimental and control group on the dependent variable at pre-, mid- and posttest.

Results of the multivariate analysis of the dependent variable, Externalizing Problems, revealed a statistically significant interaction effect of time (pretest, midtest, posttest) x group membership (experimental/active control); Wilks’s lambda = 0.57, $F(2, 21) = 8.01, p = .00$. These results indicate that the children of focus in the CTRT group demonstrated a statistically decrease in Externalizing Problems from pre- to mid- to posttreatment, when compared to the active control group. On the basis of these results, Hypothesis 4 is retained. Partial $\eta^2$ was calculated to determine the magnitude of the treatment effect. Results indicate that the CTRT intervention had a large treatment effect ($\eta^2 = 0.43$) on externalizing behavior problems of the children of focus when compared to children of focus whose teachers participated in the active control group.
Figure 4 graphically displays the interaction effect of mean group differences for externalizing behavior problems over time.

![Graph showing interaction effect of mean group differences](image)

**Figure 4.** Estimated marginal means of Externalizing Problems for Children of Focus.

**Hypothesis 5**

Children of focus in the experimental treatment group will demonstrate a significant decrease in Internalizing Problems, when compared to children of focus in the active control group over time. Table 5 presents the means and standard deviations for the experimental and control group on the dependent variable at pre-, mid- and posttest.

Results of the multivariate analysis of the dependent variable, Internalizing Problems, did not reveal a statistically significant interaction effect of time (pretest, midtest, posttest) x group membership (experimental/active control); Wilks’s lambda = 0.80, $F(2, 21) = 2.70$, $p = .09$. These results indicate that the children of focus in the CTRT group did not demonstrate a statistically significant decrease in Internalizing Problems from pre-, to mid- to posttreatment when compared to the children of focus whose teachers participated in the active control group; however, the results show a positive trend ($p < .10$), indicating a decrease in the Internalizing Problems of the children of focus in the CTRT treatment group. Given these results, Hypothesis
5 is rejected. Partial $\eta^2$ was calculated to determine the magnitude of the treatment effect. Results indicate that the CTRT intervention had a large treatment effect ($\eta^2 = 0.20$) on internalizing behavior problems of the children of focus when compared to children of focus whose teachers participated in the active control group.

Figure 5 graphically displays the interaction effect of mean group differences of the internalizing for the children of focus over time.

![Figure 5. Estimated marginal means of Internalizing Problems for Children of Focus.](image)

**Hypothesis 6**

Children of focus in the experimental treatment group will demonstrate a significant decrease in Total Behavior Problems when compared to children of focus in the active control group over time. Table 5 presents the means and standard deviations for the experimental and control group on the dependent variable at pre-, mid- and posttest.

Results of the multivariate analysis of the dependent variable, Total Problems, revealed a statistically significant interaction effect of time (pretest, midtest, posttest) x group membership (experimental/active control); Wilks’s lambda = 0.64, $F(2, 21) = 5.84, p = .01$. These results indicate that the children of focus in the CTRT group demonstrated a statistically significant
decrease in Total Problems from pre- to mid- to posttreatment when compared to the active control group. On the basis of these results, Hypothesis 6 is retained. Partial $\eta^2$ was calculated to determine the magnitude of the treatment effect. Results indicate that the CTRT intervention had a large treatment effect ($\eta^2 = 0.36$) on total behavior problems of the children of focus when compared to children of focus whose teachers participated in the active control group.

Figure 6 graphically displays the interaction effect of mean group differences of total behavior problems for the children of focus over time.

![Figure 6. Estimated marginal means of Total Problems for children of focus.](image)

**Post Hoc Analysis for Hypotheses 4 to 6**

Further inspection of Figures 4 to 6 revealed what appeared to be differences in the rate of change between treatment groups’ mean scores after CTRT Phase I (pretest to midtest) and after CTRT Phase II (midtest to posttest). Because the CTRT groups’ training protocol was divided into two phases that corresponded to the data collection points, theoretically it made sense to further examine the differences detected in the graphical displays. During CTRT Phase I the children of focus received a weekly 30-minute play session with their teacher, while the non-
children of focus did not. During CTRT Phase II all children in the study received attention from their teacher during CTR time. Therefore, I was curious about treatment effects on the children of focus during the two phases. Post hoc analysis on the interaction effects (time x group) was conducted to statistically analyze the effects of treatment for CTRT Phase I (pre to mid) and CTRT Phase II (mid to post) on each of the dependent variables when compared to the active control group.

*Post hoc analysis for Externalizing Problems, Hypothesis 4.* Table 5 presents the pretest and midtest means and standard deviations for the experimental and control groups’ ratings on the Externalizing Problems Scale. Results of the multivariate analysis of the dependent variable revealed that the interaction (time x group membership) from pre to midtesting (after completion of CTRT Phase I) was statistically significant; Wilks’s lambda = 0.75, $F(1, 22) = 7.34, p = .01$. These results indicate that the children of focus in the CTRT group demonstrated a statistically significant decrease in Externalizing Problems from pre to midtesting when compared to the active control group. Partial $\eta^2$ was calculated to determine the magnitude of the treatment effect. Results indicate that the CTRT intervention had a large treatment effect ($\eta^2 = 0.25$) on the children of focus’ externalizing behavior problems when compared to the children of focus whose teachers participated in the active control group.

Table 5 presents the midtest and posttest means and standard deviations for the experimental and active control groups’ ratings on the Externalizing Problems Scale. In looking at the interaction effect of time at the completion of Phase II of treatment (midtest to posttest) x group membership (experimental/active control) results were not statistically significant; Wilks’s lambda = 0.96, $F(1, 22) = 0.96, p = .34$. These results indicate that the children of focus in the CTRT group did not demonstrate a statistical significant decrease in Externalizing Problems
from mid- to posttesting, when compared to the control group. The practical significance of the effects of the CTRT treatment from mid- to posttesting was small ($\eta^2 = 0.04$).

Results from the post hoc analysis of the effects of treatment from pre- to mid- as well as mid- to posttesting on the dependent variable Externalizing Problems indicate that the greatest change occurred after CTRT Phase I. Although children’s behavior continued to make gains at the conclusion of CTRT Phase II the rate of change was not statistically significant.

*Post hoc for Internalizing Problems, Hypothesis 5.* Table 5 presents the pretest and midtest means and standard deviations for the experimental and control group. Results of the multivariate analysis of the dependent variable, Internalizing Problems, revealed that the interaction (time x group membership) from pre to midtesting (after completion of CTRT Phase I) was statistically significant; Wilks’s lambda = 0.80, $F(1, 22) = 5.58$, $p = .03$. These results indicate that the children in the CTRT treatment group demonstrated a statistically significant decrease in Internalizing Problems from pre- to midtesting when compared to the active control group. Partial $\eta^2$ was calculated to determine the magnitude of the treatment effect. Results indicate that the CTRT intervention had a large treatment effect ($\eta^2 = 0.20$) on the internalizing behavior problems of the children of focus when compared to children of focus whose teachers participated in the active control group.

Table 5 presents the midtest and posttest means and standard deviations for the experimental and active control groups’ ratings on the Internalizing Problems Scale. In looking at the interaction effect of time at the completion of Phase II of treatment (midtest to posttest) x group membership (experimental/active control) results were not statistically significant; Wilks’s lambda = 0.98, $F(1, 22) = 0.35$, $p = .56$. These results indicate that the children of focus in the CTRT group did not demonstrate a statistical significant decrease in Internalizing Problems from
mid- to posttesting, when compared to the active control group. The practical significance of the effects of the CTRT treatment from mid- to posttesting was small ($\eta^2 = 0.02$).

Results from the post hoc analysis of the effects of treatment from pre- to mid- as well as mid- to posttesting on the dependent variable Internalizing Problems indicate that the greatest change occurred after CTRT Phase I. Although the behavior of the children of focus continued to make gains at the conclusion of CTRT Phase II the rate of change for the target behavior was similar to the children in the active control group.

Post hoc for Total Problems, Hypothesis 6. Table 5 presents the pretest and midtest means and standard deviations for the experimental and control group. Results of the multivariate analysis of the dependent variable, Total Problems, revealed that the interaction (time x group membership) from pre to midtesting (after completion of CTRT Phase I) was statistically significant; Wilks’s lambda = 0.75, $F(1, 22) = 7.34$, $p = .01$. These results indicate that the children of focus in the CTRT group demonstrated a statistically significant decrease in Total Problems from pre- to midtesting when compared to the children of focus in the active control group. Partial $\eta^2$ was calculated to determine the magnitude of the treatment effect. Results indicate that the CTRT intervention had a large treatment effect ($\eta^2 = 0.25$) on the total behavior problems of the children of focus when compared to children of focus whose teachers participated in the active control group.

Table 5 presents the midtest and posttest means and standard deviations for the experimental and active control groups’ ratings on the Total Problems Scale. In looking at the interaction effect of time at the completion of Phase II of treatment (midtest to posttest) x group membership (experimental/active control) results were not statistically significant; Wilks’s lambda = 0.98, $F(1, 22) = 0.50$, $p = .49$. These results indicate that the children of focus in the
CTRT group did not demonstrate a statistically significant decrease in Total Problems from mid- to posttesting when compared to the active control group. The practical significance of the effects of the CTRT treatment from mid- to posttesting was small ($\eta^2 = 0.02$).

Results from the post hoc analysis of the effects of treatment from pre- to mid- as well as mid- to posttesting on the dependent variable, Total Problems indicate that the greatest change occurred after CTRT Phase I. Although the children’s behavior continued to make gains at the conclusion of CTRT Phase II the rate of change was not statistically significant.

Results for Hypotheses 7 to 9

Table 6 presents the pre-, mid- and posttest means and standard deviations for the non-children of focus in the experimental and control group on the Externalizing, Internalizing, and Total Problems Scales of the C-TRF.

Table 6

<table>
<thead>
<tr>
<th></th>
<th>Experimental group $n = 15$</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Midpoint</td>
<td>Posttest</td>
<td>Pretest</td>
</tr>
<tr>
<td>Externalizing Problem Mean</td>
<td>66.33</td>
<td>63.93</td>
<td>55.67</td>
<td>57.20</td>
</tr>
<tr>
<td>SD</td>
<td>10.81</td>
<td>14.11</td>
<td>10.81</td>
<td>8.94</td>
</tr>
<tr>
<td>Internalizing Problem Mean</td>
<td>61.00</td>
<td>59.87</td>
<td>53.53</td>
<td>56.73</td>
</tr>
<tr>
<td>SD</td>
<td>12.71</td>
<td>10.82</td>
<td>7.48</td>
<td>6.08</td>
</tr>
<tr>
<td>Total Behavior Problems Mean</td>
<td>64.73</td>
<td>63.33</td>
<td>55.40</td>
<td>58.87</td>
</tr>
<tr>
<td>SD</td>
<td>9.67</td>
<td>11.56</td>
<td>9.33</td>
<td>5.15</td>
</tr>
</tbody>
</table>

*Note. A decrease in mean scores indicates an improvement in behavior.*

Hypothesis 7

Non-children of focus in the experimental treatment group will demonstrate a significant decrease in Externalizing Problems, when compared to non-children of focus in the active control group over time. Table 6 presents the means and standard deviations for the experimental and control group on the dependent variable at pre-, mid-, and posttest.
Results of the multivariate analysis of the dependent variable, Externalizing Problems, revealed a statistically significant interaction effect of time (pretest, midtest, posttest) x group membership (experimental/active control); Wilks’s lambda = 0.79, $F(2, 27) = 3.66$, $p = .04$. These results indicate that the children in the CTRT group demonstrated a statistically decrease in Externalizing Problems from pre- to mid- to posttreatment, when compared to the active control group. On the basis of these results, Hypothesis 7 is retained. Partial $\eta^2$ was calculated to determine the magnitude of the treatment effect. Results indicate that the CTRT intervention had a large treatment effect ($\eta^2 = 0.21$) on children’s externalizing behavior problems when compared to children whose teachers participated in the active control group.

Figure 7 graphically displays the interaction effect of mean group differences for externalizing behavior problems over time.

\[ \text{Figure 7. Estimated marginal means of Externalizing Problems for non-children of focus.} \]

\textit{Hypothesis 8}

Non-children of focus in the experimental treatment group will demonstrate a significant decrease in internalizing problems, when compared to non-children of focus in the active control
group over time. Table 6 presents the means and standard deviations for the experimental and control group on the dependent variable at pre-, mid- and posttest.

Results of the multivariate analysis of the dependent variable, Internalizing Problems, did not reveal a statistically significant interaction effect of time (pretest, midtest, posttest) x group membership (experimental/active control); Wilks’s lambda = 0.94, $F(2, 27) = 0.94, p = .40$. These results indicate that the non-children of focus in the CTRT group did not demonstrate a statistically significant decrease in Internalizing Problems from pre-, to mid- to posttreatment, when compared to the non-children of focus in the active control group. Given these results, Hypothesis 8 is rejected. Partial $\eta^2$ was calculated to determine the magnitude of the treatment effect. Results indicate that the CTRT Treatment intervention had a moderate treatment effect ($\eta^2 = 0.07$) on the internalizing behavior problems of the non-children of focus, when compared to the non-children of focus whose teachers participated in the active control group.

Figure 8 graphically displays the interaction effect of mean group differences for internalizing behavior problems over time.

**Figure 8.** Estimated marginal means of Internalizing Problems for Non-Children of Focus.
Hypothesis 9

Non-children of focus in the experimental treatment group will demonstrate a significant decrease in Total Behavior Problems, when compared to non-children of focus in the active control group over time. Table 6 presents the means and standard deviations for the experimental and control group on the dependent variable at pre-, mid-, and posttest.

Box’s test of equality of covariance matrices was significant at the 0.04 level, indicating that Box’s M was violated. However, when sample sizes are equal (see Table 6), the robustness of significance tests is expected. Tabachnick and Fidell (2001) recommended ignoring Box’s M, as it is considered to be a highly sensitive test of homogeneity of variance-covariance matrices. However, if sample sizes are not equal and Box’s M is significant at $p < 0.001$, then robustness cannot be guaranteed. Sample sizes in this analysis are equal ($n = 15$); therefore, Box’s M was ignored for this analysis. Results of the multivariate analysis of the dependent variable, Total Problems, did not reveal a statistically significant interaction effect of time (pre-, mid-, posttest) x group membership (experimental/active control); Wilks’s lambda = 0.87, $F(2, 27) = 1.94$, $p = .16$. These results indicate that the non-children of focus in the CTRT group did not demonstrate a statistically significant decrease in Total Problems when compared to the non-children of focus in the active control group. Given these results, Hypothesis 9 is rejected.

Partial $\eta^2$ was calculated to determine the magnitude of the treatment effect. Results indicate that the CTRT intervention had a moderate treatment effect ($\eta^2 = 0.13$) on total behavior problems of the non-children of focus, when compared to the non-children of focus whose teachers participated in the active control group.

Figure 9 graphically displays the interaction effect of mean group differences for total behavior problems over time.
Figure 9. Estimated marginal means of Total Problems for Non-Children of Focus.

Post Hoc Analysis for Hypothesis 7 to 9

Further inspection of Figures 7 to 9 revealed what appeared to be differences in the rate of change between treatment groups’ mean scores after CTRT Phase I (pretest to midtest) and after CTRT Phase II (midtest to posttest). Because the CTRT groups’ training protocol was divided into two phases that corresponded to data collection points, theoretically it made sense to further examine the differences detected in the graphical displays. During CTRT Phase I the children of focus received a weekly 30 minute play session with their teacher, while the non-children of focus did not. During CTRT Phase II all children in the study received attention from their teacher during CTR time. Therefore, I was curious about treatment effects on the non-children of focus during the two phases. Post hoc analysis on the interaction effects (time x group) was conducted to statistically analyze the effects of treatment for CTRT Phase I (pre to mid) and CTRT Phase II (mid to post) on each of the dependent variables when compared to the active control group.

Post hoc analysis of Externalizing Problems, Hypothesis 7. Table 6 presents the pretest and midtest means and standard deviations for the experimental and active control groups’
ratings on the Externalizing Problems Scale. Results of the multivariate analysis of the dependent variable revealed that the interaction (time x group) from pre- to midtesting (after completion of CTRT Phase I) was not statistically significant; Wilks’s lambda = 1.00, $F(1, 28) = 0.01$, $p = .93$. These results indicate that the non-children of focus in the CTRT group did not demonstrate a statistically significant decrease in Externalizing Problems from pre- to midtesting when compared to the active control group. The practical significance of the effects of the CTRT treatment from pre- to midtesting was insignificant ($\eta^2 = 0.00$).

Table 6 presents the midtest and posttest means and standard deviations for the experimental and active control groups’ ratings on the Externalizing Problems Scale. In looking at the interaction effect of time at the completion of CTRT Phase II of treatment, a statistically significant interaction effect of time (midtest to posttest) x group membership (experimental/active control) was found; Wilks’s lambda = 0.85, $F(1, 28) = 4.89$, $p = .04$. These results indicate that the non-children of focus in the CTRT group demonstrated a statistically significant decrease in Externalizing Problems from mid- to posttreatment when compared to the non-children of focus in the active control group. Partial $\eta^2$ was calculated to determine the magnitude of the treatment effect. Results indicate that the CTRT Phase II intervention had a large treatment effect ($\eta^2 = 0.15$) on externalizing behavior problems of the non-children of focus when compared to the non-children of focus whose teachers participated in the active control group. These results indicate that the great change for the non-children of focus occurred during CTRT Phase II, which is when the teachers were being coached in using the skills in the classroom.

*Post hoc analysis for Internalizing Problems, Hypothesis 8.* Table 6 presents the pretest and midtest means and standard deviations for the experimental and active control groups’
ratings on the Internalizing Problems Scale. Results of the multivariate analysis of the dependent variable revealed that the interaction (time x group) from pre- to midtesting (after completion of CTRT Phase I) was not statistically significant; Wilks’s lambda = 0.97, $F(1, 28) = 0.98$, $p = .33$. These results indicate that the non-children of focus in the CTRT group did not demonstrate a statistically significant decrease in Internalizing Problems from pre- to midtesting when compared to the non-children of focus whose teachers participated in the active control group. The practical significance of the effects of the CTRT treatment from pre- to midtesting was small ($\eta^2 = 0.03$).

Table 6 presents the midtest and posttest means and standard deviations for the experimental and active control groups’ ratings on the Internalizing Problems Scale. In looking at the interaction effect of time at the completion of Phase II of treatment (midtest to posttest) x group membership (experimental/active control) results were not statistically significant; Wilks’s lambda = 0.99, $F(1, 28) = 4.33$, $p = .57$. These results indicate that the non-children of focus in the CTRT group did not demonstrate a statistical significant decrease in Internalizing Problems from mid- to posttesting when compared to the non-children of focus whose teachers participated in the active control group. The practical significance of the effects of the CTRT treatment from mid- to posttesting was small ($\eta^2 = 0.01$). The change across both phases of CTRT indicates that the behavior change in the non-children of focus was gradual and consistent across time.

Post hoc analysis of Total Problems, Hypothesis 9. Table 6 presents the pretest and midtest means and standard deviations for the experimental and control groups’ ratings on the Total Problems Scale. Results of the multivariate analysis of the dependent variable revealed that the interaction (time x group) from pre- to midtesting (after completion of CTRT Phase I) was not statistically significant; Wilks’s lambda = 0.10, $F(1, 28) = 0.07$, $p = .80$. These results
indicate that the non-children of focus in the CTRT group did not demonstrate a statistically significant decrease in Total Behavior Problems from pre- to midtesting when compared to the non-children of focus whose teachers participated in the active control group. The practical significance of the effects of the CTRT treatment from pre- to midtesting was small ($\eta^2 = 0.00$).

Table 6 presents the midtest and posttest means and standard deviations for the experimental and active control groups’ ratings on the Total Problems Scale. In looking at the interaction effect of time at the completion of CTRT Phase II of treatment (midtest to posttest) x group membership (experimental/active control) statistical significance was not met; Wilks’s lambda = 0.90, $F(1, 28) = 2.99, p = .10$. These results indicate that the non-children of focus in the CTRT group did not demonstrate a statistically significant decrease in Total Problems from mid- to posttesting when compared to the non-children of focus in the active control group; however, the results indicate a positive trend ($p < .10$), indicating a decrease in the total behavior problems of the non-children of focus in the CTRT group when compared to the non-children of focus whose teachers participated in the active control group. The practical significance of the effects of the CTRT treatment from mid- to posttesting was moderate ($\eta^2 = 0.10$). The change across both phases of CTRT indicates that the behavior change in the non-children of focus was gradual and consistent across time.

Comparison of Children of Focus and Non-Children of Focus

The children of focus group and the non-children of focus groups were compared to determine the significance of the difference between the two groups. The mean scores of the children of focus are reported in Table 5, and the mean scores for the non-children of focus are reported in Table 6. Results of this comparison indicated that the two groups did not differ over
time on the Externalizing Problems, Internalizing Problems or Total Problems scales. Box’s test of equality of covariance matrices was not violated, indicating that the groups were considered equal across all matrices. Results of the analysis for Externalizing Problems did not yield a statistically significant difference across matrices Box’s M for equality of covariance matrices (23.34) produces: $F (18, 7921.78) = 1.15, p = .30$. Results of the analysis for Internalizing Problems did not yield a statistically significant difference across matrices Box’s M for equality of covariance matrices (20.30) produces: $F (18, 7921.78) = 1.00, p = .45$. Results of the analysis for Total Problems did not yield a statistically significant difference across matrices Box’s M for equality of covariance matrices (24.12) produces: $F (18, 7921.78) = 1.19, p = .26$. These results confirm homogeneity of covariance matrices across groups and for each scale measured.

Discussion

Researchers in the mental health field have been challenged to report beyond a discussion of the statistical significance of their findings (Kazdin, 1999). Researchers must consider the therapeutic value of the intervention, which may be difficult to determine through statistical significance. Researchers are encouraged to calculate effect sizes to better understand the magnitude of the changes. The statistical and practical significance of this study, are reported to provide valuable insight into the impact of this study.

Results examined in this study are the effects of child teacher relationship training (CTRT) on children enrolled in Head Start with behavior problems. Children ($n = 54$) who met the criteria to be considered for this study scored in the borderline or clinical range on at least one subscale of the Child Behavior Checklist-Caregiver-Teacher Report Form (C-TRF). Treatment outcomes were measured through teachers’ ratings of children’s internalizing,
externalizing, and total behavior problems as exhibited in the classroom. Of the nine hypotheses, five were retained at the .05 level of significance, and two yielded positive trends, indicating an improvement in the experimental group targeted behavior when compared to the active control group. Partial $\eta^2$ was also calculated to determine the practical significance of the treatment findings. Of the nine hypotheses, six showed large treatment effects, while the other three showed moderate effects on the behavior of children whose teachers participated in the CTRT intervention.

The discussion of treatment results is organized as follows: (a) externalizing behavior problems and (b) internalizing behavior problems.

Externalizing Behavior Problems

Externalizing behavior problems are behavioral difficulties that children have in relationships with others, especially with adults. These behaviors include aggression and attention problems and are often considered more difficult to manage by adults. Externalizing behavior problems are often less tolerated by teachers than by parents and are often the major reason for referrals for counseling services (Keiley, Bates, Dodge, & Pettit, 2000). Treatment outcomes on Externalizing Problems were significant for the experimental treatment group. Each of the three hypotheses that examined the effects of the CTRT treatment on Externalizing Problems was retained.

Discussion of Externalizing Problems for all child subjects, Hypothesis 1. Results of Hypothesis 1 indicated that over time, the children in the CTRT treatment group demonstrated a statistically significant ($p = .00$) improvement on the Externalizing Problems Scale of the C-TRF at the 0.05 level when compared to the children whose teachers participated in the active control
group. Practical significance was found to be large ($\eta^2 = .20$), as interpreted by Cohen (1988), indicating that the treatment effect on the children in the CTRT group was large. These results were further analyzed in post hoc to determine whether there was a statistically significant difference between treatment groups’ mean scores from pretest to midtest (CTRT Phase I) and midtest to posttest (CTRT Phase II).

Results for the post hoc analysis of the effects of CTRT Phase I on Externalizing Problems revealed no statistically significant difference ($p = .16$) between the groups during this time period, and practical significance was determined to be small ($\eta^2 = .04$). These results were consistent with my expectations, given that the teachers in the experimental group were instructed not to utilize their CTRT skills in the classroom during CTRT Phase I treatment. Results of CTRT Phase II on Externalizing Problems were analyzed, and statistical significance was found between the experimental and active control groups ($p = .03$). Practical significance of these findings indicated a moderate treatment effect ($\eta^2 = .09$) due to CTRT Phase II. These results revealed that the largest treatment effect occurred during CTRT Phase II when teachers were coached in the use of CTRT skills in the classroom.

Discussion of Externalizing Problems for children of focus, Hypothesis 4. For the purpose of this study, the children of focus were analyzed as a distinct group. This separation was important given the training that occurred for the teachers in CTRT Phase I. During CTRT Phase I teachers were trained and supervised via videotape in weekly 30-minute individual play sessions with their children of focus; thus, this group of children received an individual intervention from their teachers, while the non-children of focus group did not. The statistically significant ($p = .00$) results indicated that the children of focus in the CTRT group made a
noteworthy improvement in Externalizing Behavior Problems, with the treatment effect ($\eta^2 = .43$) also supporting the significant impact of the CTRT intervention on the children of focus.

In post hoc analysis of the interaction effects of the different phases of CTRT, statistical significance ($p = .01$) was found at the completion of Phase I. Practical significance was found to be large ($\eta^2 = .29$). These results support the benefits of children receiving individual play sessions from their teachers. These results were consistent with research on the CPRT model (Landreth & Bratton, 2006) which demonstrated that play therapy conducted by paraprofessionals (parents, teachers, and mentors) has shown a significant impact on children’s externalizing behavior. Other studies have demonstrated that teachers can learn the play therapy skills and communicate empathy and understanding to children during the play sessions (Post et al., 2004, D.M. Smith & Landreth, 2004). Results of these studies support the notion that teachers can be therapeutic agents and communicate effectively enough to impact a child with whom they have a strong relationship, similar to the therapeutic relationship between play therapist and child. This present study’s results were consistent with meta-analytic findings on the effects of play therapy on externalizing behavior problems. In a meta-analytic study of 93 controlled play therapy studies, Bratton et al. (2005) found that play therapy had a large treatment effect on children’s externalizing behavior problems ($ES = 0.78$) when compared to no treatment. However, these results were different from a similar study by Post et al. (2004) and D.M. Smith and Landreth (2004), who found no significance in the improvement of externalizing problems.

Further analyses of the results at the conclusion of CTRT Phase II were interesting. Statistical significance ($p = .34$) was not found and a small effect ($\eta^2 = .04$) was found when practical significance was calculated. During CTRT Phase II, when children of focus no longer
received play sessions, their behavior continued to improve, but not at the statistically significant level they attained after CTRT Phase I. It makes sense that if the children of focus had already made statistically significant improvement after CTRT Phase I of treatment that it would not be expected for them to continue to change at a statistically significant rate. Several teachers made comments that support the finding noting that the behavior improvement of the children of focus was more noticeable during the individual play sessions. Results indicate that children benefited from this individual intervention with their teacher, which supports the power of the child-teacher relationship. These results show whereas the greatest behavior changed occurred while children of focus received one-on-one play sessions, they continued to make gradual change without an individual intervention. The fact that these children continued to make improvements without an individual intervention speaks highly of the strength of the classroom intervention. The child-teacher relationship has great significance in the lives of children and providing the teachers with therapeutic skills enables the teacher to be a therapeutic agent for children in the classroom.

Discussion of Externalizing Problems for non-children of focus, Hypothesis 7. The non-children of focus were analyzed to more purely evaluate the effects of the CTRT treatment on children who only received the classroom intervention. Hypothesis 7 was retained because statistical significance ($p = .04$) was found in the improvement of the externalizing behaviors of the non-children of focus in the CTRT group when compared to the active control. Practical significance was also calculated to determine the magnitude of the treatment effect and was found to have a large effect ($\eta^2 = .21$). Post hoc analysis of CTRT Phase I and CTRT Phase II revealed that the greatest change in the behavior of the non-children of focus occurred during
CTRT Phase II ($p = .04$). These results are promising and lend credibility to CTRT as a classroom intervention for children with significant externalizing behavior problems.

**Summary of discussion for Externalizing Problems.** The findings for CTRT’s effects on externalizing behaviors were significant in light of the focus in current literature regarding the mental health needs of this particular population. Children with these particular difficulties are considered to be at risk for a wide variety of problems, including depression, drug abuse, juvenile delinquency, violence, and antisocial personality disorders (Webster-Stratton & Reid, 2003). Webster-Stratton and Reid (2003) further speculated that the problems for conduct disorders in adolescence and adulthood are established in the preschool years. The impact of the CTRT treatment is especially important to note when looking at the effect on the non-children of focus. These children made significant improvements in externalizing behavior problems and never received one-on-one treatment. Therefore, CTRT should be considered a viable intervention targeting externalizing behavior problems of preschool children.

Teachers in this study responded to children with the skills presented in the CPRT manual such as reflection of feeling, therapeutic limit setting, and building children’s self-esteem. Results of this study indicate the power of these types of responses in the context of a strong child-teacher relationship. There is a long history of research involving parents using the CPRT model and indicating its effectiveness with a wide variety of emotional and behavioral problems (Landreth & Bratton, 2006). Andronico and Guerney (1969a) were the first to suggest using teachers as therapeutic agents given the strength of the teacher-child relationship and its similarity in significance to the parent-child relationship. For preschool children, teachers often function as caregivers. In Head Start, teachers feed children two meals each day, help them brush their teeth and nap in addition to the academics taught in the program. Given the strong caregiver
role these teachers have in the lives of children, equipping teachers with therapeutic skills in keeping with the CPRT model seemed logical. Kinder training, developed by White and her colleges (1997, 1999) is a similar model and has found promising success using teachers as therapeutic agents. In the Draper et al. (2001) kinder training study, teachers were found to be able to learn and apply the skills while in the playroom with children and results indicated an improvement of the children’s overall clinical scales. The significance in the improvement of externalizing problems for both the children of focus and non-children of focus on the CTRT group indicated that this intervention is a viable option as a classroom intervention for preschools.

**Internalizing Behavior Problems**

Internalizing behavior problems are difficulties that the child expresses internally and therefore are more difficult for teachers to notice (Keiley et al., 2000). Children who are highly anxious, withdrawn from others, and have significant somatic complaints exhibit internalizing behavior problems. All three hypotheses that analyzed Internalizing Problems were rejected. Practical significance was calculated to determine the magnitude of the treatment effect. Moderate-to-large effect sizes ($\eta^2 = .00$ to $0.204$) were found for each of the rejected hypotheses, indicating that the impact of CTRT on internalizing behavior was greatest during CTRT Phase I of treatment.

*Discussion of Internalizing Problems for all child subjects, Hypothesis 2.* Children in the CTRT group did not make statistically significant improvements in Internalizing Problems when compared to the active control group. However, a medium treatment effect size ($\eta^2 = .105$) was found, indicating that the CTRT treatment had a moderate effect on the internalizing behavior problems of the children in the CTRT group when compared to the children whose teachers
participated in the active control treatment. The post hoc analysis of this particular hypothesis was of particular interest. A statistically significant ($p = .03$) improvement and a moderate effect size ($\eta^2 = .09$) in internalizing behavior problems were found at the end of Phase I. This was especially interesting considering that teachers were asked not to use CTRT skills in the classroom at this time. There are several possible explanations for these results. The CTRT training could have impacted the teachers’ perceptions of internalizing problems and increased their sensitivity to children’s internalizing problems needs. Secondly, the midpoint data were collected in November. Therefore, the children who were experiencing anxiety at the beginning of the school year may have adjusted to the new situation with the support of their CTRT-trained teacher and were feeling more comfortable at school. Thirdly, internalizing behavior problems that manifest at the beginning of the school year may be easier to remediate and are less ingrained in children than externalizing behavior problems particularly for preschool children who are new to the school situation.

*Discussion of Internalizing Problems for children of focus, Hypothesis 5.* The children of focus in the CTRT group did not make a statistically significant improvement in internalizing behavior problems ($p = .09$). However, the results indicated a positive trend ($p < .10$) in the internalizing behavior problems of the CTRT children of focus when compared to the active control group. The practical significance of the effects of the CTRT treatment was large ($\eta^2 = .20$). This indicated that, although the CTRT children of focus did not make a statistically significant improvement in internalizing problems, there were positive gains in the target behavior and treatment had a large effect on their improvement. These results may reflect the difficulty teachers have in noticing and responding to internalizing behavior problems (Keiley et al., 2000).
Post hoc analysis of this hypothesis indicated that there was a statistically significant \( (p = .03) \) improvement on internalizing problems at the conclusion of CTRT Phase I (pre- to midtest) and a large treatment effect \( (\eta^2 = .20) \) for this period of treatment. As previously noted, the children of focus received individual play sessions during this time, while the non-children of focus did not. These results supported the benefits of children receiving individual play sessions from their teachers. These results were consistent with the research on the CPRT model (Landreth & Bratton, 2006) demonstrating the effectiveness of play therapy conducted by a paraprofessional (parent, teacher, or mentor) can significantly impact the child’s behavior.

Post hoc analysis for data at the completion of CTRT Phase II did not yield statistically significant results \( (p = .56) \), and practical significance was found to be small \( (\eta^2 = .01) \). However, the results indicate a positive trend \( (p < .10) \) on the internalizing behavior problems of the children of focus in the CTRT treatment group when compared to the active control group. During CTRT Phase II, when the children of focus no longer received play sessions, their behavior continued to improve but not at a statistically significant level. It seems logical that if the children had already made statistically significant improvement it would not be expected for them to continue to change at a statistically significant rate. After significant improvement children experience the ceiling effect, there is only so much change that is possible during a short period of time. This is especially true for the children who moved from the borderline/clinical range to the Normal range in scores on the C-TRF.

**Discussion of Internalizing Problems for non-children of focus, Hypothesis 8.** The non-children of focus in the CTRT group did not make a statistically significant \( (p = .40) \) improvement on internalizing problems when compared to the non-children of focus whose teachers participated in the active control group. When practical significance was calculated and
interpreted by Cohen (1988), a medium treatment effect was found ($\eta^2 = .07$). Therefore, the CTRT treatment had a moderate effect on the improvement of the internalizing problems for the non-children of focus in the experimental group. In post hoc analysis, results at the conclusion of CTRT Phase I and Phase II yielded no statistical significance and small effect sizes relative to each treatment phase.

Summary of Internalizing Problems results. While the results of the experimental group did not yield statistically significant results, the CTRT intervention demonstrated a large treatment effect on children of focus and a moderate treatment effect on non-children of focus. Internalizing behavior problems are subtle problems associated with anxiety and depression. Teachers may associate these behaviors with being shy or quiet, behaviors that are common in such young children and that adults assume children will outgrow them. Suicide is the third leading cause of death in adolescents and an increasing number of suicides occur in middle school students’ ages 10 to 14 years (U.S. Centers for Disease Control and Prevention, 2003). It is critical that the mental health field identify successful interventions that successfully target internalizing behavior problems. The findings of this study provide support for a filial therapy intervention targeting internalizing problems in preschool-aged children.

Researcher’s Observations

I observed several aspects of working with the teachers in this study that were noteworthy. The 2 ½ days of training that occurred during the teachers’ inservice days, before school started, truly motivated teachers. Teachers commented that this training was the, “best and most meaningful” training they had ever attended. Training teachers before school started was not
only convenient in that the intensive training allowed the research to begin immediately but it also spurred excitement for teachers to start the school year using their new skills.

All teachers reported enjoying their time in their individual play sessions with their child of focus. Teachers were able to focus on the child, listening with their eyes and ears which they reported enjoying most of all. Teachers also stated they enjoyed watching their child of focus grow and change as a result of the individual play sessions. When the idea of leaving the classroom once a week to conduct individual play sessions was first presented, most of the teachers were concerned about scheduling this time. However, once the sessions began, both teachers and aides reported the child’s behavior improved as early as the third play session. At the conclusion of CTRT, most teachers reported that the individual play sessions was their favorite part of the training. At the end of the school year one teacher had already chosen a child of focus for the following school year and requested the opportunity to conduct play sessions with her; indicating her commitment and belief in this intervention.

Center time was chosen as the time for child teacher relationship (CTR) time, this decision was made as it is typically a time of free play for children in the classroom and since teachers were to generalize playroom skills into the classroom this seemed like a logical time. After spending time in the classrooms during center time, researchers noticed that teachers often used this time to disengage from children. Teachers worked on paperwork or ran errands during this time period interacting very little with children. Therefore, this was the perfect time to bring teachers back into the classroom to focus on the child-teacher relationship. Initially, teachers had mixed responses to this concept; however, the general consensus was that once they got into CTR time they truly enjoyed it. Teachers reported having fun with their students which reminded them of why they became teachers. Classroom teachers also reported of the importance of this
training for their aide, who may have had very little training in working with children. Improvement in their ability to connect and communicate with the students was reported by teachers. All teachers reported that CTRT was worthwhile and a good experience for them and their students. One teacher characterized CTRT as a “breakthrough” for her students. Another teacher reported that one student in her classroom did not speak before CTR time began and now he is interactive with her and the other students, she believes this student would not be talking had she not had CTR time with him.

These observations support the strength of the child-teacher relationship which not only impacts children’s behavior but also teachers’ attitude toward students. Teachers were more able to enjoy their job and their students as a result of their participation in CTRT. This support is especially noteworthy given the teachers initial complaints about scheduling and logistics of CTRT. The teachers’ enthusiasm and support lends strength and credibility to this classroom model.

Limitations of the Study

While the real-world setting of this study lends credibility to its ability to be replicated by a school counselor or other mental health professional, this setting also contributes to several limitations. True randomization assignment to groups for the teacher subjects was not possible. Teachers new to the district had to be assigned to the active control group because the intensive training phase was held prior to school. This training conflicted with the requirement of the school district for the new teachers to attend new teacher training. There is also the possibility that teachers in the active control group were influenced by the teachers receiving CTRT. Due to the timing of this intervention, teachers were required to complete C-TRFs on
their students at the beginning of the school year. Although approximately half of their students were returning from the previous school year, teachers may not have known the new students in their classroom well enough to assess their behavior accurately.

An additional limitation is that teachers who were involved in the training completed the C-TRF on their students as a measure of behavior change and could be biased in their answers. Teachers’ perceptions of their students may have been altered by the CTRT intervention. Their altered perception may have influenced their C-TRF ratings more than the child’s true change in behavior. Because this study involved training both English-speaking and Spanish-speaking teachers, language proficiency may have presented a limitation. This potential difficulty was addressed by the use of both English- and Spanish-speaking CTRT trainers to provide instruction to the teachers in their first language; however, a few issues related to language arose in the classroom. For example, in one CTRT bilingual classroom, where Spanish was the primary language of the children, the aide was fluent in Spanish but more comfortable with English. Hence, when the aide used CTRT skills in the classroom she most frequently responded in English. The children may not have fully understood and therefore not benefited from the CTRT skills as much as they would have from a more fluent Spanish speaker. The teachers’ ability to learn and genuinely utilize the skills in the classroom could limit these results, some teachers incorporated these skills into their personality and classroom better than other teachers. During the coaching and modeling in CTRT Phase II, I demonstrated how to use the skills with children in the classroom therefore, the children could have benefited from my involvement in the classroom more than from the teachers’ use of the intervention.

A further limitation was that I was unable to control for the amount of Conscious Discipline training the active control group received. The amount of training received by this
group is typical of Conscious Discipline training and was provided by the school; however, I did not control for the amount and intensity of training.

Research Implications

Researchers in the field of early childhood education have emphasized the need for mental health services for disadvantaged children enrolled in Head Start (Thompson & Happoid, 2001; Yoshikawa & Knitzer, 1997). Yoshikawa and Knitzer (1997) stressed that Head Start teachers should be equipped with mental health skills to help them meet the demands of increasingly difficult behavior problems in the children they teach. Providing teachers with mental health skills is especially helpful considering that Head Start does not require a full-time mental health professional. Therefore teachers are often left with caring for the emotional and behavioral needs of the children without training or supervision. CTRT answers the call for preventative mental health services that teachers can provide in the classroom under the supervision of a school counselor or school psychologist trained in play therapy. It is also important to note that this modality utilizes the strength of the child-teacher relationship and attends to children in a developmentally responsive manner. Utilizing school-based programs such as CTRT is especially helpful for disadvantaged children who most likely would not receive mental health services outside of the school setting.

Results of this study indicate that CTRT is a viable treatment for preschool children exhibiting clinical behavioral problems. The children of focus showed the greatest decrease in internalizing and externalizing behavior problems, thus validating the impact of the traditional 10-session CPRT training protocol as outlined by Landreth and Bratton (2005). These results also support the teachers’ ability to learn the CPRT skills and the therapeutic value of the
teacher-conducted one-on-one play sessions. It is important to note that the non-children of focus also demonstrated significant decreases in externalizing problems. These results are promising in that the non-children of focus made significant improvements despite the fact that they did not receive one-on-one intervention during CTRT Phase I or Phase II of treatment. The non-children of focus only received attention from their teacher in their classroom during CTR time in Phase II of treatment. These significant findings on the impact of CTRT on children exhibiting externalizing behavior problems are of particular note. Keiley et al. (2000) found that teachers are less tolerant of externalizing behavior problems as children progress through school. Preschool children with significant externalizing problems at such a young age have been reported to be more likely to develop serious conduct disorders in adolescence and adulthood, including violence, substance abuse, and property crimes (Webster-Stratton & Reid, 2003). Thus the results of the present study are especially noteworthy, providing an early treatment option for children with externalizing behavior problems that could be easily incorporated in a cost efficient manner.

Because CTRT is a manualized treatment, it could easily be included as a mental health component in the preservice training of early childhood teachers, thus potentially impacting large numbers of disadvantaged preschool children who might not otherwise receive help. The CTRT model is a viable model for school counselors, trained in play therapy, to replicate in a Head Start program. Head Start classrooms have both a teacher and classroom aide, therefore, when one teaching partner conducts a play session, a second adult remains in the classroom. All training occurred during teacher inservice and the regular school day, thus feasible for a school counselor to replicate. Providing CTRT supervision and coaching would be an exceptional use of a school counselor’s time.
Recommendations for Further Research

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

1. Conduct a replication study using a larger sample size. A larger sample size would increase the power of the statistical measures.

2. Conduct a follow-up study to determine maintenance of improved behavior and to ascertain whether the teachers maintained their skills in the classroom over time.

3. Utilize an assessment instrument that measures teacher-child relationship or teacher stress to determine the impact of training on the teacher.

4. Utilize an assessment tool that measures variables from the child’s perceptive, thus reducing the reliance upon outside observation and the effects of rater bias.

5. Collect parent data to determine whether there were behavior changes in the children at home as well as at school.

6. Assess teachers’ skill attainment and correlate teacher skill with children’s improvement.

7. Utilize additional sources of objective measurement of children’s behavior change, such as direct observations of children by trained professionals and parent report of behavior change at home.
APPENDIX A

PARENT AND TEACHER CONSENT FORMS
Title of the study: Investigating the Effectiveness of Training and Supervising Teachers in Culturally Responsive Play-Based Skills with At-Risk Primary School Aged Minority Children

Principal Investigator: Dr. Sue Bratton, Assistant Professor, Counseling Program, Director, Center for Play Therapy;

Before agreeing to participate in this research study, it is important that you read and understand the following explanation of the proposed procedures. It describes the procedures, benefits, risks and discomforts of the study. It is important for you to understand that no guarantees or assurances can be made as to the results of this study.

Your participation is voluntary and you may choose to withdraw at any time during the study without penalty of any kind. Your signature indicates that you meet all of the requirements for participation and have decided to participate and you have been told that you will receive a signed copy of this consent form. Your decision whether or not to participate will not affect your child’s standing at school. At the conclusion of the study, a summary of results will be made available to all interested parents and teachers.

Purpose of the study and how long it will last:
The purpose of this study is to examine the effects of Child-Teacher-Relationship Training (CTRT) on children’s behavior at your school. Child development literature emphasizes the vital importance of the teacher-child relationship for young children’s academic success. In addition, the purpose of the CTRT training is to help teachers respond more appropriately to young children’s behavior and create a more positive classroom environment for learning. This study involves teachers participating in training and supervision for a period of 23 weeks.

Description of the study including the procedures to be used:
If you choose to participate, you will be placed in either the CTRT treatment group or the control group that receives no training during cycle one. Teachers who receive no training during cycle one will receive CTRT training in cycle two. CTRT is a model that trains teachers in skills of empathy, encouragement, limit setting and choice giving. These skills are designed to help teachers effectively manage children’s behavior and maintain classroom discipline in order to maximize learning. Teachers selected for the CTRT treatment group will participate in training and supervision on a weekly basis for a total of 23 weeks. Educational activities and schedules will not be impacted as a result of this study. Participating teachers will be asked to complete the Child Behavior Checklist (Caregiver-Teacher version- C-TRF) three times this school year, at the beginning, middle and end of the training, to evaluate the effects of teacher training on student behavior. The C-TRF will take approximately 20 minutes to complete. In addition teachers will be video taped during one-on-one play-based interactions with a child, as well as directly observed during classroom interactions in order to provide supervision of skills. The researcher is also interested in interaction between teacher and child specifically the teacher’s ability to communicate empathy and acceptance as well as execute the skills taught. Therefore, videotapes will be utilized to examine the effects of CTRT on the teacher-child relationship.
Training and supervision will be provided by counseling professionals with advanced training in play therapy and the CTRT model. The Principal Investigator and Research Project Coordinators will insure that all information will be kept confidential.

Child-Teacher-Relationship-Training (CTRT)

CTRT is a developmentally appropriate teacher training model that uses play based intervention skills to train teachers in skills of empathy, encouragement, limit setting and choice giving. These skills are designed to help teachers effectively manage children’s behavior and maintain classroom discipline in order to maximize learning. This training focuses on the development of a positive teacher-child relationship based on the philosophy that children who feel more connected to their teacher are more successful in school. This training also utilizes developmentally appropriate culturally responsive play-based activities and skills to help teachers more effectively communicate with and manage behavior of young children. Teachers will be trained and closely supervised by counseling professionals who have advanced training in play therapy and the CTRT model. CTRT training consists of 2 ½ days of intensive training in the skills followed by 22 weeks of 1 hour per week training and supervision of the skills.

Description of procedures/elements that may result in discomfort or inconvenience:

There is no personal risk or discomfort directly involved with this study other than those associated with your normal daily teaching activities. You may choose to withdraw at any time without penalty or prejudice.

Description of the procedures/elements that are associated with foreseeable risks:

There are no foreseeable risks involved with this study other than those associated with normal daily activities.

Benefits to the subjects or others:

The teacher-child relationship is significant to the development of young children. Due to this significant relationship, teachers have the potential to make a considerable difference in a child’s development. Therefore, training teachers to respond to children in a more encouraging and developmentally appropriate way can benefit aspects of your students’ development, including cognitive, behavioral, social and emotional. Research suggests that children who feel more connected to their teacher have more positive attitudes towards school and demonstrate higher levels of academic achievement.

Teacher-child relationship training can benefit you by: increasing your ability to effectively respond to students’ emotional and behavioral needs; enhance your ability in providing effective classroom management and discipline. Literature suggests that teachers who feel more confident of their ability to respond effectively to students’ needs have reported more satisfaction in their careers.
Confidentiality of research records:
The information you provide when you answer the questionnaire will be kept confidential, and will not be disclosed in any publication or discussion of this material. All data including assessments and video tapes will be assigned a code number and kept in a locked filing cabinet in order to preserve confidentiality. Only the principle investigator and research assistants will review the video tapes for coding teacher-child interactions. For research purposes, only the Principle Investigator and Research Project Coordinators will have access to the list of participants’ names and code numbers. At the end of the study the list of names will be destroyed.

The only exceptions to confidentiality are if the parent or legal guardian requests release of information on C-TRF results.

Review for protection of participants:
This research study has been reviewed and approved by the UNT Committee for the Protection of Human Subjects. Contact the UNT IRB at (940)565-3940 or sbourms@unt.edu if you have questions regarding your rights as a research subject.

Research Subjects’ Rights:
I have read or have had read to me all of the above.

The Principle Investigator or Research Project Coordinators have explained the study to me and answered all of my questions. I have been told there are no foreseeable risks or discomfort directly involved with this study other than those associated with normal daily activities. I have also been informed of the possible benefits participating in this study.

I understand that I do not have to take part in this study, and my refusal to participate or to withdraw will involve no penalty or loss of rights or benefits or legal recourse to which I am entitled. The study personnel may choose to stop my participation at any time.

In case there are problems or questions, I have been told I can call Dr. Sue Bratton at telephone number 940-565-3864.

I understand my rights as a research subject, and I voluntarily consent to participate in this study. I understand what the study is about and how and why it is being done. I have been told I will receive a signed copy of this consent form.

_____________________________________________________________________
Signature of Subject    Date
Signature of Witness
Date

For the Investigator or Research Project Coordinators:
I certify that I have reviewed the contents of this form with the person signing above, who, in my opinion, understood the explanation. I have explained the known benefits and risks of the research.

_________________________________________  Date
Signature of the Principal Investigator or Research Project Coordinators
RESEARCH CONSENT FORM

Subject Name:________________________________  Date:__________________

Title of the study: Investigating the Effectiveness of Culturally-Responsive Play Therapy and Related Play-Based Preventative Services with At-Risk Primary School Aged Minority Children and Their Families.

Principal Investigator:  Sue Bratton, Ph.D., LPC-S, RPT-S
Licensed Professional Counselor-Supervisor
Registered Play Therapist-Supervisor
Director, Center for Play Therapy
Associate Professor, University of North Texas
940-565-3864

Before agreeing to participate in this research study, it is important that you read and understand the following explanation of the proposed procedures. It describes the procedures, benefits, risks, and discomforts of the study. It is important for you to understand that no guarantees or assurances can be made as to the results of this study.

Your participation is voluntary and you and/or your child may choose to withdraw at any time during the study without penalty of any kind. Your signature indicates that you meet all of the requirements for participation and have decided to participate and you have been told that you will receive a signed copy of this consent form. Your decision whether or not to participate will not affect your child’s standing at school. At the conclusion of the study, a summary of results will be made available to all interested parents and teachers.

Purpose of the study and how long it will last:
This project is designed to examine the effects of play-based school counseling, also called play therapy, and play-based mentoring in helping minority children attending elementary schools in Denton, Texas who are at-risk for not achieving school success. Providing school counseling services for minority children at the earliest possible age is critical in order to address problems early and help them achieve the most school success.

The study involves 45 minute counseling sessions for your child, one time per week for approximately 10 weeks. You and your child’s teacher will also be asked to complete two questionnaires at the beginning and at the end of your child’s counseling. Each questionnaire will take approximately 20 minutes to complete.

Description of the study including the procedures to be used:
If your child qualifies and you decide you want your child to participate, your child will be assigned to receive one of the following school counseling services: play therapy, mentoring, or group counseling. The counselors and mentors who provide these services are specially-trained to work with children and are closely supervised by Dr. Sue Bratton, project coordinator, to insure the highest quality services.
Play therapy:
In play therapy, also called counseling with children through play and toys, a counselor who has advanced training in play therapy will take your child to the playroom at school, equipped with a variety of developmentally appropriate toys and materials such as arts/craft supplies, clay, games, toy people and animals, cars and trucks, dolls, puppets, dress-up/pretend clothes, a play kitchen area, and sand/water.

Using play and toys in counseling to help children who are having problems at school is based on the fact that children more easily communicate through play, while adults generally communicate through words. Elementary-age children think at a very concrete level, thus it is easier for them to use the toy figures and other materials to show the counselor what they are thinking and feeling. Trying to explain how you are feeling and why you feel that way can be hard even for an adult—especially when you are upset! This is especially true for children who are struggling to learn a second language.

Play-based mentoring:
In the mentoring program, a junior or senior college student or teacher with special training in counseling and therapeutic play procedures to help children will work with your child 45 minutes each week. Mentors provide a special toy kit with a variety of toys and games to help children express how they are feeling and what they are thinking.

Group counseling:
In the skill-based counseling groups, also called school guidance groups, the counselor will provide children with a variety of activities from a school-approved curriculum, including: 1) reading stories and asking children questions about the stories or asking them to draw about them, 2) showing children pictures of different emotions such as anger and happiness and asking them to identify the emotion, and 3) asking them to practice social skills such as how to solve disagreements with other children and how to make socially acceptable choices.

Description of procedures/elements that may result in discomfort of inconvenience:
There is no personal risk or discomfort directly involved with this study other than the normal expression of anger, sadness, or frustration associated with expressing emotions through play. You and/or your child may choose to withdraw at any time without penalty or prejudice.

Description of the procedures/elements that are associated with foreseeable risks:
There are no foreseeable risks involved with this study other than those associated with normal daily activities.

Benefits to subjects:
Elementary school is a very important time in your child’s development; a time when children develop life-long attitudes concerning school, as well as self, peers, social groups and family. Many children have difficulties adjusting to the demands of school, particularly children who are struggling to learn a second language and adapt to a new culture. Often, these children’s problems aren’t addressed until they are old enough to communicate their problems in words. Play-based counseling services offered through this research project are designed to help elementary-age children at an early age---before problems become more serious, by providing
age-appropriate activities designed to help children a) better understand their thoughts and feelings and how to express them in appropriate ways; b) develop confidence in their abilities; and c) become more responsible, as they learn self-control and problem-solving skills. Counselors will also be available to parents to discuss how your child is doing, help you with parenting concerns, or share ideas about how you can better help your child be successful.

Confidentiality of research records:
The questionnaires that you and your child’s teacher complete before and after the study are kept confidential. They are not identified by your name or your child’s name; a special code number is used instead of your child’s name. The questionnaires provide important information about your child’s behaviors and provide information about the effectiveness of the counseling services that your child received. However, no information about your child or you will be shared with your child’s teacher, school officials, or anyone else. The only exceptions to confidentiality are if 1) a child disclosed abuse, neglect, or exploitation, 2) the child is a danger to oneself or to someone else, 3) a court orders disclosure of information, or 4) the parent or legal guardian requests release of information.

Dr. Sue Bratton, Principal Investigator, will record all results and give you feedback if you are interested. At the end of the study, all forms will be destroyed.

The researcher is also interested in children’s type of play, toys used, and the use of language (Spanish or English) during the counseling sessions. For this reason the researcher will videotape individual play sessions. Videotapes will not identify a child by name, rather a special number will be used to code tapes and only the researcher will know to whom the tape belongs. The tapes will be kept in a locked cabinet in the researcher’s office. Only the researcher and her employed associate will review the tapes for coding play and language patterns. In addition, sessions are videotaped for supervision purposes and watched by Dr. Sue Bratton, researcher/principal investigator, to insure that your child is receiving the highest quality of counseling services. At the completion of the study, all tapes will be destroyed unless parent consent is received to use the tapes for training and educational purposes.

Review for protection of participants:
This research study has been reviewed and approved by the UNT Committee for the Protection of Human Subjects (940) 565-3940.

Research Subjects’ Rights:
I have read or have had read to me all of the above. This study has been explained to me and all of my questions have been answered. I have been told the risks or discomforts and possible benefits of the study.

I understand that my child and I do not have to take part in this study, and that my refusal to participate or my decision to withdraw will involve no penalty or loss of rights or benefits or legal recourse to which I am entitled. I also understand that the investigator may choose to stop my child’s participation at any time.
In case there are problems or questions, I have been told I can call Dr. Sue Bratton, (940) 565-3864.

I understand my rights as a research subject, and I voluntarily consent to participate in this study. I understand what the study is about and how and why it is being done. I have been told I will receive a signed copy of this consent form.

__________________________________________
Signature of Parent or Guardian                                      Date

__________________________________________
Signature of Witness                                                  Date

**For the Investigator or Designee:**
I certify that I have reviewed the contents of this form with the person signing above, who, in my opinion, understood the explanation. I have explained the known benefits and risks of the research.

__________________________________________
Signature of the Principal Investigator                               Date
FORMA DE CONSENTIMIENTO PARA LA INVESTIGACION

Nombre de la Persona: ___________________________ Fecha: __________________

Título del Estudio: Investigando la Efectividad de la Terapia de Juego que sea Culturalmente Sensible y los Servicios Preventivos Relacionados utilizando la Terapia de Juego para Niños Minorías y sus Familias en las Escuelas Primarias.

Investigadora Principal: Sue Bratton, Ph.D., LPC-S, RPT-S
Consejera-Supervisora con Licenciatura Profesional
Registrada Terapista-Supervisora de Juego
Directora del Centro de Terapia del Juego
Profesora Asociada de la Universidad del Norte de Texas
940-565-3864

Antes de que usted decida participar en este estudio de investigación, es muy importante que usted lea y entienda las siguientes explicaciones de los procedimientos propuestos. *Este documento* le describe los procedimientos, beneficios, riesgos, e incomodidades del estudio. Es muy importante *entender* que no hay garantía ni tampoco seguridad de los resultados que pueden tenerse con este estudio.

Su participación es totalmente voluntaria y usted y/o su niño(a) pueden decidir *salir del programa* en cualquier momento durante el estudio investigativo sin preocuparse por cualquier tipo de pena o multa. Su firma indica que usted *cumple con* todos los requisitos para participar y que ha decidido tomar parte en el estudio, además que a usted se le ha explicado que al final recibirá una copia firmada de esta forma de consentimiento. La decisión que usted tome, de participar o no, no afectará en lo absoluto la permanencia de su niño(a) en la escuela. A la conclusión del estudio, un resumen de los resultados *estará* a la disposición de todos los padres y maestros interesados.

El propósito del estudio y por cuánto tiempo durará:
Este proyecto está designado para examinar los efectos de la consejería escolar basada en el juego, también llamada terapia de juego. Este proyecto también está basada en el juego con el maestro o mentor para ayudar a los niños menores que se asisten a las escuelas primarias de Denton, Texas y que se incluyen en un grupo de alto riesgo de no alcanzar el éxito en sus estudios escolares. Es muy importante ofrecer los servicios de consejería a los niños menores a la edad más joven posible para confrontar problemas al principio y para apoyarles en sus estudios.

Este estudio entraña 45 minutos de consejería para su niño(a), una vez por semana por aproximadamente 10 semanas. Al comienzo y al fin de la participación de su hijo(a) en las sesiones de consejería, usted y el (la) maestro(a) de su niño(a) se completarán dos cuestionarios. Cada cuestionario tomará aproximadamente 20 minutos para completarlo.
Descripción del estudio incluyendo los procedimientos usados:
Si su niño califica y usted quisiera que su niño(a) participe, su niño(a) recibirá uno de los siguientes servicios de consejería escolar: terapia de juego, maestro o mentor, o consejería de grupo. Los consejeros y los mentores que ofrecen estos servicios están especialmente entrenados para trabajar con niños y estarán supervisados directamente por la Dra. Bratton, la coordinadora del proyecto, para asegurar la máxima calidad de los servicios.

Terapia de juego:
En la terapia de juego, también llamada consejería con niños a través de los juegos y los juguetes, un consejero que tiene entrenamiento avanzado en juegos de terapia llevará a su niño(a) un cuarto de jugar en la escuela, que está proveído con una variedad de juguetes debidamente desarrollados y creados para este propósito, también ofrecen materiales como artes plásticas, objetos para construir, plastilina, juegos, muñecos y animales, carros y camiones, peluches, títeres, ropa para disfrazarse o fingir ser alguien, un área de cocina, arena y agua.

Usando los juguetes y los juegos en las terapias de consejería para ayudar a los niños que están teniendo problemas en la escuela, se basa en la realidad de que los niños se comunican más fácilmente a través del juego, mientras que los adultos generalmente se comunican a través de las palabras. Los niños de la edad primaria piensan en un nivel muy concreto, de manera que es más fácil para ellos usar figuras de juguetes y otros materiales para mostrarle al consejero lo que ellos piensan o se sienten. Explicar cómo se siente y porque se siente de esa manera puede ser muy difícil para niños igual como para un adulto—especialmente cuando está trastornado! Es sobretodo cierto para los niños que se encuentran problemas de aprendizaje de un idioma segundo o asistirse a una escuela nueva.

El mentor o maestro del aprendizaje del juego:
En este programa de asesoría, un estudiante de los últimos años de la universidad o un maestro con entrenamiento especial en consejería y juegos terapéuticos, juega con varios procedimientos para ayudar a los niños mientras interactúan con ellos por 45 minutos cada semana. Los maestros ofrecen un juguete especial o varios, con diferentes tipos de juegos y juguetes para ayudar a que los niños expresen como se sienten y que piensan.

Consejería de grupo:
En los grupos de consejería, que también se llaman grupos de guía escolar, la idea se basa en que el consejero ofrecerá a los niños una variedad de actividades a través de un currículo aprobado por la escuela, incluyendo: 1) leyendo historias y preguntando a los niños acerca de la historia o pidiéndoles a ellos que dibujen algo relacionado con la historia, 2) mostrando a los niños fotos de diferentes emociones como la de estar bravo y la de estar feliz y preguntándoles si pueden identificar que tipo de emoción sea, y 3) pidiéndoles que practiquen normas de relaciones sociales básicas, por ejemplo: como resolver un desacuerdo con otros niños y como saber elegir de una manera amigable.

Descripción de los procedimientos/elementos que poderse resultar en molestia o inconveniencia:
No hay riesgos personales o molestias directamente relacionadas con este estudio más que las formas normales de expresión como la de estar bravo, la tristeza, o la frustración asociada con las
expresiones de emociones producidas a través del juego. Usted y/o su niño o niña pueden elegir si quieran salir del programa en cualquier momento sin tener ninguna multa o pena.

**Descripción de los procedimientos/elementos que están asociados con riesgos previsibles:**
No existen riesgos que pueden prevenirse envueltos con este estudio más que los que están asociados con las actividades normales de la vida.

**Beneficios para los sujetos:**
La escuela primaria es una época muy importante en el desarrollo de su niño(a), es la época en que los niños se desarrollan las actitudes o comportamientos que van a durarle toda la vida en cuanto a la escuela, en las relaciones con otros niños, con ellos mismos, con grupos sociales y la familia. Muchos niños tienen dificultades para conformarse a las demandas de la escuela, en particular los niños que se encuentran problemas aprender un idioma segundo y adaptarse a una nueva cultura. Con frecuencia, los problemas de estos niños no se atienden hasta que ellos han crecido lo suficiente para poder comunicarse sus problemas con palabras. Los servicios de consejería basados en el juego ofrecen la oportunidad a través de este proyecto de investigación, de ayudarlos con actividades de juego apropiadas para la edad juvenil de estos niños--antes de que los problemas se conviertan en algo más serio, por ejemplo: a) un mejor entendimiento de sus propios pensamientos e ideas y como pueden expresar éstas en muchas maneras diferentes; b) empezando a desarrollar seguridad en sus propias habilidades; y c) llegando a ser más responsable, en la manera en que aprenden a controlarse a ellos mismos y resolver sus propios problemas. Los consejeros estarán también disponibles para los padres para poder discutir como sus niños están progresando, ayudarlos con útiles consejos parentales, o compartiendo ideas acerca de cómo usted puede ayudar, de una manera mejor para que su niño triunfe.

**Privacidad de los datos del estudio:**
Los cuestionarios que usted y como el (la) maestro(a) de su niño(a) completen antes y después del estudio estarán guardados confidencialmente. Ellos no estarán identificados con su nombre o con el nombre del niño; un número de código especial se usan en vez del nombre del niño(a). Los cuestionarios ofrecen información muy importante acerca del comportamiento de su niño(a) y ofrecen también información acerca de los sucesos de los servicios de consejería que su niño(a) recibió. Sin embargo, ninguna información acerca de su niño(a) o usted mismo será compartida con los maestros de su niño(a), los directivos de la escuela, o cualquier otra persona. Las únicas excepciones a la privacidad son si 1) el niño (a) declara ser abusado, abandonado o explotado 2) el niño(a) está en una situación peligrosa por si mismo o por otra persona, 3) un orden judicial ordena la exposición de esta información, o 4) los padres o guardianes legales solicitan que la información sea publicada.

La Dra. Sue Bratton, Investigadora Principal, guardará y firmará todos los resultados y le puede dar cualquier información si usted está interesado. Al final del estudio, todas las formas serán destruidas.

La investigadora también se interesa en que tipo de juguetes el niño(a) elige usar, que tipos de juegos le gustan, y en el uso del idioma (si es español o inglés) durante las sesiones de consejería. Por esta razón la investigadora usará una cámara de video para grabar las sesiones de juego individuales. Los videos no identificarán el nombre del niño(a), al contrario, se usará un número especial para codificar las cintas y sólo la investigadora sabrá a quien le pertenece el video. Las
cintas de video se guardarán en una caja especial bajo llave en la oficina de la investigadora. Solo la investigadora y los empleados asociados a ella, revisarán las cintas de video para poder codificar los juegos y los patrones de lenguaje. Además, las sesiones serán grabadas para propósitos de supervisión y serán vistos por la Dra. Sue Bratton, investigadora principal del estudio, para asegurar que su niño(a) recibe la mejor calidad de servicios de consejería. Al final de este estudio, todas las cintas de video serán destruidas a menos que los padres den un consentimiento por escrito que permita usar los videos para entrenamiento y propósitos educativos.

Revisión para la protección de los participantes:
Este estudio investigativo ha sido revisado y aprobado por el Comité para la Protección de los Derechos Humanos de la UNT (940) 565-3940.

Los derechos de los participantes de la investigación:
Yo he leído o he hecho que me lean todo lo expresado arriba. Este estudio me ha sido explicado y todas las preguntas que he tenido han sido contestadas. Se me ha informado de todos los riesgos o molestias y posibles beneficios de este estudio.

Yo entiendo que mi niño(a) y yo no tenemos que tomar parte de este estudio, y que mi negación a participar o mi decisión de salirme no conllevará ninguna pena o perdida de los derechos o los beneficios o los recursos legales a los cuales tengo derechos. También entiendo que la investigadora puede decidir interrumpir la participación de mi niño(a) en cualquier momento.

En caso de que existan problemas o preguntas, se me ha dicho que puedo llamar a la Dra. Sue Bratton, (940) 565-3864.

Yo entiendo mis derechos como participante o parte del estudio investigativo, y yo voluntariamente estoy dando mi consentimiento para participar en el estudio. Yo entiendo a lo que se refiere este estudio y como y porque se están haciendo. Se me ha explicado que yo recibiré una copia firmada de esta forma de consentimiento.

Firma del Padre o Madre o Guardian    Fecha

Firma del Testigo    Fecha

Para la Investigadora o el (la) Designado(a):
Yo certifico que he recibido el contenido de esta forma con la persona que firmó más arriba, quien, en mi opinión, entendió la explicación. Yo he explicado los beneficios y riesgos conocidos de esta investigación.

Firma de la Investigadora Principal    Fecha
RESEARCH CONSENT FORM-CLASSROOM CONSENT

Subject Name:_____________________________________ Date:______________

Title of the study: Investigating the Effectiveness of Training and Supervising Teachers in Culturally Responsive Play-Based Skills with At-Risk Primary School Aged Minority Children

Principal Investigator: Dr. Sue Bratton, Assistant Professor, Counseling Program, Director, Center for Play Therapy

Before agreeing to participate in this research study, it is important that you read and understand the following explanation of the proposed procedures. This form describes the procedures and any potential benefits, risks and discomforts of the study. It is important for you to understand that no guarantees or assurances can be made as to the results of this study.

Your participation is voluntary and you and/or your child may choose to withdraw at any time during the study without penalty of any kind. Your signature indicates that you meet all of the requirements for participation and have decided to participate and you have been told that you will receive a signed copy of this consent form. Your decision whether or not to participate will not affect your child’s standing at school. At the conclusion of the study, a summary of results will be made available to all interested parents and teachers.

Purpose of the study and how long it will last:

The purpose of this study is to examine the effects of Child-Teacher-Relationship Training (CTRT) on children’s behavior at your child’s school. Child development literature emphasizes the vital importance of the teacher-child relationship for young children’s academic success. This study involves training and supervision of your child’s teacher once a week for 23 weeks. The purpose of the CTRT Training is to help your child’s teacher to respond more appropriately to young children’s behavior and create a more positive classroom environment for learning.

Description of the study including the procedures to be used:

Your child’s teacher is participating in a research study to evaluate the effectiveness of Child-Teacher Relationship Training (CTRT) compared to a control group of teachers who will not receive CTRT training. Your child’s teacher will receive CTRT training either in the first or second cycle of teacher training. CTRT is a model that trains teachers in skills of empathy, encouragement, limit setting and choice giving. These skills are designed to help teachers effectively manage children’s behavior and maintain classroom discipline in order to maximize learning. Teachers at your child’s school will be participating in training and supervision on a weekly basis. Your child’s daily educational activities or schedule will not change as a result of this study.

Teachers and parents will be asked to complete the Child Behavior Checklist parent version (CBCL) and teacher version (C-TRF) three times this school year, at the beginning, middle and end of the training, to evaluate the effects of teacher training on student behavior. Both the parent and teacher questionnaire take approximately 20 minutes to complete. The Principal Investigator
and Research Project Coordinators will insure that all information on your child will be kept confidential. During the first cycle of training your child’s teacher will be assigned to either receive CTRT training or assigned to the control group, which will receive no specialized training. All teachers assigned to the control group during cycle one will receive CTRT training during cycle two.

**Child-Teacher-Relationship-Training (CTRT)**

CTRT is a developmentally appropriate teacher training model that uses play based intervention skills to train teachers in skills of empathy, encouragement, limit setting and choice giving. These skills are designed to help teachers effectively manage children’s behavior and maintain classroom discipline in order to maximize learning. This training focuses on the development of a positive teacher-child relationship based on the philosophy that children who feel more connected to their teacher are more successful in school. This training also utilizes developmentally appropriate culturally responsive play-based activities and skills to help teachers more effectively communicate with and manage behavior of young children. Teachers will be trained and closely supervised by counseling professionals who have advanced training in play therapy and the CTRT model. CTRT training consists of 2 ½ days of intensive training in the skills followed by 22 weeks of 1 hour per week training and supervision of the skills.

**Description of procedures/elements that may result in discomfort or inconvenience:**

There is no personal risk or discomfort directly involved with this study. You and/or your child may choose to withdraw at any time without penalty or prejudice.

**Description of the procedures/elements that are associated with foreseeable risks:**

There are no foreseeable risks involved with this study other than those associated with normal daily activities.

**Benefits to the subjects or others:**

The teacher-child relationship is significant to the development of young children. Due to this significant relationship, teachers have the potential to make a considerable difference in a child’s development. Therefore, training teachers to respond to children in a more encouraging and developmentally appropriate way can benefit aspects of your child’s development, including cognitive, behavioral, social and emotional. Research suggests that children who feel more connected to their teacher have more positive attitudes towards school and demonstrate higher levels of academic achievement.

**Confidentiality of research records:**

The information you provide when you answer the questionnaire will be kept confidential, and will not be disclosed in any publication or discussion of this material. All data including assessments will be assigned a code number and kept in a locked filing cabinet in order to
preserve confidentiality. For research purposes, only the Principle Investigator and Research Project Coordinators will have access to the list of participants’ names and code numbers. At the end of the study the list of names will be destroyed. No school officials will have access to the participants’ data at any time.

The only exceptions to confidentiality are if a) a child disclosed abuse, neglect or exploitation, b) the child is a danger to oneself or to someone else, c) a court orders disclosure of information, or d) the parent or legal guardian requests release of information.

**Review for protection of participants:**

This research study has been reviewed and approved by the UNT Committee for the Protection of Human Subjects (940) 565-3940.

**Research Subjects’ Rights:**
I have read or have had read to me all of the above.

The Principle Investigator or Research Project Coordinators have explained the study to me and answered all of my questions. I have been told there are no foreseeable risks or discomfort directly involved with this study other than those associated with normal daily activities. I have also been informed of the possible benefits of my child participating in this study.

I understand that I do not have to take part in this study, and my refusal to participate or to withdraw will involve no penalty or loss of rights or benefits or legal recourse to which I am entitled. The study personnel may choose to stop my participation at any time.

In case there are problems or questions, I have been told I can call Dr. Sue Bratton at telephone number 940-565-3864.

I understand my rights as a research subject, and I voluntarily consent to participate in this study. I understand what the study is about and how and why it is being done. I have been told I will receive a signed copy of this consent form.

_________________________________________  Date  
Signature of Parent or Guardian

_________________________________________  Date  
Signature of Witness

**For the Investigator or Designee:**
I certify that I have reviewed the contents of this form with the person signing above, who, in my opinion, understood the explanation. I have explained the known benefits and risks of the research.

_________________________________________  Date  
Signature of Principal Investigator or Research Project Coordinators
RESEARCH CONSENT FORM

Nombre del Cliente: ___________________________________ Fecha: ____________

**Título de la Investigación:** Investigando la efectividad de Entrenamiento y Supervisión de profesores respondiendo usando habilidades basadas en juego con niños de colegio de primaria, quienes están en riesgo y son parte de una minoría.

**Investigador Principal:** Dra. Sue Bratton, Profesora Asistente, Programa de Consejería, Directora del Centro para Terapia de Juego.

Antes de que decida participar en este estudio, es importante que usted lea y entienda la siguiente explicación de los procedimientos propuestos. Este formulario describe los procedimientos y cualquier potencial beneficio, riesgos y malestares como consecuencia participar en el estudio. Es importante que usted entienda que no hay garantías o aseguramientos que se puedan hacer referentes a los resultados de este estudio.

Su participación es voluntaria y usted o su niño pueden elegir retirarse a cualquier tiempo durante el estudio sin penalidad cualquiera. Su firma indica que usted obtiene todos los requisitos para participar, que ha decidido participar y que le han dicho que usted recibirá una copia de este formulario de consentimiento. Su decisión de participar o no participar no afectará la situación de su niño(a) en el colegio. En la conclusión del estudio, todos los padres y profesores interesados podrán obtener un resumen de los resultados.

**Propósito del Estudio y cuanto durara:**

El propósito de este estudio es para examinar los efectos del Entrenamiento ayudando la Relación entre Niños y Profesoras (ERNP) y el comportamiento de su niño(a) en el colegio. Literatura del desarrollo del niño acentúa la importancia de la relación entre el niño(a) y su profesora para el éxito académico de su niño. Este estudio requiere entrenamiento y supervisión de la profesora de su niño una vez por 23 semanas. El propósito del entrenamiento de ERNP es para ayudar a la profesora de su niño que responda más apropiadamente al comportamiento de los niños pequeños y crear un ambiente positivo y adecuado para el aprendizaje en el salón de clase.

**Descripción del estudio incluyendo los procedimientos usados:**

La profesora de su niño esta participando en un estudio evaluando la afectividad del Entrenamiento ayudando la Relación entre Niños y Profesoras (ERNP) comparadas a un grupo de control con profesoras que no reciben el ERNP entrenamiento. El ERNP es un modelo que entrena profesoras con habilidades de empatía, estimulo, ajuste de límites y el dar escogidos. Estas habilidades son diseñadas para ayudar las profesoras manejar el comportamiento de los niños efectivamente y que mantengan disciplina en la clase para que maximicen el aprendizaje. Profesoras en el colegio de su niño(a) van a participar semanalmente en el entrenamiento y supervisión. Las actividades educativas diarias y horario no cambiaran como resultado de este estudio.
Profesoras y padres serán pedidos completar un formulario llamado Lista de Comportamiento del Niño versión para padres (CBCL) y versión para profesoras (C-TRF) tres veces durante el año escolar, al principio, mitad y al fin del entrenamiento para evaluar los efectos del entrenamiento de los profesores en el comportamiento de los estudiantes. Junto el formulario de los padres y profesoras se toman como 20 minutos para completar. La investigadora principal y la coordinadora del estudio tomará toda la información sobre su niño(a) y la mantendrá completamente confidencial. Durante el primer ciclo de entrenamiento la profesora de su niño será escogida para recibir el entrenamiento de ERNP o será escogida para el grupo de control cual no recibirá entrenamiento especializado. Todas las profesoras escogidas para el grupo de control durante el primer ciclo recibirán entrenamiento de ERNP durante el segundo ciclo.

**Entrenamiento de la Relación entre Niños-Profesoras (ERNP)**

ERNP es un modelo de desarrollo basado en juego apropiado para el entrenamiento de profesoras que usa intervenciones como la habilidad de empatía, estimulo, ajuste de límites y el dar escogidos. Estas habilidades son diseñadas para ayudar profesoras que manejen el comportamiento de los niños efectivamente y que mantengan disciplina en la clase para que maximicen el aprendizaje. Este entrenamiento le pone enfoque al desarrollo de una relación de profesora y estudiante basado en la filosofía que los niños que se sienten mas conectados a sus profesoras cuando tienen éxito en el colegio. Este entrenamiento también utiliza actividades basadas en el juego que son culturalmente responsivas y apropiadas para el desarrollo y habilidades que ayudan a las profesoras comunicarse con más eficacia con el manejo de el comportamiento de niños pequeños.

Profesoras serán entrenadas y supervisadas por consejeros profesionales que tienen entrenamiento avanzado de terapia de juego y el modelo de ERNP. El entrenamiento de ERNP consiste de 2 días y medio de entrenamiento intensivo de habilidades seguido por 22 semanas de 1 hora de entrenamiento y supervisión por semana.

**Descripción de los procedimientos/elementos que pueden resultar en molestia o inconveniencia:**

No hay riesgo personal o molestia directamente tributado a este estudio. Usted y/o su niño(a) pueden elegir a terminar su participación sin sanción o prejuicio.

**Descripción de los procedimientos/elementos que pueden ser asociados como previsible riesgos:**

No hay riesgos previsibles implicados con este estudio con excepción de éos asociados con actividades normales diarias.

**Beneficios para los participantes y otros:**

La relación entre el profesor y el niño(a) es significante para el desarrollo de niños jóvenes. Debido a esta importante relación, el profesores tiene potencialmente una considerable oportunidad para afectar el desarrollo de el niño(a). Por lo tanto, entrenando profesores para que
respondan a los niños con una manera más animadora y apropiada para el desarrollo del niño puede beneficiar aspectos del desarrollo de su niño incluyendo maneras cognitivas, comportamiento, socialización, y emocionales. Los niños que se sienten más conectados a sus profesoras tienen mejor actitud hacia el colegio y demuestran un nivel más alto de ambición y éxito académico.

**Confidencialidad de las notas del estudio:**

La información que usted nos ha proporcionado cuando usted contesta al cuestionario será mantenida confidencial, y no divulgada en cualquier publicación o discusión de este material. Todos los datos incluyendo evaluaciones serán asignados un número de código y mantenidos en un gabinete con candado para preservar confidencialidad. Para los propósitos de la investigación, solamente el investigador principal y el coordinador del proyecto tendrán acceso a la lista de nombres de los participantes y números de código. Al final del estudio la lista de nombres será destruida. A ningún momento funcionarios del colegio tendrán acceso a los datos de los participantes.

Las únicas excepciones a la confidencialidad son si a) un niño divulgó abuso, negligencia o la explotación, b) el niño son es un peligro a si mismo o a otra, persona c) una corte judicial ordena acceso a la información, o d) el padre o cuidandero legal peticiona soltar la información.

**Review for protection of participants:**

Este estudio investigativo ha sido revisado y aprobado por el Comité para la Protección de los Derechos Humanos de la UNT (940) 565-3940.

**Los derechos de los participantes de la investigación:**

Yo he leído o he hecho que me lean todo lo expresado arriba. Este estudio me ha sido explicado y todas las preguntas que he tenido han sido contestadas. Se me ha informado de todos los riesgos o molestias y posibles beneficios de este estudio.

Yo entiendo que mi niño(a) y yo no tenemos que tomar parte de este estudio, y que mi negación a participar o mi decisión de salirme no conllevará ninguna pena o perdida de los derechos o los beneficios o los recursos legales a los cuales tengo derechos. También entiendo que la investigadora puede decidir interrumpir la participación de mi niño(a) en cualquier momento.

En caso de que existan problemas o preguntas, se me ha dicho que puedo llamar a la Dra. Sue Bratton, (940) 565-3864.

Yo entiendo mis derechos como participante o parte del estudio investigativo, y yo voluntariamente estoy dando mi consentimiento para participar en el estudio. Yo entiendo a lo que se refiere este estudio y como y porque se están haciéndolo. Se me ha explicado que yo recibiré una copia firmada de esta forma de consentimiento.
Para la Investigadora o el (la) Designado(a):
Yo certifico que he recibido el contenido de esta forma con la persona que firmó más arriba, quien, en mi opinión, entendió la explicación. Yo he explicado los beneficios y riesgos conocidos de esta investigación.
APPENDIX B

CHILD-TEACHER RELATIONSHIP BUILDING SKILLS- CENTER TIME OBSERVATION FORM
Child-Teacher Relationship Building Skills- Center Time Observation Form

__Teacher  __Aide:  

Classroom Climate  1  2  3  4  5  

Name_____________________________ Observer___________________________  

Date______________________________ Begin Time_____ End Time_________

<table>
<thead>
<tr>
<th>RESPONSE</th>
<th>5 Minutes</th>
<th>5 Minutes</th>
<th>5 Minutes</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tracking/Reflect Non-verbal Play</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reflect Content</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respond to feelings, wants, wishes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Esteem building/ Encouragement</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Returning Responsibility (Show me what you want you me to do)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relational Responses (You wanted me to see…)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Choice Giving (You can choose the dolls or the puppets. Which do you choose?)</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>A-C-T Limit Setting</td>
<td></td>
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</tr>
<tr>
<td>Acknowledge Feeling</td>
<td></td>
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<tr>
<td>Communicate Limit</td>
<td></td>
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</tr>
<tr>
<td>Target Alternative</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Instructional Response</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Response</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*******************************************************************************

To be completed after the 15 minute observation

Ability to “Be With” Child Circle one:  1  2  
(Including being on child’s level, attention and interest, facial expression and tone matching child)

Additional Observer Notes:

REFERENCES


