

Research article

On the Investigation of the Effects of Play on Educational Behavior; Evidence from Elementary Schools

Dr. Marzieh Dehghani

Assistant Professor
E-mail: dehghani_m33@gmail.com

Elnaz Bakhshi

E-mail: elnazbakhshi5@gmail.com
(M.A Student at Virtual Learning Course)
Department of Educational Sciences and Psychology
Tehran University, Tehran, Iran



This work is licensed under a [Creative Commons Attribution 4.0 International License](http://creativecommons.org/licenses/by/4.0/).

Abstract

This study was intended to focus the viability of play as a system for mediation for youngsters with a mixture of passionate and behavioral issues. Particularly, the study was pointed at deciding the effectiveness of play help in: (an) enhancing plans toward oneself of kids with change troubles; (b) lessening disguising conduct issues, for example, withdrawal, physical grumblings, nervousness, and melancholy; (c) lessening externalizing behavioral issues, for example, hostility and reprobate practices; (d) diminishing general conduct issues, social issues, thought issues, and consideration issues of kids with change troubles; and (e) diminishing child rearing anxiety of folks of kids who were encountering modification challenges. The experimental group comprised of 15 kids who were encountering a mixture of change troubles and accepted play help once for every week for 7 to 10 weeks. The control group comprised of 14 kids who were encountering a mixture of change troubles and who were on a holding up rundown to accept mediation, and consequently, did not accept any medication throughout the time of information gathering. Experimental and control groups were randomly selected from 5 elementary schools in Ahvaz Province, Iran. An increase scores investigation uncovered that kids in the test gathering exhibited a

noteworthy change on disguising conduct issues. Likewise, a lessening in externalizing conduct issues and child rearing anxiety was watched. No change in thought toward oneself was exhibited. This study gives confirm that play treatment is a feasible intercession for treating an assortment of passionate and behavioral troubles in junior kids, especially youngsters who are encountering disguising conduct issues.

Keywords: Educational Behavior, Elementary Schools, Role Playing,

Introduction

Meeting the mental health needs of children is increasingly challenging due to limitations of the managed health care delivery system, coupled with alarming rises in child abuse and neglect, child violence, and emotional and behavioral problems of children (Friedman, 1997; Ginsberg, 1995; Gullotta, Adams, & Montemayor, 1998). Friedman (1997) argued that mental health services have been significantly affected by the increased reliance on managed care companies due to out-of-control costs of health care. Thus, issues of accountability, efficiency, and effectiveness play a larger role in mental health services than ever before. Furthermore, national statistics on children point to the need for greater efforts to provide services that will ensure the mental and emotional health of our children (Ginsberg, 1995). Ginsberg (1995) asserted, "the plight of children, perhaps the most disadvantaged Americans, will become increasingly severe as the development of services continues to lag behind the development of social problems and needs" (p. 89). Importantly, unresolved childhood problems are likely to extend into adulthood, where their amelioration poses a much greater challenge. In order to effectively help young children who are experiencing emotional and behavioral difficulties, mental health professionals must be particularly sensitive to children's unique developmental needs (Landreth, 1991). In the early years of development, children are rapidly undergoing cognitive, socio-emotional, and physiological changes. An important part of early development is the acquisition of language (Piaget, 1980). Piaget maintained that language development is structured by, and dependent upon, cognitive development. According to Piaget (1952), the child between the ages of 4 and 7 is in a preoperational stage of cognitive development and the child from 7 to 11 is in a concrete operational stage. Children at these stages have not yet developed the language capacity of adults. They have a limited ability to accurately articulate their life experiences and the content of their inner cognitive and emotional world (Landreth, 1991). Rather than continuously engage in verbalizations to express their inner life, as do adults, children in the preoperational and concrete operational stages are absorbed in play throughout most of the waking day, acting out their experiences, experimenting with adult roles, rehearsing for future events, developing competencies, achieving mastery, and simply trying to make sense of their world (Landreth, 1991). The preoperational stage is characterized by the development of basic language and other forms of representation and rapid conceptual development (Wadsworth, 1984). According to Piaget, preoperational thought is prelogical. Children at this stage are not able to perform operations, or, schemas of connected relational reasoning. For example, preoperational children cannot conserve, or grasp the reality that two things that are equal remain so if their shape is manipulated. Also, their logic is also limited by irreversibility: once they concentrate on one aspect of a phenomenon, they have difficulty reverting to a previously experienced perception of that same event or object. Next, children at this stage reason by transduction: they move from particular to particular without taking the general into account, and simultaneous events seem to have a cause and effect relationship. Finally, they tend to concentrate, focusing on one aspect of a situation and neglecting others, and cannot decenter, or think about several aspects of an event simultaneously. Through the developmental processes of assimilation and accommodation, the plethora of experiences and activities that fill children's lives during their early years lead them into the stage of concrete operational at about age 7 (Wadsworth, 1984). Children at this stage are able to think logically about the here and now, conserve quantities, serialize items, and deal with logical relationships. They also begin to assimilate the concepts of time and space. However, problem solving remains at the trial and error level. Children generally remain in this stage until about age 11. Piaget has probably been one of the most influential child developmentalists, fostering increased sensitivity toward and awareness of the uniqueness of children's capacities at varying stages of cognitive development. Piaget's

(1962) research has indicated that children are not able to competently engage in abstract reasoning until about the age of 11, which supports the notion that children have an underdeveloped capacity for language processing. Despite his landmark contributions to the body of knowledge on children's cognitive development and language acquisition, researchers following Piaget's work have suggested that even Piaget had a tendency to overestimate the young child's cognitive ability to understand and use language. In several experiments, children misinterpreted tasks they were asked to perform and had difficulty retelling stories they had just heard (Mandler, in Pines, 1983). Often, children had an accurate grasp of cause and effect relationships, but experienced difficulty comprehending language and using language to convey their understanding of events. This research further supports the notion that children have an underdeveloped capacity for language. Language is a complex process that requires the ability to abstract (Piaget, 1980). Since words are made of abstract symbols, language requires the ability to form abstract cognitions and to effectively verbalize those cognitions in order to be utilized proficiently. Before the age of 11, children are developmentally functioning in a concrete reality where their capacity to verbalize their knowledge of experiences is far less than that of adults. Language is only one way among others to communicate one's knowledge (Sinclair-deZwart, 1973). Unlike adults, whose natural medium of expression is verbalization, the child's natural medium of self expression is play (Axline, 1947; Ginott, 1960; Landreth, 1991).

Review of Literature

The review of the literature concentrates on the following three elements: (a) History and Development of Play Therapy, (b) Rationale for Using Play Therapy, and (c) Clinical Efficacy of Play Therapy. Prior to this century, cognitive and emotional difficulties of children were not recognized. Instead, children's negative behavioral manifestations were attributed to forms of excess such as studying or working too hard, climatic changes, or being frightened or shocked (Gelfand, Jensen, & Drew, 1997). Little was understood about human development and stages of development, and thus, it was commonplace for children to be viewed as miniature adults. By the turn of the century, no methods or approaches to working with children could be considered child psychotherapy (Kanner, 1957, as cited in Landreth, 1991). In the early part of this century, however, children's problems started gaining recognition and there were several attempts to administer psychological treatment to children. Sigmund Freud authored the first published case describing a psychological approach to working with a child in 1909. This was the classic case of "Little Hans," a five year old boy with a phobia. Importantly, "Little Hans" is the first recorded case in which a child's problems were attributed to emotional difficulties (Landreth, 1991). Freud treated Hans indirectly by advising the child's father of ways to resolve Hans' underlying conflicts and fears. Freud's work led others to investigate the utilization of psychotherapy with children. There are four major developments in play therapy: psychoanalytic play therapy, release therapy, relationship therapy, and non-directive therapy. The first major development in play therapy took place after efforts to apply psychoanalysis to children proved to be ineffective and inappropriate. Analysts discovered that unlike adults, children did not verbalize their anxieties. Furthermore, children were reluctant to describe issues in their past and resisted attempts to have them free-associate (Landreth, 1991). Play was not directly used in child therapy until 1919 by Hermine Hug-Hellmuth (O'Connor, 1991). Hug-Hellmuth was one of the first therapists to emphasize the importance of child therapy and to provide play materials to children in therapy to foster self-expression. Although she did not develop a theoretical approach, she did discourage the application of methods of adult analysis to children (Landreth, 1991). Shortly after Hug-Hellmuth introduced the use of play in child therapy, Melanie Klein (1955) began utilizing play to analyze children under the age of six years. Klein believed that play therapy provided direct access to the child's unconscious. Therefore, analysis took place without needing the child to "free associate." In essence, the child's play served as a substitute for verbalization and free association, and provided the material (e. g. the expression of the unconscious) from which she drew her interpretations. Klein also believed a key role of the therapist was to be a facilitator of transference. According to Klein, the best way to explore the child's unconscious was to analyze the child's transference relationship with the therapist (Landreth, 1991). In 1928, Anna Freud (1946) applied principles of psychoanalysis to children in therapy. However, Freud did not agree with Klein's view in the necessity of the therapist being a facilitator of transference or with Klein's use of interpretations which she felt to be excessive and

extreme (Schaefer, 1985). Instead, she used play as a means of developing a therapeutic alliance an emotional relationship - with the child before interpreting the unconscious motivations behind a child's behavior. Thus, play was utilized as a means of fostering the child's emotional attachment to the therapist in order to attain access to the child's inner world. Although Klein and Freud used play in different ways, the primary goal of each of their approaches was to help children work through difficulties by facilitating insight. The two women both agreed that the therapist should work to uncover the child's past and to strengthen the child's ego by understanding and interpreting the symbolic content of the child's play. The 1930's marked the second major development in play therapy with the introduction of release therapy. David Levy (1939) developed this structured approach for working with children which is characterized by the following: (1) a psychoanalytic framework, (2) at least a partial belief in the cathartic value of play, and (3) the active role of the therapist in determining the course and focus of therapy (O'Connor, 1991). Levy (1939) differed from psychoanalysts in that he believed the release play therapist should not utilize interpretations or attempt cognitive restructuring. The child's play was not used as a means of achieving insight. Instead, he viewed the therapeutic experience as an opportunity for the child to abreact feelings associated with traumatic events. Gove Hambidge (1955) expanded upon Levy's release therapy, retitling it "structured play therapy." He saw structured play therapy as a technique used whereby the therapist implements a series of stimulus situations that the child plays out. The therapist assumes the responsibility for the play therapy experience. The therapist's job is to gain background from the child's family and to attempt to recreate in dramatic play an event or situation like the one causing distress (Landreth, 1991). Hambidge attempted to directly recreate the event or anxiety-producing situation to facilitate the child's abreaction. "Structuring a child's play so he or she reexperiences a stressful situation can not only allow for a release of pent-up emotions but also assist the child to cognitively assimilate the event and master it" (Schaefer, 1985, p. 101). The third significant development in play therapy took place with the emergence of relationship play therapy. This approach is based on the work of Otto Rank (1936), who stressed the importance of birth trauma in development. Rank de-emphasized the significance of transference and past events in therapy. His focus was on the therapist-client relationship and the here and now of the client's life. Taft (1933), Allen (1934), and Moustakas (1959) applied Rank's basic philosophical principles to work with children in play therapy (as cited in O'Connor, 1991). All three believed that birth trauma may cause children to have difficulty individuating from their primary caretaker and to have problems forming deep positive relationships. In relationship play therapy, emphasis is placed on the "curative power" (Landreth, 1991, p. 31) of the therapeutic relationship. Allen (1942) asserted, "Therapy emerges, then, from an experience in living, not in isolation but within a relationship with another from whom the patient can eventually differentiate himself as he comes to perceive and accept his own self as separate and distinct" (p. 49). In this approach, the child takes the lead in the therapy process, and the therapist focuses on material that is of importance to the child. The work of Virginia Axline (1947) marked the fourth major development in play therapy. Axline modified concepts of Carl Rogers' non-directive therapy and applied them to children in play therapy. The objectives of non-directive play therapy are self-awareness and self-direction (Landreth, 1991). In non-directive play therapy, the therapist does not attempt to foster a transference relationship, to offer interpretations, to structure the session, or to lead the child's play in any way. Instead, the non-directive play therapist "actively reflects the child's thoughts and feelings believing that when a child's feelings are expressed, identified, and accepted, the child can accept them and then is free to deal with these feelings" (Landreth, 1991, p. 32). Axline (1947) argued that children have within them all of the necessary components for growing and becoming. She stressed the importance of the relationship between therapist and child, which allows the child to feel safe so that the process of growth may occur. Through the therapeutic relationship, the child is able to achieve emotional maturity and to grow through expression and exploration of the various levels of the emotional process. Until the relationship conveys conditions of empathy, warmth, and permissive understanding in the playroom, the child will continue to be maladjusted. Once the child experiences a relationship where he/she feels fully accepted, respected, and understood, the child is free to fully experience self and is driven towards health and a self-directed life. Recent developments in play therapy have concentrated on integrating elements of the aforementioned approaches into other theoretical frameworks and applications. For example, the development of Gestalt play therapy, Adlerian play therapy, family play therapy, and the introduction of filial therapy (training parents in child-centered techniques). Children's problems are complicated by communication barriers with adults in their lives.

Often, adults are unable to understand or to respond appropriately to children's feelings or attempts to communicate (Landreth, 1982). Adults express their thoughts and feelings through verbalization, which is a formal mental process requiring the ability to transform personal experiences into abstract symbols. Children do not have the capacity to accurately perform such complex operations until the age of eleven (Piaget, 1962). Instead, children express their thoughts and feelings via play (Ginott, 1960). To limit young children to strictly verbal communication is to deprive them of the means by which they communicate. Ginott (1960) posited that the rationale for using play in the diagnosis and treatment of maladjusted children is that play is the child's symbolic language of self-expression. "Through the manipulation of toys the child can state more adequately than in words how he feels about himself and the significant people and events in his life. To a considerable extent, the child's play is his talk and the toys are his words" (p. 243). Children develop character through experiences with persons and situations, which do not come about as a result of words. They internalize their experiences, assimilate them, and make them a part of their personality. Lowenfield (1935) contended that the process of play therapy bridges the gap between the child's consciousnesses and emotional experiences. She reasoned that its therapeutic usefulness is derived from the fact that it represents to children the externalized expression of their emotional lives and "fulfills the role that conversation, introspection, philosophy, and religion have for the adult" (p. 324). Likewise, Froebel (1912) argued, "Play...is the highest expression of human development in childhood, for it alone is the free expression of what is in a child's soul." (as cited in Lowenfield, 1935, p. 30). Axline (1947) believed play allows children to express themselves in areas that have been pressing for expression and exploration. Through play, the child is able to feel and release feelings and attitudes that need to be resolved. By "playing out" emotions, the child is able to realize the power the child has to make decisions and to become an independent and mature person. Lowenfield (1935) asserted, "without adequate opportunity for play, normal and satisfactory emotional development is not possible (p. 324). Erikson (1964) asserted, "I propose the theory that child's play is the infantile form of the human ability to deal with experience by creating model situations and to master reality by experience and planning"(p. 10). Furthermore, he summarized his rationale for utilizing play as a therapeutic technique when he said, "The child uses play to make up for defeats, sufferings and frustrations, especially those resulting from a technically and culturally limited use of the language" (Erikson, 1940, p. 561). Moustakas (1959) contended that play in and of itself is not therapeutic, but rather a relationship that develops in a free play situation based on faith, acceptance, and trust is therapeutic. Patterson (1974) concurred with this line of thinking when he posited that children can only grow and develop fully as persons in the context of relationships with other people. In the same vein, Landreth (1991) emphasized the importance of the therapeutic relationship in play therapy. Of particular importance is "the ability of the therapist to understand the child's communications and to create an environment which allows the child to communicate freely" (p. 117). The attitude and skill of the therapist creates the therapeutic environment while play provides the medium through which the child can communicate. Play therapy has been utilized and assessed for effectiveness in a number of studies and with a variety of populations. However, little research has been experimentally designed. Most has been in the form of case studies or anecdotal reports. Case studies have been described as the weakest approach to assessing treatment outcomes due to the lack of internal and external validity (Gall, Borg, & Gall, 1996) and the inability to control for confounding variables. LeBlanc (1998) stated, "While case study or descriptive research provides an interesting perspective of play interventions and suggests its effectiveness, such research should not be considered as evidence of the utility of play therapy" (p. 39). Experimental studies are preferred to case studies since they increase the validity of research by controlling for the effects of extraneous variables. Experimentally designed studies involve at least two equivalent groups of children formed by randomization procedures: a treatment group and at least one comparison group. The following section includes controlled studies concerned with determining the effectiveness of play therapy; specifically, the available studies that investigated the effectiveness of individual play therapy. Bills (1950) tested the use of child-centered play therapy to improve reading skills of third graders who were experiencing delayed reading development. Statistically significant gains in reading skills were observed in the treatment group after receiving six individual and three group play therapy sessions. The results were believed to be from either: (1) the children having learned at a more rapid pace because of the play therapy or, more likely, (2) the children were able to maximize retained information that they had previously experienced difficulty using effectively. Mundy (1957) assessed the impact of non-directive play therapy on levels of I.Q. and social adjustment

of children who were mentally challenged. Quantitative results indicated relevant differences between treatment and control groups with respect to I.Q. measurements. A qualitative assessment of social adjustment determined that after treatment, most of the children in the treatment group became qualified for special academic programs for which they had previously been considered unqualified. Additionally, there were observed decreases in tantrums, while socially cooperative and constructive behaviors increased. Siegel (1970) investigated the efficacy of child-centered play therapy in a year-long study. Forty-eight second to fifth grade children with learning disabilities were divided into the following groups: children who received play therapy, children whose parents received parental counseling, children who received play therapy and whose parents received parental counseling, and children assigned to a control group. Learning disabled children who received play therapy demonstrated significant improvement in cognitive, affective, psychomotor, and environmental domains. Pelham (1972) found play therapy to be an effective intervention for immature kindergarten children. Pelham sought to determine whether self-directed play therapy effectively increases the social maturity of kindergartners who had been identified by teachers as socially immature. When compared children in the control group, children who had received either individual or group play therapy demonstrated significantly increased maturity. Measures of self-concept and flexibility to new experiences revealed that children in these two groups scored more positively than those in the control group. In addition, classroom behaviors as reported by teachers improved significantly. Newcomer and Morrison (1974) assessed the impact of play therapy interventions on the social and intellectual functioning of institutionalized children who were mentally challenged. Quantitative analysis revealed significant results both for children receiving individual play therapy and children receiving group play therapy. Children in the control group demonstrated no change. Additionally, the results revealed no difference in the efficacy of individual versus group play therapy. Qualitative observations corresponded with the quantitative results and suggested that directive play therapy may be more effective in treating children's emotional and behavior problems than non-directive play therapy.

Methodology

A quasi-experimental design was utilized in this study to measure the effectiveness of individual play therapy with young children experiencing a variety of behavioral and emotional problems. Participants were children ages 4 through 6 with a variety of adjustment difficulties (n=29). Both experimental group (n=15) and control group (n=15) participants were referred by parents and/or teachers for counseling due to adjustment difficulties. Only the experimental group received play therapy. At termination of the study and as counselors became available, control group participants received intervention for their presenting adjustment problems. No child was denied treatment as a result of being in the control group. Test (JPPSST). A global score indicates the child's self-concept. Child participants' behaviors were rated by one of the child's parents via completion of the Child Behavior Checklist (CBCL). The specific behaviors measured are grouped under Internalizing Behavior Problems and Externalizing Behavior Problems. The total score also includes social problems, thought problems, and attention problems. Parent participants' stress levels were rated by their completion of the Parenting Stress Index (PSI). Specific levels measured are categorized in a Child Domain and a Parent Domain. The following discussion includes the hypotheses, definitions of terms, instrumentation, and selection of subjects, collection of data, and the statistical analyses.

Hypotheses

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

- 1) Children in the experimental group will attain a significantly higher mean total score at post testing than will children in the control group.
- 2) Children in the experimental group will attain a significantly lower mean total score on the Child Behavior Checklist (CBCL) posttest than will children in the control group.

- 3) Parents of children in the experimental group will attain a significantly lower mean total score on the Parenting Stress Index (PSI) posttest than will children in the control group.
- 4) Children in the experimental group will attain a significantly lower mean score on Externalizing Behavior Problems on the CBCL posttest than will children in the control group.
- 5) Children in the experimental group will attain a significantly lower mean score on Internalizing Behavior Problems on the CBCL posttest than will children in the control group.
- 6) Parents of children in the experimental group will attain a significantly lower mean total score on the Parent Domain of the PSI posttest than will children in the control group.
- 7) Parents of children in the experimental group will attain a significantly lower mean total score on the Child Domain of the PSI posttest than will children in the control group.

Data Collection

The investigator met with qualified participants and their guardians prior to the beginning of the investigation to: a) explain the purpose and requirements of the study; b) provide information pertaining to the maintenance of confidentiality; c) address any questions or concerns of participants and their guardians; and d) obtain informed consent. The guardian was asked to identify the child by writing the child's name on the consent form prior to signing it. In addition, the child was given a copy of the child consent form to read or look at as the investigator read the form aloud to the child. The child was asked to sign or make his or her mark if the child agreed to participate. After obtaining informed consent from parents, each subject in the experimental group participated in a 45- 47 minute play therapy session once per week for 7 to 10-weeks. The individuals administering the treatment, play therapy, were graduate students who were pursuing either a master's degree or doctorate degree in counseling, and who specialized in play therapy. Two of the therapists were doctoral students who held master's degrees in counseling, and eleven were master's students who were in the final phase of their training. The CBCL, the PSI, and the JPPSST were administered for the purpose of pretest and posttest data collection. Pretest and posttest instruments were administered to experimental subjects by the play therapists who were administering the treatment. The instruments were administered immediately prior to treatment and immediately following treatment for the purpose of data collection. Control group subjects were administered the pretest and posttest instruments immediately prior to and immediately following a ten-week period whereby no treatment was administered. All information provided by the participants was kept confidential.

Data Analysis

Instruments were scored and double-checked following the collection of the pretests and posttests. The data were keyed into the computer and analyzed by the researcher using SPSS for MS Windows Release 8.0. The data were then analyzed via a sequence of two one-way multivariate analyses of variance (MANOVA). The independent variable for the analysis was group membership (i.e. experimental and control); the dependent variables for the first MANOVA consisted of change scores on the Total CBCL, Total PSI, and the JPPSST. The dependent variables for the second MANOVA consisted of change scores for the Internalizing and Externalizing subscales of the CBCL and the Parent Domain, Child Domain, and Life Stress subscales of the PSI. A MANOVA of change scores was deemed more appropriate than analyzing the data using a MANCOVA. Specifically, a MANOVA was utilized to analyze change from pretest to posttest as opposed to artificially equating the groups at pretest as in MANCOVA (Maxwell & Delaney, 1990). A level of significance of .05 was established as the criterion for either retaining or rejecting the hypotheses.

Results and Discussion

The results of this study are presented in the order the hypotheses were tested. Multivariate analyses were performed on all hypotheses and a level of significance of .05 was established as the criterion for either retaining or rejecting the hypotheses. Results of evaluation of assumptions of normality, homogeneity of variance-covariance matrices, linearity, multi-collinearity, and detection of outliers were deemed satisfactory. The data were analyzed via a sequence of two one-way multivariate analyses of variance (MANOVA). The independent variable for the analysis was group membership (i.e. experimental or control). The dependent variables for the first MANOVA consisted of change scores on the JPPSST, Total CBCL, and Total PSI. The dependent variables for the second MANOVA consisted of change scores for the internalizing and externalizing subscales of the CBCL, and the Parent Domain and the Child Domain of the PSI. Table 1 presents the results of the first MANOVA. Table 2 presents the results of the second MANOVA.

Table 1. Multivariate Analysis of Variance

F-Tests	F Ratio	df	p	η^2
Multivariate Analysis Wilks Lambda	1.21	3.23	0.34	0.15
Univariate Analysis				
CBCL	0.69	1.25	0.43	0.04
PSI	3.58	1.25	0.08	0.14
JPPSST	0.12	1.25	0.75	0.02

The first MANOVA using the Total Scores from the CBCL, PSI, and JPPSSC was not significant, $F(3,23) = 1.203$, $p = .34$, $h^2 = .14$. Although the MANOVA was not significant, the effect size was sufficiently large enough to present the univariate ANOVAs for clarification. It is presumed that the lack of significance was due to low power due to small group sizes as opposed to the absence of a group effect. Analysis of the univariate ANOVAs (i.e. change scores for JPPSSC, Total CBCL, and Total PSI) revealed that the change in parenting stress demonstrated a marginally significant difference between experimental and control groups, $F(1,24) = 4.566$, $p = .07$, $h^2 = .13$ (see Table 2). As seen in Table 2, analysis of the mean change scores demonstrated that subjects in the experimental group (mean = 36.38; standard deviation = 50.88) demonstrated a larger decrease in stress than did subjects in the control group (mean = 5.38; standard deviation = 30.26). The second MANOVA using scores from the CBCLs ubtests, Internalizing Behavior scale and Externalizing Behavior scale; and from PSI subtests, Child Domain and Parent Domain, was significant $F(5,21) = 6.69$, $p = .001$, $h^2 = .61$. Therefore, it was necessary to proceed to

interpreting the univariate ANOVAs. Analysis of the univariate ANOVAs revealed that the change in Internalizing Behaviors demonstrated a significant difference between experimental and control groups. Table 2 presents the pre and posttest means and standard deviations for the experimental and control groups.

Table 2. Mean Scores of Pre- and Post Tests

Group	Pre-test			Post-test	
	N	Mean	SD	Mean	SD
Experimental	15	60.076	9.461	58.434	11.322
Control	15	50.776	10.643	48.997	8.009

The results of this study revealed that children receiving individual play therapy experience at least moderate improvement in adjustment difficulties. Of the 7 presented hypotheses, 1 was retained and the other 6 were rejected. However, a positive trend is evidenced in each of the dimensions under investigation, with the exception of self-concept, which remained stable. An explanation of these findings is discussed below. Experimental group children showed no significant improvement in self-concept as indicated by the Joseph Pre-School and Primary Self-Concept Screening Test (JPPSST) (gain mean = 0.000). However, parents' comments and therapists' observations supported the notion that most of these children demonstrated greater self-confidence, increased autonomy, and improved comfort in social situations and interpersonal relationships – all characteristic of an improved self-concept (Joseph, 1979). For example, one father of an experimental group child reported that his son had become more "self-assured" since he started receiving play therapy. The father stated, "Chris is initiating more frequent interactions with peers; and at school, he is starting to raise his hand to answer questions - something he has not attempted in the past for fear of what the other children would think of him if his answer were wrong." Several play therapists also elaborated on how experimental group children developed more confidence and independence. Important is the possible existence of a ceiling effect, one of the limitations of performing a gain scores analysis (Gall, Borg, & Gall, 1996) due to children rating themselves in the moderately high to high range at the administration of the pretest. A ceiling effect would place a restriction on the distribution of gain scores across initial levels of self-concept, leaving virtually no room for improvement. Although there appears to have been observable improvement as reported by parents and play therapists, children in the experimental group did not report significant change as a group (gain mean = 0.000) in perception of self. There are several possible explanations for the occurrence of a ceiling effect in this study. First, all of the participants' behavioral problems developed after the occurrence of one or more recent life changes, such as starting kindergarten, divorce of parents, moving, death in the family, birth of a sibling, etc.; and it is believed that participants' internalizing and externalizing behaviors are manifestations of their attempts to adjust to recent experiences in their lives (Gil, 1991). Since self-concept is a part of the individual that is stable over time (Joseph, 1979; Brownfain, 1965; Rogers, 1951), there may not have been enough time between the precipitating life events and the administration of the pretest for children to experience a change in self view. Thus, their reports revealed high self-concepts. If this is the case, it is hoped that play therapy has made a large enough impact on the experimental group children to prevent any future damage to their self-concepts by ameliorating current behaviors that may have otherwise resulted in negative emotional consequences.

Conclusion

This study has demonstrated the effectiveness of play therapy as a viable intervention for a variety of emotional and behavioral problems in children; particularly, difficulties such as shyness, social withdrawal, somatic complaints, anxiety and depression. Children receiving play therapy demonstrated more improvement in adjustment problems,

and parents evidenced less parenting stress, than children who were not receiving any type of intervention. The most remarkable improvements were observed in internalizing behaviors. Specifically, children became more socially interactive, experienced less anxiety, evidenced less somatic complaints, withdrew from social situations less often, and demonstrated greater feelings of security and contentment with themselves. Play therapy can serve as a treatment for problematic behaviors and has the potential to preclude the development of future emotional and behavioral problems. In addition to ameliorating immediate adjustment difficulties, play therapy can foster improved social acceptance by peers, family, teachers, and others. Social acceptance and a sense of belonging help provide security, comfort, and confidence in one's surroundings; and help foster the development of a positive self-concept. Joseph (1979) believed a child's self-concept may be the best predictor of a child's ability to succeed in life due to its instrumental role in influencing "emotional growth, academic achievement, interpersonal relationships, and the outcome of major life experiences" (p. 1). Social acceptability, a sense of belonging, and a healthy self-concept will benefit all children throughout the duration of their development and will help to ensure their becoming fully-functioning, socially-minded, well-adjusted adults.

References

- [1] Abidin, R. (1983). Parenting stress index. Charlottesville, VA: Pediatric Psychology Press.
- [2] Achenbach, T. M. (1991). Manual for child behavior checklist and 1991 profile. Burlington, VT: University Associates in Psychiatry.
- [3] Achenbach, T. & Edelbrock, C. (1983). Child behavior checklist. Burlington, VT: Author.
- [4] Allen, F. H. (1942). Psychotherapy with children. New York: Norton.
- [5] Axline, V. M. (1947). Play therapy: The inner dynamics of childhood. Boston: Houghton Mifflin.
- [6] Bills, R. E. (1950). Non-directive play therapy with retarded readers. *Journal of Consulting Psychology*, 14, 140-149.
- [7] Brownfain, J. (1965). Stability of the self-concept as a dimension of personality. In D. E. Hamacheck (Ed.), *The self in growth, teaching, and learning*. Englewood Cliffs, N. J.: Prentice-Hall.
- [8] Clatworthy, S. (1981). Therapeutic play: effects on hospitalized children. *Journal of Association for Care of Children's Health*, 9(4), 108-113.
- [9] Crow, J. (1990). Play therapy with low achievers in reading. Doctoral dissertation, University of North Texas, 1989. *Dissertation Abstracts International*, 50(9), B2789.
- [10] Crowley, S. L. (1985). Family functioning in families of children with disabilities: An intensive psychometric investigation of five family measures. Doctoral Dissertation, Utah State University.
- [11] Daniel, C. A., Rae, W. A., Sanner, J. H., Upchurch, J., & Worchel, F. R. (1989). The psychosocial impact of play on hospitalized children. *Journal of Pediatric Psychology*, 14(4), 617-627.
- [12] Donovan, D. M. (1997). Therapeutic play. *Journal of the American Academy of Child and Adolescent Psychiatry*, 36(1), 3-5.
- [13] Erikson, E. H. (1964). The meaning of play. In M. Haworth (Ed.), *Child psychotherapy*, (pp. 3-11). New York: Basic Books.
- [14] Erikson, E. H. (1940). Studies in the interpretation of play. *Genetic Psychology Monograph*, 22, 557-571.

- [15] Frank, L. K. (1955). Therapeutic play techniques: Play in personality development. *American Journal of Orthopsychiatry*, 25,576-590.
- [16] Friedman, S. (1997). Time-effective psychotherapy: Maximizing outcomes in an era of minimized resources. Boston: Allyn & Bacon.
- [17] Freud, A. (1946). The psycho-analytical treatment of children. New York: International Universities.
- [18] Gadow, K. D., & Pomeroy, J. C. (1993). Pediatric psychopharmacotherapy: a clinical perspective. In T. Kratochwill & R. Morris (Eds.), *Handbook of psychotherapy with children and adolescents*, pp. 356-402. Boston: Allyn & Bacon.
- [19] Gelfand, D. M.; Jensen, W. R.; Drew, C. J. (1997). *Understanding child behavior disorders*(3 rd ed.). Orlando: Harcourt Brace.
- [20] Gil, E. (1991). *The healing power of play: working with abused children*. New York: Guilford Press.
- [21] Ginott, H. (1960). A rationale for selecting toys in play therapy. *Journal of Consulting Psychology* 24(3), 243-246.
- [22] Ginsberg, L. (1995). *Social work almanac*(2ed.). Washington, D. C.: NASW Press.
- [23] Gullotta, G., Adams, G. R. & Montemayor, R. (1998). *Delinquent violent youth: theory and interventions*. Thousand Oaks, CA: Sage.
- [24] Hambidge, G. (1955). Structured play therapy. *American Journal of Orthopsychiatry*, 25,601-617.
- [25] Hauenstein, E., Scarr, S., & Abidin, R. R. (1987). Detecting children at-risk for developmental delay: Efficacy of the Parenting Stress Index in a non-American Culture. Unpublished manuscript, University of Virginia at Charlottesville.
- [26] Kelley, M. (1985). Review of Child Behavior Checklist. In J. V. Mitchell (Ed.). *The Ninth Mental Measurements Yearbook*, Vol. I. Lincoln, NE: University of Nebraska Press.
- [27] Klein, M. (1955). The psychoanalytic play technique. *American Journal of Orthopsychiatry*, 25,223-227.
- [28] Kot, S. (1995). Intensive play therapy with child witnesses of domestic violence. Unpublished dissertation, University of North Texas, Denton, TX.
- [29] Krall, V. (1989). *A play therapy primer: Therapeutic approaches to children with emotional problems*. New York: Human Sciences Press.
- [30] Landreth, G. L. (1996). *Play therapy interventions with children's problems*. Northvale, NJ: Aronson Landreth, G. L. (1993). Self-expressive communication. In C. E. Schaefer (Ed.), *The therapeutic powers of play* (pp. 41-63). Northvale, NJ: Aronson.
- [31] Landreth, G. L. (1991). *Play therapy: The art of the relationship*. Muncie, IN: Accelerated Development Press.
- [32] Landreth, G. L. (Ed.). (1982). *Play therapy: Dynamics of the process of counseling with children*. Springfield, Illinois: Thomas.
- [33] Landreth, G. L., Homeyer, L. E., Glover, G. & Sweeney, D. S. (1996). *Play therapy interventions with children's problems*. New Jersey: Aronson.

- [34] Levy, D. (1939). Trends in therapy: Release therapy. *American Journal of Orthopsychiatry*, 3,266-277.
- [35] Lowenfeld, M. (1935). *Play in childhood*. London: Gollancz.
- [36] McMahon, L. (1992). *The handbook of play therapy*. London: Routledge.
- [37] Milos, M. E., & Reiss, S. (1982). Effects of three play conditions on separation anxiety in young children. *Journal of Counseling and Consulting Psychology*, 50(3), 389-395.
- [38] Moustakas, C. E. (1959). *Psychotherapy with children: The living relationship*. New York: Harper.
- [39] Mundy, L. (1957). Therapy with physically and mentally handicapped children in a mental deficiency hospital. *Journal of Clinical Psychology*, 3-9
- [40] Newcomer, B. L., & Morison, T. L. (1974). Play therapy with institutionalized mentally retarded children. *American Journal of Mental Deficiency*, 78(6), 727-733.
- [41] O'Connor, K. (1991). *The play therapy primer: An integration of theories and techniques*. New York: John Wiley & Sons.
- [42] Oulline, V. J. (1975). Behavioral outcomes of short-term non-directive play therapy with preschool deaf children. Unpublished doctoral dissertation, North Texas State University, Denton, TX.
- [43] Patterson, C. (1974). *Relationship counseling and psychotherapy*. New York: Harper & Row.
- [44] Pelham, L. E. (1972). Self-directive play therapy with socially immature kindergarten students. Doctoral dissertation, University of Northern Colorado, 1971. *Dissertation Abstracts International* 32(07): A378.
- [45] Perez, C. (1987). A comparison of group play therapy and individual play therapy for sexually abused children. Doctoral dissertation, University of Northern Colorado. *Dissertation Abstracts International*, 48,(12A).
- [46] Piaget, J. (1962). *Play, dreams and imitation in childhood*. New York: Norton.
- [47] Piaget, J. (1952). *The origins of intelligence in children*. New York: Norton.
- [48] Piaget, J. (1980). Schemes of action and language learning. In Piattelli-Palmarini, M. (Ed.), *Language and learning: the debate between Jean Piaget and Noam Chomsky*. Cambridge: Harvard University Press.
- [49] Pines, M. (1983). In D. E. Papalia, & S. W. Olds, *Human development*, (5th ed.). New York: McGraw-Hill.
- [50] Quayle, R. L. (1991). The primary mental health project as a school-based approach for prevention of adjustment problems: an evaluation. Unpublished dissertation.
- [51] Rank, O. (1936). *Will therapy*. New York: Knopf.
- [52] Rogers, C. (1951). *Client-centered therapy: Its current practice, implications, and theory*. Boston: Houghton, Mifflin.
- [53] Satir, V. (1983). *Conjoint family therapy* (3rd ed.). Palo Alto, CA: Science & Behavior Books.
- [54] Satir, V.; Banmen, J.; Gerber, J.; & Gomori, M. (1991). *The Satir model: Family therapy and beyond*. Palo Alto, CA: Science & Behavior Books.
- [55] Schaefer, C. E. (1993). *The therapeutic powers of play*. Northvale, NJ: Aronson.

- [56] Schaefer, C. E. (1985). Play therapy. *Early Child Development and Care*, 19(2), 95-108.
- [57] Schaefer, C. E. & O'Connor, K. (Eds.) (1983). *Handbook of play therapy*. New York: Wiley & Sons.
- [58] Siegel, C. L. F. (1970). The effectiveness of play therapy with other modalities in the treatment of children with learning disabilities. *Dissertation Abstracts International* 31(08):A3970.
- [59] Sinclair-deZwart, H. (1973). Language acquisition and cognitive development. In Moore, T. E. (Ed.), *Cognitive development and the acquisition of language*. New York: Academic Press.
- [60] Yawkey, T. D. & Pelligrini, A. D. (1984). *Child's play and play therapy*. Lancaster, PA: Technomic Publishing.
- [61] Zakreski, J. (1983). Prematurity and the single parent: Effects of cumulative stress on child development. Unpublished doctoral dissertation: University of Virginia, Institute of Clinical Psychology.