2014

Child–Senior Relationship Training: Adaptation of CPRT for Kindergarten Students

Angela M Yoder

Danessa Carter, *Eastern Illinois University*

Breanna Way, *Eastern Illinois University*

Bobbi Ward, *Eastern Illinois University*

Alyssa Swan, *Eastern Illinois University*, et al.

Child–Senior Relationship Training: Adaptation of CPRT for Kindergarten Students

Angela M. Yoder, Danessa Carter, Breanna Way, Bobbi Ward, Alyssa Swan, and Amy Allison

Eastern Illinois University

Child–senior relationship training (CSRT) is an adaptation of child–parent relationship therapy (CPRT), a highly effective intervention for children, where trained senior citizen volunteers provide free play sessions for children whose parents are unable or unwilling to participate in CPRT. This study explored the effects of CSRT on kindergarten children and the senior volunteers' effectiveness with children following training. The researchers propose CSRT provides benefits to busy school counselors by closing the gap between the high number of students needing services and the historically low number of providers. Although CPRT has been shown to be more effective when used with parents, many times parent involvement is not feasible. CPRT has been successfully adapted for use with other populations such as teachers, aides, high school students, and fifth-grade students. School counselors can potentially provide services to many children by training and supervising seniors for 1.5 hr per week. In this study, researchers used findings from a pilot study to improve delivery of CSRT. Senior citizens were trained to provide 30-min play sessions each week to kindergarten children. Children's behaviors were measured by the Teacher Report Form. Although not considered therapy, results indicate seniors were capable of providing a therapeutic relationship that is hypothesized to assist children in improving behavioral and social-emotional problems. Four single-case studies are presented to examine the effects of CSRT.

Keywords: child–parent relationship therapy, child–senior relationship training, play therapy, play therapy in schools, senior citizens as therapeutic agents

Children in schools today face issues far beyond academic concerns. Although school counselors are expected to prioritize academic concerns for service delivery, social-emotional issues certainly impact a student's academic work. With high student-to-counselor ratios, school counselors have very little time to address life-changing concerns such as abuse, neglect, domestic violence, homelessness, grief, loss, and mental illness. Abdelnoor and Hollins (2004) examined how death of a family member affected children and found a decrease in school achievement and an increase in anxiety among those who had lost parents. According to Glaze and Maruschak (2008), over half of all prisoners in the United States are parents of minor children. The Department of Health and Human Services (2012) reported over half a million indicated cases of abuse and neglect annually. The majority of those cases involve children under the age of 10.

According to the National Institute of Mental Health (NIMH), roughly one out of every five children meets the criteria for a mental health disorder (NIMH, 2010). Unfortunately, many of these children are not receiving services because of service costs, transportation problems, and stigma associated with visiting a mental health facility (Catron & Weiss, 1994). Schools are natural choices to close the gap between the number of children who need services and the number of children who are actually receiving them as school services are normally provided free of charge. Because children attend school daily and are regularly pulled from classes for a variety of reasons, neither transportation nor stigma is an issue.

In today's educational system, school financial problems often prevent the ratio recommended by American School Counseling Association (ASCA) of 1 school counselor for every 250 students (ASCA, 2009). Therefore, many students are unable to be seen by their school counselor. School counselors are overwhelmed and spread thin between meetings, character education classes, students in crisis, trainings, and large group guidance activities. This leaves little time for them to meet on a consistent basis with students, although they are typically required to respond to their behavioral problems. According to ASCA (2009), the national average is one school counselor for every 450 students, while Illinois' average is one school counselor for every 667 students. At the school where the current study was conducted, there was one school counselor employed for 755 students. Because of the high number of students under one counselor's caseload, there was a waiting list for students throughout the fall semester. Because of the child-senior relationship training (CSRT) intervention, students who otherwise would not have been seen regularly by the counselor were able to receive services. Another advantage to the study was that parents/guardians did not face issues with transportation or cost because play sessions were done at school during school hours. Lastly, although four volunteers were used due to a site change, a school counselor could likely accommodate a CSRT group of eight to 10 volunteers, under normal circumstances. In time, seniors could potentially serve more than one child as their developing skills are monitored in group supervision, allowing the counselor to provide services to many more children with an investment of a few hours a week.

CHILD-PARENT RELATIONSHIP THERAPY

Originally conceptualized by Bernard and Louise Guerney in 1964, filial therapy is designed to help children heal and grow through play sessions led by a parent or primary caregiver (Landreth, 2012). After adding more structure to this model, Landreth and Bratton (2006) later coined the term child-parent relationship therapy (CPRT). Play, a child's medium of communication, is used to facilitate and strengthen the relationship between the child and the parent. In CPRT, trained play therapists lead 10 group sessions where caregivers are trained in child-centered play therapy techniques and receive ongoing group supervision of weekly recorded play sessions. By using these skills, the parent ideally develops a therapeutic relationship with the child. This relationship is argued to be transformative for the child, causing positive changes in behavioral and social-emotional functioning

(Landreth & Bratton, 2006). Parents meet with their child for 30-min play sessions once a week and bring these taped sessions to the group for supervision. Results of a meta-analysis on play therapy suggest this therapeutic model is highly effective (Bratton, Ray, Rhine, & Jones, 2005). Other researchers have noted the success of CPRT to treat a variety of problems. Specifically, researchers have noted decreases in externalizing and internalizing behavior problems (Kidron & Landreth, 2010; Landreth & Bratton, 2006), greater child adaptability, leadership, and social behavior (Post, McCallister, Shelly, Hess, & Flowers, 2004), improved academic success (Landreth & Bratton, 2006); and improved parental acceptance of children and decreased parenting stress (Dillman, Purswell, Lindo, Jayne, & Fernando, 2011; Bratton & Landreth, 1995). CPRT also appears to have long-lasting effects. In one study, 80% of parents reported using CPRT a year after the group ended (Kidron & Landreth, 2010).

CPRT ADAPTATIONS

In CPRT, the parent is crucial to the model's success; however, researchers have proven that this intervention is effective with other parties serving as the therapeutic agent. CPRT has been successfully adapted for use with a variety of school personnel serving as the therapeutic agent. Morrison, Bennett, and Bratton (2011) studied the effectiveness of the child-teacher relationship training, using teachers instead of parents. The researchers concluded that children in the experimental group experienced a significant reduction in target behaviors, with a statistically significant reduction in externalizing and total problem behaviors. After training kindergarten teachers, paraprofessionals, and firstgrade teachers using kinder training, Draper et al. (2001) noted a significant decrease in negative behaviors and improvements in use of adaptive behaviors and literacy skills. Post et al. (2004) found that 2-4 year-old children whose teachers completed kinder training showed decreases in internalizing behavior problems and increases in adaptive coping skills, whereas teachers demonstrated increases in empathy and improvements in play therapy skills. One year later, those same teachers reported continued use of play therapy and empathy skills in the classroom setting (Hess, Post, & Flowers, 2005). Similarly, results of a CPRT adaptation study with high school students revealed decreases in behavioral problems of pre-K and kindergarten students (Jones, Rhine, & Bratton, 2002).

ETHICAL CONCERNS AND THE USE OF PARAPROFESSIONALS

Because paraprofessionals, by definition, do not possess formal university training, concern exists regarding using them with child populations. According to Yoder et al. (2013), potential problems may occur with regard to confidentiality, boundaries, and child problems surpassing the volunteer's skill level. Senior volunteers must be carefully screened and closely supervised to maintain all participants' safety and comfort levels. In the current study, each participant was screened through a two-part process. Appropriate volunteers were selected through a senior volunteer program and then met with the principal investigator to complete an interview and

preliminary screening materials. In addition, each play session was videotaped. Graduate assistants were outside the playroom for every session to provide assistance if necessary. A research team member met with each child's teacher around the middle of the study to rule out any problems and to monitor the child's progress. In addition, the principal investigator had weekly contact with the principal to discuss any problems. Training material must specifically address boundaries, roles, countertransference, and confidentiality issues both before and potentially after they arise (Yoder et al., 2013). In the current study, volunteers were not allowed to meet with the children until after they had received basic CPRT training and information about boundaries, confidentiality, and their roles as CSRT volunteers. Despite the potential problem areas, the authors submit that with proper attention to these issues, the benefits outweigh the risks associated with use of paraprofessionals as these children would not otherwise receive any services at all. In addition, because school counselors are at the school each day, they can more easily monitor progress and be available for emergencies while continuing to do their own work. Lastly, unlike traditional mental health centers, schools routinely use volunteers and often already have many necessary protocols in place.

PRACTICAL IMPLEMENTATION

Because school counselors are stretched thin, time-efficient models must be developed in which counselors invest small amounts of time to produce many opportunities for clinical intervention. The children targeted for CSRT take time from administrators, teachers, and school counselors due to absences, behavioral problems, and parent meetings. It is proposed that school counselors work with administrators before the school year begins to negotiate the 1.5 hr needed to run the CSRT group, asking that an activity such as lunchroom, recess, or an administrative duty be dropped from their schedule. It is our experience that administrators welcome interventions that decrease discipline referrals and problematic behaviors. In the pilot study (Yoder et al., 2013), one principal noted that a child who had previously been in his office three to four times per week hadn't been seen all semester. In the current study, behavioral problems decreased and therefore took less time away from the principal, teachers, and school counselor. In CSRT, the roots of behavioral problems are able to be addressed rather than reacting to each situation as it arises. For example, CSRT may uncover that a child is homeless or experiencing domestic violence, when she had previously been viewed by the school staff as defiant. CSRT also optimally prevents problems from becoming worse and requiring more staff time. This model requires very little preparation time on the part of school counselors due to the fact that the curriculum is already established. For schools in which the counselor is unable or unwilling to make the time, other mental health professionals might negotiate use of CSRT with school administration. The following outlines practical implementation of this model.

Prior to School

1. Training in child-centered play therapy and CPRT.
2. Connect with RSVP coordinator to explain CSRT program and provide selection criteria to assist coordinator in choosing appropriate volunteers. (1 hr)
3. Explain CSRT to potential participants in group format. Volunteers provide availability. (1 hr)
4. Choose participants and contact via email to set up orientation meeting. (15–30 min)
5. Orientation meeting. Begin rapport building. Collect emergency contact information, release to be videotaped, and supervision contract. Cover confidentiality, boundaries, dos and don'ts. Participants provide preferred playtimes. (1 hr)
6. Begin to select toys (for school counselors who do not possess a totebag playroom, they may try a toy drive where they send out a request the first week of school or at registration for donated toys). (minimum of 30 min to 1 hr)
7. Set up at registration to have parents fill out forms to avoid problems getting paperwork returned and to answer questions. Provide handout on CSRT and contact information for questions.
8. Schedule play times with teachers via email. (15 min)
9. Weeks 1–3: Meet with seniors to cover training on reflective responding, utilizing play therapeutically, and to practice skills. These sessions could be done before or after school begins depending on school counselor preference. (4.5 hr)

After School Begins

10. Weeks 4–15: Meet with seniors 1.5 hr per week for training and supervision.

The authors propose that the holiday and summer vacations are natural breaks that assist children and seniors with termination. For maintenance, Weeks 1–3 may be omitted and seniors may be assigned more children at the discretion of the CSRT group leader, further lightening the case load for school counselors.

METHOD

Participants

Participants were four kindergarten children and four senior citizen volunteers. Seniors were recruited by the Lifespan Center Retired Senior Volunteer Program director from over 450 listed volunteers. Seniors completed a criminal background check and were screened for appropriateness with the following requirements: (a) age 55 and older in good physical and mental health, having never been convicted of a felony; (b) never been formally accused or convicted of a child-related crime of any kind including physical abuse, sexual abuse, emotional abuse, or neglect; (c) ability to be playful and enjoy the company of a child; and (d) open to feedback from others. All four seniors self-identified as White, with an age range between 64 to 80 years of age. These four seniors were paired with four kindergarten children

ranging from 5 to 6 years old, two boys and two girls; three children identified as White and one as biracial.

Although the study was initially designed for a larger sample size at an elementary school, complete with an experimental and control group, a school staff health emergency necessitated the study to be offered at a nearby kindergarten school. The kindergarten school's staff felt uncomfortable with a control group; therefore, the methodology was adapted to four single-case studies. The school social worker identified children who were struggling with some sort of psychosocial or environmental problem but were not currently suffering from a psychological disorder or receiving counseling. Parents/guardians were then contacted by a researcher to determine if they were interested in participating in the study. Following parental informed consent, children met with the research team to determine child assent for the project using an age-appropriate informed consent that was read and explained to each child.

Measures

Because the researchers felt strongly about the need for adequate training before having any play sessions with children, seniors received CSRT for 3 weeks before play sessions began. Although a true baseline was therefore not possible for measuring each senior's ability to be therapeutic, the researchers nevertheless decided to monitor their skills at pre and postintervention with the Measurement of Empathy in Adult-Child Interactions (MEACI; Bratton, Landreth & Homeyer, 1993) as is often the standard in CPRT studies. Because of the small sample size, a single-case study design (Ray & Schottelkorb, 2010) was adopted. To measure child behavior problems reported by teachers, The Teacher Report Form (TRF; Achenbach & Rescorla, 2001) was used because of its well-established validity and reliability. The researchers were also interested in parent and primary caregiver ratings of child behavior and therefore the Child Behavior Checklist (CBCL; Achenbach & Rescorla, 2001) was also used. Both the TRF and CBCL have three domain scales: Internalizing, Externalizing, and Total Problem scales. Scores below 65 are considered in the normal range. Clinical range is > 65 with a borderline range of 60-65. The Attention Deficit Hyperactivity Disorder (ADHD) ADHD subscale was also examined due to elevations in two of the children's scores and referral problems. Clinical range for this subscale is > 70 with a Borderline range of 65-70. The Older Adult Self Report (Achenbach, Newhouse, & Rescorla, 2004) was selected to screen for overall potential problems for senior volunteers and to monitor quality of the relationship.

Procedure

Senior volunteers were trained at the university for 1.5 hr and conducted 30-min play sessions with a kindergarten child each week for 10 weeks. At the beginning of the study, seniors met with the primary researcher to ask questions about the pilot study and select play times. A kick-off party including seniors, children, and the

research team was then scheduled with the children to explain the study and facilitate relationship building. Seniors met the children and received potential questions to ask their target child for rapport-building. At the kickoff, children saw the toys and learned more about the play sessions, where sessions would take place, how long sessions would last, start/end date of the study, and signed an assent form. All children at the kick-off chose to participate in the study.

Small adjustments were made to adaptations of the curriculum from the pilot CSRT study (Yoder et al., 2013) including changing the developmental information to fit the kindergarten population and emphasizing certain parts of the curriculum per feedback from participants regarding what was most helpful (i.e., practicing the skills together, practicing common problems). The remainder of the curriculum remained the same, with the exception of extending the number of sessions per the findings of the pilot study (Yoder et al., 2013). The study was initiated later in the school year in an attempt to avoid honeymooning behaviors in children at the beginning of the school year and behavioral problems were screened with even more vigor at the beginning to assure an appropriate level of problem behaviors to match the child's need and the volunteer's ability to work with each child (Yoder et al., 2013). In the pilot study, changes to the CPRT material included consideration of time of year and subsequent driving conditions, larger type print of materials, scheduling of sessions to allow for travel/medical appointments, personalization of examples to fit a newly developing relationship versus an intact one, removing parent-child specific information and adding a brief review of child development to facilitate accurate understanding of child communication in play sessions and typical behaviors of school-age children (Yoder et al., 2013). Motivational stories were a favorite part of each training session as reported by participants. Attention was given to gearing this material toward the senior citizen population and their interests in helping children, as well as addressing worries that the CSRT wasn't working, as this was a prevalent issue for seniors in the pilot study (Yoder et al., 2013). Graduate assistants were present outside the room in case of emergency and burned DVDs for supervision purposes. However, seniors often helped with setup and cleanup, commenting that they could manage these tasks by themselves.

RESULTS

The effectiveness of CSRT was measured via four single-case studies to provide detailed data and to account for a small sample size. Children's behaviors were also measured before, at midpoint, and after the CSRT intervention by the TRF. The CBCL was provided to parents/caregivers as well, but the posttest materials were not returned. Names, identifying information, and some details were changed to protect confidentiality of participants.

Stacey

Stacey was a 6-year-old White female referred by her teacher for uncontrolled energy, attentional problems, defiance, stealing, and impulsive behavior. Stacey also

displayed regressive behaviors such as thumb sucking, asking to be held, or rocking in the fetal position on the floor. According to the teacher, Stacey was very unhappy that her mother was expecting a baby in the next few months. The teacher had attempted a variety of behavioral methods such as positive reinforcement and a reward system to attempt to curb the problematic behaviors without success prior to the CSRT treatment.

During play sessions, a distinct “disease to please” quickly emerged as Stacey began to subtly, and then very overtly, work to earn the affection of the volunteer. She poured tea, made the volunteer’s “favorite” cookies, cleaned up after herself, made her pictures, tried to make her laugh, attempted to be cute, and giggled incessantly. Her volunteer, Karen, struggled to refrain from praising Stacey, as her need to be liked was so apparent. Stacey resisted her volunteer’s calm redirection. During one session, Karen reflected Stacey’s need to hear that people liked what she did, and added that in here, it was more important what she thought. Stacey yelled back at her, “Yes you are right! NOW, Yay or Nay! Do you like it or not?!” In addition, toward the beginning of the study, the teacher became concerned about Stacey’s repeated stealing. Upon further inquiry, it was discovered that Stacey was taking items from wealthier students and giving them to poor students whom she wanted to befriend. The case conceptualization determined by the team was that Stacey acted out to gain the attention of others related to a deep need to be liked. This need to gain others’ affection was intensified by her fear of being rejected and replaced by her sibling who was about ready to be born.

Although Karen worried Stacey wouldn’t feel accepted, she followed through with the group’s recommendations to celebrate Stacey’s efforts, prize her uniqueness, return responsibility, and reinforce the child’s opinion as more important. Gradually, as Stacey settled into a relationship with a deep, abiding unconditional acceptance, she began to trust Karen. More importantly, she began to listen for her own voice and began to trust herself. As Stacey began to engage in a healthy, therapeutic relationship, she thrived under the positive regard and acceptance and began to see herself as more competent. She began exploring the playroom, became more creative, and stopped trying to entertain the volunteer. The giggling stopped and she ceased asking if the volunteer liked what she was doing. As the play themes began to change, her behavior at school changed as well. Despite her mother having the baby in the middle of the study, Stacey’s referral behaviors steadily declined (see Figure 1). It is notable that on both the Externalizing and ADHD problems subscales (see Figure 1 and 2), her scores decreased from clinical level at pretest to borderline level at posttest.

Laura

Laura was a 5-year-old White female referred for hostility, impulsivity, negativity, defiance, noncompliance, academic problems, and attachment issues related to a hostile and chaotic home environment. Laura’s brother had been seen by the school social worker for similar referral problems. Both the teacher and social worker

described a high amount of familial conflict and punitive parenting practices reported by children and witnessed by school personnel.

Figure 1. Stacey's Teacher Report Form domain scale scores.

Figure 2. Stacey's Teacher Report Form ADHD subscale scores. ADHD attention deficit hyperactivity disorder.

During play sessions, Laura was incredibly negative toward her volunteer, Bonnie. Bonnie was especially adept at waiting for Laura to label toys and only used labels the child provided. However, when Bonnie used Laura's labels, she would yell at the volunteer and tell her it was something else. This dynamic continued during the sessions to the point that the volunteer began feeling very defeated. With encouragement and support, along with a greater understanding of the child's issues, Bonnie forged ahead, maintaining unconditional positive regard, while reflecting the child's anger and frustration. Interestingly, Bonnie was a former speech pathologist, as were a few members of the group. Each noticed a speech problem that likely frustrated Laura. The group hypothesized that, along with her mother's alleged negativity and hostility toward her, she was also contending with speech problems that caused others to constantly correct her. Having very few anger management skills herself and unhealthy attachments with others, Laura was left to manage a great deal of anger, frustration, and fear. As a result, the child was

referred for speech services. In addition, Bonnie steadfastly maintained her positive regard and assisted the child in identifying, accepting, and appropriately expressing her emotions. The group soon noted that the child began to calm considerably and enjoy her time with Bonnie. Her “corrections” began decreasing both in number and intensity over the course of the study. Group members noticed that a relationship was clearly forming as Laura finally began to physically approach Bonnie, engage her in reciprocal play, and develop an appropriate attachment to her. Laura began “caring” for Bonnie via nurturing play and occasionally singing to her. Her teacher reported fewer episodes of anger, defiance, and hostility. She continued to describe her as “standoffish” and Laura continued some noncompliant behavior, but at a much lower rate. This was surprising to the school and the CSRT group as Laura’s father was incarcerated and the family became homeless in the middle of the study. As Figures 3 and 4 illustrate, Laura’s scores on the both the TRF Total and ADHD subscales steadily declined from clinical to borderline level.

Figure 3. Laura’s Teacher Report Form domain scale scores.

Figure 4. Laura’s Teacher Report Form ADHD subscale scores. ADHD attention deficit hyperactivity disorder.

John

John was a 6-year-old White male referred for separation anxiety and school refusal. John's teacher reported John was missing more days of school than he was in attendance. John's parents had been contacted several times, but because kindergarten is not required, the school could not enforce the attendance policy. The team planned for John to view the playroom ahead of time with a trusted adult present, but John remained hesitant. He struggled greatly to feel comfortable in the playroom despite the volunteer's careful attention to providing a sense of safety, security, and predictability. During play sessions, John repeatedly asked when playtime would be over and watched the clock. His volunteer, Gladys, began feeling increasingly insecure about her ability to help this child or to develop a relationship with him. He often sat still and asked his volunteer what he should do or sat with his back to her and explored the toys quietly. As Gladys reflected John's anxiety and continued to provide predictability and permissiveness with safety, John began to visibly relax.

In fact, during one supervision session, the volunteer was asked to stop the tape and reflect on the physical differences she noticed in the child. John was now sitting directly in front of Gladys with his legs and arms open and facing her, looking up into her face smiling. He had stopped asking about or referring to time and began engaging in meaningful play. In fact, the play themes included elements of danger and problems with personal safety. There was typically a mother and child figure that would eventually be chased down by an angry monster of some sort and both would hide under the stairs. The school contacted the principal investigator approximately midway through the study asking for help as John was failing to benefit academically due to missing more days than he was present. The investigator agreed to meet with the mother to offer support as John had seemed to change his attitude toward school and seemed to look forward to being there. His absences were also affecting his participation, although the volunteer frequently rescheduled to make certain he received his play time. During this meeting, the mother acknowledged keeping the child at home due, in part, to fear of domestic violence occurring in the home. She denied the child being harmed or herself for that matter, but described fear of physical violence based on the amount of verbal aggression that had sometimes occurred in the past. John's mother described his father as a changed man, but reported her own lifelong anxiety intensified her fears that violence may return. The child failed to report any abuse or neglect, so no formal reports were made to Child Protective Services. However, the primary researcher provided referrals for family and individual counseling, shelters, and financial assistance for which the mother expressed appreciation.

As their relationship developed, John began looking forward to both his sessions and coming to school. His teacher reported that his anxiety had decreased significantly and she did not notice any more separation anxiety. She added that the parents would occasionally elicit school protest by returning to the room after dropping him off, and turning around several times to get additional goodbye hugs

despite knowing that would cause crying episodes. Although John's attendance improved slightly, truancy continued to be a problem even disrupting the goodbye party the group held for the children. After a phone call and offers to provide transportation if needed, John's mother did bring him for the party. Although John's internalizing behavior problems declined, there was not a steady decline (see Figures 5 and 6). However, it is notable that separation anxiety was the primary referral problem.

Figure 5. John's Teacher Report Form domain scale score.

Figure 6. John's Teacher Report Form ADHD subscale scores. ADHD attention deficit hyperactivity disorder.

Leigh

Leigh was a 6-year-old biracial female residing with her father. According to the father, Leigh's mother was addicted to drugs and possibly incarcerated. As a result, visitation with her had been disrupted. Leigh reported anger and confusion regarding her lack of contact with her mother, especially because her mother was expecting a new baby. She was referred for failing to have appropriate boundaries,

active defiance, verbal aggression, and social skills problems. Upon meeting her at the kickoff party, her volunteer immediately identified Leigh's boundary problems as Leigh repeatedly asked to remove items from the room and playroom and violated school rules. She was quite persistent with her requests, rattling the volunteer from the beginning, despite her training in therapeutic limit setting. Leigh's volunteer, Sarah, struggled to set and maintain appropriate limits and often asked the group leader if she could buy Leigh a toy or allow her to violate a rule by allowing her to leave the blanketed area during play sessions. Leigh frequently roamed around the room as the volunteer struggled to maintain the boundary. Leigh very much looked forward to her sessions with Sarah and was quite upset if she could not have a session. Sarah was very touched by this and, as a result, worried that the child would feel rejected or angry if she set limits. This dynamic, along with the volunteer's family medical crisis in the middle of the study, strongly impacted their therapeutic relationship. Sarah went above and beyond to have every session with Leigh, scheduling her travel around her play sessions. However, she missed some group trainings, and therefore the support, which likely would have assisted her in her development. She also struggled to play her DVDs on her home computer. Because her computer was too old to play a DVD, the team provided Sarah with a DVD player. But this delay impeded Sarah's ability to watch and benefit from viewing her sessions. This likely affected Sarah's MEACI scores, which actually worsened over the course of the study. Similarly, Leigh's scores did not improve as can be seen in Figures 7 and 8.

Figure 7. Leigh's Teacher Report Form domain scale scores.

DISCUSSION

First, all children engaged in play that reflected the general problems and psychosocial stressors they were having in their lives. Stacey engaged in regressive play and worked to gain the acceptance of her volunteer; Laura demonstrated hostile relationship and attachment themes; John played out frightening domestic problems; and Leigh tested limits. Second, the senior volunteers were able to build meaningful relationships with the children, which appeared to help each child use

Figure 8. Leigh's Teacher Report Form ADHD subscale scores. ADHD attention deficit hyperactivity disorder.

the play to make sense of and cope with life difficulties. Researchers noted a general trend for problematic scores on the TRF to decrease with three out of four children from baseline to midpoint to posttest. These decreases in scores appeared to correspond with training and comprehension of skills. It is notable that the senior who was unable to complete training had a child whose scores did not decrease over time. Training and supervision is obviously a critical piece of this type of intervention. Although this senior watched tapes of the group training, being part of the training and practicing with others is of considerable importance. In addition, this senior struggled to view her sessions in a timely manner due to technology problems. This has implications for future research and application of CSRT in school settings.

Per the findings of the pilot CSRT study (Yoder et al., 2013), the researchers began the study later in the year, increased the number of sessions, and attempted to target children with sufficient symptomology to benefit from CSRT, while not surpassing the paraprofessional's skill level. Although this appeared to have positive results, the researchers and volunteers hypothesized that increasing the sessions even more may have yielded a greater change between pre- and posttest TRF scores because the relationship between senior volunteer and child is not an already established one, nor an ongoing relationship (e.g., such as with parents or teachers). In addition, in most CPRT studies, child behavior change is reported by the individual providing the play sessions. Because CPRT is a relationship-based model, it changes the way the child perceives and interacts with the adult, as well as the way in which the adult connects with and engages with the child. Through training and supervision, adults optimally learn to empathize with their target child. A natural result is that their understanding of the child's problematic behaviors increases, and also likely changes their endorsement of symptoms. Lastly, the child may change their behavior within the context of this therapeutic relationship before

generalizing this change to other relationships. This issue is important to consider when evaluating the current study and planning for future research in this area.

The current study sought to determine whether CPRT could be successfully adapted for use with senior citizen volunteers in the kindergarten setting. A previous study (Yoder et al., 2013) used a pretest–posttest design to measure change in problem behaviors before and after CSRT with elementary-aged children. Although results were not statistically significant, anecdotal evidence provided some support for its effectiveness. In the current study, researchers originally set out to use an experimental and a control group with a larger sample size to address some of the limitations of the pilot study. Unfortunately, the chosen school abruptly withdrew from the study because of an unforeseen staff medical problem. Therefore, the team approached a local kindergarten to offer CSRT services and adapted the research design to include four in-depth single-case studies. This unforeseen change in methods prevented planning for a proper single-case design with multiple data points (Ray & Schottelkorb, 2010), as school staff felt the TRF was too lengthy to fill out more frequently (e.g., weekly or biweekly). The small sample size continues to be a major limitation of the study, limiting the conclusions one can draw from the data and the study's generalizability. However, it does add to a body of knowledge that will optimally grow regarding the effectiveness of CSRT. This study echoes some of the anecdotal evidence from the pilot study including improvement of adaptive behavior problems and the ability of the senior volunteers to establish strong, meaningful relationships with the children. In addition, the school reported ongoing gratitude and positive comments regarding the usefulness of CSRT in the school setting.

It is hypothesized that a trained school counselor could lead a CSRT group of 8–10 seniors. Although it is recommended that initially seniors only work with one child at a time, following adequate training and supervision, seniors could work with more children as their skills developed. This 1.5–2-hr investment in CSRT groups could result in many children being seen. Because school counselors are housed in the school, they would be available for emergencies and supervision problems if they occurred (graduate assistants were available in this study but were never used). School counselors could more easily identify appropriate children and monitor progress as they enjoy more ongoing contact with teachers and other staff who provide referrals and data about how the child is doing. A computer could be made available for seniors to burn DVDs or simply view them at the school. The researchers in this study were able to find uncomplicated, yet effective cameras that easily burned to economical CDs. Consent forms could be collected at registration as counselors frequently already have an idea of children that need assistance from the previous year.

CONCLUSION

According to ASCA, one school counselor should serve approximately 250 children. Because this is far from the reality, school counselors struggle to address the

multilayered problems they must face in their school systems. Senior volunteers provide free services and have the potential to see children that would not otherwise receive services. At the same time, training senior volunteers in CSRT appears to benefit the senior population by providing opportunities for giving back and continued generativity and developmental integrity, as well as new learning opportunities and a feeling of usefulness through a therapeutic relationship with a child (Yoder et al., 2013). Similarly, children have the benefit of a relationship with a caring, empathic adult and the opportunity to learn to appropriately identify and express feelings, solve problems, practice impulse control, and make positive choices. As noted by Yoder et al., paraprofessionals should not be confused with therapists, and attention must be given to supervision, training, and monitoring of play sessions by a trained school counselor. However, using this model, a school counselor could provide 1.5 hr of group supervision and gain in return several hours of services provided by senior volunteers. As seniors continue training and demonstrate skill mastery, the number of students receiving play sessions could increase.

Although many submit that studies must have large numbers of participants and both an experimental and control group to produce scientific information, others argue that case studies have been widely used since the beginning of the psychotherapy field and provide critical information and deeper insight into the use of particular interventions (Ray & Schottelkorb, 2010; Snow, Wolff, Hudspeth, & Etheridge, 2009). This study investigated the effectiveness of CSRT via four singlecase studies in a kindergarten setting to provide detailed and specific information for practitioners. The findings suggest a value to the children but are limited in generalizability. Future research should be done with a larger sample size and optimally a control group.

REFERENCES

Abdelnoor, A., & Hollins, S. (2004). The effect of childhood bereavement on secondary school performance. *Educational Psychology in Practice*, 20, 43–54. doi:10.1080/0266736042000180401

Achenbach, T. M., Newhouse, P. A., & Rescorla, L. A. (2004). *Manual for the ASEBA older adult forms and profiles*. Burlington: University of Vermont, Research Center for Children, Youth, & Families.

Achenbach, T. M., & Rescorla, L. A. (2001). *Manual for the ASEBA school-age forms and profiles*. Burlington: University of Vermont, Research Center for Children, Youth, & Families.

American School Counseling Association. (2010). Student to counselor ratio by state: 2009–10. Retrieved from <http://schoolcounselor.org/files/Ratios09-10.pdf>

Bratton, S., & Landreth, G. (1995). Filial therapy with single parents: Effects on parental acceptance, empathy, and stress. *International Journal of Play Therapy*, 4, 61–80. doi:10.1037/h0089142

Bratton, S., Landreth, G., & Homeyer, L. (1993). An intensive three day play therapy supervision/ training model. *International Journal of Play Therapy*, 2, 61–79. doi:10.1037/h0089366

Bratton, S. C., Ray, D., Rhine, T., & Jones, L. (2005). The efficacy of play therapy with children: A meta-analytic review of treatment outcomes. *Professional Psychology: Research and Practice*, 36, 376–390. doi:10.1037/0735-7028.36.4.376

Catron, T., & Weiss, B. (1994). The Vanderbilt school-based counseling program: An interagency, primary-care model of mental health services. *Journal of Emotional and Behavioral Disorders*, 2, 247–253. doi:10.1177/106342669400200407

Department of Health and Human Services. (2012). Child maltreatment. Retrieved from <http://www.acf.hhs.gov/sites/default/files/cb/cm2012.pdf#p.31>

Dillman, D., Purswell, K., Lindo, N., Jayne, K., & Fernando, D. (2011). The impact of child parent relationship therapy on child behavior and parent-child relationships: An examination of parental divorce. *International Journal of Play Therapy*, 20, 124–137. doi:10.1037/a0024469

Draper, K., White, J., O'Shaughnessy, T. E., Flynt, M., & Jones, N. (2001). Kinder training: Play-based consultation to improve the school adjustment of discouraged kindergarten and first grade students. *International Journal of Play Therapy*, 10, 1–29. doi:10.1037/h0089441

Glaze, L. E., & Maruschak, L. M. (2008). Parents in prison and their minor children (Bureau of Justice Statistics Special Report). Washington, DC: Bureau of Justice Statistics.

Hess, B. A., Post, P., & Flowers, C. (2005). A follow-up study of kinder training for preschool teachers of children deemed at-risk. *International Journal of Play Therapy*, 14, 103–115. doi:10.1037/h0088898

Jones, L., Rhine, T., & Bratton, S. (2002). High school students as therapeutic agents with young children experiencing school adjustment difficulties: The effectiveness of a filial therapy training model. *International Journal of Play Therapy*, 11, 43–62. doi:10.1037/h0088864

Kidron, M., & Landreth, G. (2010). Intensive child parent relationship therapy with Israeli parents in Israel. *International Journal of Play Therapy*, 19, 64–78. doi:10.1037/a0017516

Landreth, G. L. (2012). *Play therapy: The art of the relationship* (3rd ed.). New York, NY: BrunnerRoutledge.

Landreth, G. L., & Bratton, S. C. (2006). *Child parent relationship therapy (CPRT): A 10-session filial therapy model*. New York, NY: Routledge.

Morrison, B., Bennett, M. O., & Bratton, S. (2011). The effects of child teacher relationship training on the children of focus: A pilot study. *International Journal of Play Therapy*, 20, 193–207. doi: 10.1037/a0025833

National Institute of Mental Health. (2010). Statistics for children and adolescents. Retrieved May 23, 2012, from <http://www.nimh.nih.gov/statistics/index.shtml>

Post, P., McCallister, M., Shelly, A., Hess, B., & Flowers, C. (2004). Child-centered kinder training for teachers of pre-school children deemed at-risk. *International Journal of Play Therapy*, 13, 53–74. doi:10.1037/h0088890

Ray, D., & Schottelkorb, A. (2010). Single-case design: A primer for play therapists. *International Journal of Play Therapy*, 19, 39–53. doi:10.1037/a0017725

Snow, M. S., Wolff, L., Hudspeth, E. F., & Etheridge, L. (2009). The practitioner as researcher: Qualitative case studies in play therapy. *International Journal of Play Therapy*, 18, 240–250. doi:10.1037/a0016364

Yoder, A. M., Larson, H. A., Washburn, F., Mills, S., Carter, D., Brausch, B., & Lee, J. (2013). Adaptation of the child-parent relationship therapy model for use with senior citizen volunteers in school settings: A pilot study. *International Journal of Play Therapy*, 22, 75–89. doi:10.1037/a0032325