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**A STUDY OF THE EFFECT OF GROUP FAMILY PLAY ON FAMILY  
RELATIONS FOR FAMILIES WITH CHILDREN CONSIDERED  
AT-RISK FOR EDUCATIONAL FAILURE**

by

**Carmen Colleen Baldus**

**A Dissertation  
Submitted to the  
Faculty of The Graduate College  
in partial fulfillment of the  
requirements for the  
Degree of Doctor of Education  
Department of Counselor Education  
and Counseling Psychology**

**Western Michigan University  
Kalamazoo, Michigan  
December 2001**

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**Carmen Colleen Baldus**

## TABLE OF CONTENTS

|   |             |
|---|-------------|
| <b>ACKNOWLEDGMENTS .....</b>  | <b>ii</b>   |
| <b>LIST OF TABLES .....</b>   | <b>viii</b> |
| <b>CHAPTER</b>  |             |
| <b>I. INTRODUCTION .....</b>  | <b>1</b>    |
| <b>Problem Situation.....</b>   | <b>4</b>    |
| <b>Purpose of the Study .....</b>   | <b>6</b>    |
| <b>Research Questions.....</b>  | <b>8</b>    |
| <b>Assumptions .....</b>  | <b>9</b>    |
| <b>Rationale and Theoretical Framework.....</b>   | <b>9</b>    |
| <b>Play Therapy .....</b>   | <b>10</b>   |
| <b>Family Therapy .....</b>   | <b>12</b>   |
| <b>Family Play Therapy .....</b>  | <b>16</b>   |
| <b>Theoretical Differences Between Family Therapy<br/>        and Play Therapy .....</b>  | <b>17</b>   |
| <b>Alliances Between Play Therapy and Family Therapy .....</b>                            | <b>19</b>   |
| <b>Benefits of Play in Therapy .....</b>  | <b>21</b>   |
| <b>Marriage of Family Therapy and Play Therapy:<br/>        Family Play Therapy .....</b> | <b>23</b>   |
| <b>Delineation of the Research Problem.....</b>   | <b>24</b>   |
| <b>Hypotheses.....</b>  | <b>25</b>   |



## Table of Contents—Continued

### CHAPTER

|  |    |
|--|----|
| Importance of This Study .....                                   | 25 |
| Definition of Terms.....   | 28 |
| Summary .....  | 30 |
| II. LITERATURE REVIEW.....                                       | 31 |
| Play.....  | 31 |
| Play Therapy History and Development .....                       | 33 |
| Play Materials .....   | 37 |
| Beyond the Scope of Children.....                                | 37 |
| Parents as a Support to Children in Therapy .....                | 38 |
| Parent Needs Exhibited .....                                     | 40 |
| Play Therapy Techniques for Families.....                        | 41 |
| History and Development of Family Therapy .....                  | 48 |
| Uniting Principles of Family Therapy With Play Therapy .....     | 51 |
| The Medium of Play .....   | 52 |
| Direct and Indirect Communication.....                           | 54 |
| Inclusion of All Family Members in the Therapeutic Process ..... | 55 |
| Engagement as a Form of Enactment.....                           | 57 |
| Paradoxical Nature of Play .....                                 | 59 |
| Summary of Common Ties.....                                      | 60 |
| Family Play Therapy .....  | 61 |

## Table of Contents—Continued

### CHAPTER

|  |           |
|--|-----------|
| Rationale for Family Play Therapy .....      | 61        |
| Empirical Study on Family Play Therapy ..... | 63        |
| Summary .....                                | 65        |
| <b>III. METHODOLOGY .....</b>                | <b>67</b> |
| Overview .....                               | 67        |
| Research Design .....                        | 67        |
| Selection of Subjects .....                  | 69        |
| Sampling .....                               | 70        |
| Instruments .....                            | 71        |
| Self-Report Family Inventory (SFI) .....     | 71        |
| Parenting Stress Index (PSI) .....           | 75        |
| Play Group Procedures .....                  | 77        |
| Research Assistants .....                    | 77        |
| Research Assistant Orientation .....         | 79        |
| Setting .....                                | 80        |
| Participation Agreement .....                | 81        |
| Pretest and Posttest Schedules .....         | 83        |
| Goals of Group Family Play Sessions .....    | 84        |
| Discussion Questions .....                   | 85        |
| Nature of Play Group Activities .....        | 85        |

## Table of Contents—Continued

### CHAPTER

|   |     |
|---|-----|
| Procedures .....                                    | 97  |
| Data Collection .....                               | 101 |
| Data Tabulation.....                                | 102 |
| Data Analysis.....                                  | 103 |
| Limitations.....                                    | 105 |
| Summary .....                                       | 106 |
| IV. FINDINGS .....                                  | 108 |
| Participants .....                                  | 108 |
| Procedure for Analyzing Data .....                  | 111 |
| Reporting the Data .....                            | 112 |
| Testing the Hypotheses .....                        | 113 |
| Results .....                                       | 114 |
| Summary .....                                       | 116 |
| V. DISCUSSION OF FINDINGS AND RECOMMENDATIONS ..... | 117 |
| Summary .....                                       | 117 |
| Discussion.....                                     | 119 |
| Recommendations.....                                | 131 |
| Conclusions .....                                   | 137 |

## **Table of Contents—Continued**

### **CHAPTER**

### **APPENDICES**

|  |            |
|--|------------|
| <b>A. Guidelines for MSRP Eligibility .....</b>                              | <b>141</b> |
| <b>B. Agency Agreement to Participate.....</b>                               | <b>143</b> |
| <b>C. Script for Telephone Interview.....</b>                                | <b>146</b> |
| <b>D. Adult Agreement to Participate.....</b>                                | <b>149</b> |
| <b>E. Child Agreement to Participate .....</b>                               | <b>152</b> |
| <b>F. Puppet Story Guide.....</b>  | <b>154</b> |
| <b>G. Informational Flyer .....</b>  | <b>156</b> |
| <b>H. Pretest and Posttest Scores.....</b>                                   | <b>158</b> |
| <b>I. Human Subjects Institutional Review Board Letter of Approval .....</b> | <b>167</b> |
| <b>BIBLIOGRAPHY .....</b>  | <b>169</b> |

**LIST OF TABLES**

1. **Solomon Four Group Design ..... 68**

2. **Demographic Data for Participants ..... 110**

3. **Group Mean Scores for SFI (Health/Competence) ..... 112**

4. **SFI Health/Competence ANOVA Results ..... 113**

5. **SFI Conflict (Raw Score) ANOVA Results..... 115**

6. **SFI Style ANOVA Results..... 115**

## **CHAPTER I**

### **INTRODUCTION**

**Ring around the rosies  
Pockets full of posies  
Ashes Ashes  
We all fall down.**

**Journey back to the days when, as a child engaged in this proverbial game, you rolled around in laughter and rose to play the game again. This was rehearsal for life, for life is about beauty, but it is also about death and falling down. Play is the vehicle through which children process life experience (Landreth, 1991).**

**Family Play Therapy is an eclectic technique combining elements from Family Therapy and Play Therapy and is designed for families with grade school or preschool aged children. It is to be used at the therapist's discretion as an adjunct to other kinds of intervention techniques, rather than as a therapeutic entity in itself. Wachtel (1994) used the analogy of the bay and the ocean to describe how the individual child is a separate entity from the family, yet influences and is influenced by the family constellation. This technique attempts to understand the child's anxieties, attitudes, and coping styles, as well as how the child's psychological makeup may in turn contribute to the family's stress and dysfunctional system.**

**Adults can share a childhood experience with their own children and may find therapeutic benefits result from engaging in play (Gil, 1994). The therapeutic value of play techniques is frequently misunderstood with respect to its impact on both**

children and adults. However, in an attempt to provide a therapeutic experience for children and parents where mutual acceptance, understanding, and the freedom to share feelings are possible, many professionals have found play to be an effective tool. Experimentation with the use of play techniques while working with both children and adults has held promise for some therapists (Eaker, 1994; Gil, 1994; Griff, 1983; Pare & Allen, 1996). The literature documents several benefits of the use of play techniques in therapy. The use of play increases the feasibility of including all family members in therapy (Keith, 1986). Play techniques also may foster communication between parents and children (Keith & Whitaker, 1981). In addition, the use of play techniques serves to reduce the anxiety experienced by family members in counseling (Eaker, 1986). More flexibility in family relationships is allowed when play techniques are introduced in counseling (Kobak & Waters, 1984). Play techniques also promote observation of family interaction patterns (Gil, 1994). Family Play Therapy, as a technique for working with individuals of all ages, is worthy of further exploration (Schaefer & Carey, 1994).

Because family members have in common a childhood experience, it is reasonable to expect that they will be able to understand and relate to each other if given an appropriate medium. Within such a medium, a shared language must exist. Although it may seem peculiar to discuss the use of play as a suitable adult therapy tool, Fogarty (1979) has observed, "Adults are large children and children are small adults, but aside from this there is little difference" (p. 6). Thus, Family Play Therapy is currently under investigation as a useful technique for engaging family members of

all ages in therapy (Gil, 1994). Therapeutic play techniques provide a shared medium in which the expressive and receptive communication between generations is fostered (Eaker, 1986; Keith & Whitaker, 1994).

Family Play Therapy, developed by Griff (1983), is considered a short-term technique used with children and families. The technique is used at a therapist's discretion as an adjunct to other kinds of intervention techniques. Griff stated:

Family play therapy provides an approach wherein parents can learn more effective parenting skills and styles of interaction in an environment that not only facilitates their receptiveness to this information, but also provides a medium that is comfortable for their children. This technique allows the therapist to be a role model for parents who previously had been exposed to deficient role models. It also provides a controlled and nonthreatening environment in which parents can comfortably experiment with change. (p. 67)

Literature on Family Play Therapy intervention was widely scattered and practitioners were poorly informed concerning developments in the field until 1994, when Charles Schaefer and Lois Carey published an overview in their comprehensive interdisciplinary book, entitled *Family Play Therapy*. In addition, Eliana Gil's book *Play in Family Therapy*, also published in 1994, was designed to offer a rationale for the use of play within family therapy sessions. Gil provides a history of the use of play in family therapy, with references to the late 1950s work of Nathan Ackerman, Virginia Satir, and Salvador Minuchin, all rigorous supporters of the inclusion of children in therapy. Although play materials and games were mentioned in their research, they did not extensively discuss the use of play in family therapy. Play in family therapy gained relatively little momentum throughout the 1960s and 1970s. In the early 1980s, Keith and Whitaker received a grant from the National Institute of



**Mental Health and published *Play Therapy: A Paradigm for Work With Families* (1981), which challenged the psychiatric community to consider play as an integral part of the family session. In addition to these earlier proponents of the use of play with families, Zilbach (1986), Scharff and Scharff (1987), Combrinck-Graham (1989), Ariel (1992), and Duff (1995) have all upheld the idea that families can be engaged in the therapeutic process through the use of play techniques.**

### **Problem Situation**

**Although Family Play Therapy has been recommended as worthy of investigation by therapists such as Keith and Whitaker (1994), Ariel (1992), Gil (1994), and Duff (1995), limited research is available on the subject, and empirical literature is severely lacking. The use of play with families was suggested in the late 1950s by family therapy pioneers such as Ackerman, Satir, and Minuchin, and limited research was conducted on the topic during the 1960s and 1970s. Gil (1994) speculated as to why Family Therapists were not prepared to deal with the foreign world of family-play combinations following its introduction. She suggested that family play may have been perceived as a passing fad, thus not given enough recognition. Family Play Therapy was also founded on a much smaller scale than other therapies at the time, possibly generating less interest. Therapists may have viewed play as too complex or abstract to be used in a practical manner with families, or they may have felt the techniques were too difficult to teach. Finally, Gil suggested the possibility that family play techniques may have had a paradoxical effect. Because**

they were proposed and demonstrated by charismatic and exceptional therapists, these very techniques may have seemed impossibly prohibitive to the standard practitioner.

Renewed interest in family play in the 1980s and 1990s has supported the development of creative and energetic techniques that may provide adults and children a common ground on which to communicate and problem-solve. Nonetheless, research efforts to study the effectiveness of techniques such as Family Play Therapy should be undertaken prior to dismissing them as impractical or embracing them uncritically.

In examining the literature concerning the specific technique of Family Play Therapy, one must rely primarily on the theoretical writings and experience of those who have forged a way to include even the youngest children in a family therapy setting. Much of the literature reviewed concerning the technique of Family Play Therapy involved case studies. In general, Kazdin (1982) noted that case studies have a valuable impact on the social sciences by potentially bridging the gap between researchers and practitioners in the applied social science fields (Moon & Trepper, 1996). As important as case studies are to the field, empirical evidence is needed to validate the impact of play on family relationships. Empirical research is extremely important as increasing numbers of families with children are presenting for counseling at various mental health agencies, with increasing restrictions on length of treatment. Documentation concerning effective family techniques remains crucial. Furthermore, a technique that can teach a family to take responsibility for its own

communication and problem-solving skills should serve to reduce recidivism. The use of Family Play Therapy as a viable technique for promoting growth and development in family systems remains under investigation.

### **Purpose of the Study**

This research design evaluates the effectiveness of Group Family Play on a family's perceived difficulty with health/competence, style (cohesion), and stress level. These constructs are noted to play a role in differentiating healthy from less healthy families (Abidin, 1995; Beavers & Hampson, 1990). The Beavers Systems Model emphasizes family competence, defining how well the family, as an interactional unit, performs the nurturing tasks of organizing and managing itself. This model assesses the structure of the family unit, using egalitarian leadership, strong parental or other adult coalition, and established generational boundaries as indicators of competence. Related to competence is the development of autonomy in individual family members, which carries with it increasing trust, clear boundaries, direct and clear communication, and the ability to resolve and accept differences. Those families viewed as competent are more readily able to resolve conflict and communicate openly and directly. One instrument derived from the Beavers Systems Model is the Self-Report Family Inventory (SFI). The SFI provides information concerning competence, style, cohesiveness, conflict, leadership, and emotional expressiveness (Beavers & Hampson, 1990). While the SFI provides significant information regarding family health, the Parenting Stress Index (PSI) looks at stress factors most

commonly associated with dysfunctional parenting. The literature suggests that these factors can lead to intense and frequent behavioral and emotional disturbance among children. The PSI assesses many facets, not just one element of the parent-child system. Child Characteristics, Parent Characteristics, and Life Stress are domains considered by the PSI. The present study investigates family play as a technique for working with all family members and will examine its effect on health/competence, style/cohesion, conflict, and stress level.

The present research expands upon a study by Duff (1995) in which families who scored in the optimal and adequate ranges of health on the SFI noted significant improvement in health/competence following the use of play intervention. To contribute to the field of Family Play Therapy, Duff designed an empirical study to investigate the effects of group play on family relationships. Her intervention with groups of families is referred to as Group Family Play. Volunteer families from several churches in Dallas, Texas, participated in a program involving seven structured play activities that required minimal therapist interaction. In the study, the SFI measured the major elements of health/competence and style. Six consistent factors assessed were health, conflict resolution, communication, cohesion, leadership, and emotional expression. Participation in "Group Family Play" resulted in more optimal functioning across all of these areas. Results of a Solomon Four Group Design indicated that the families viewed themselves differently following the play sessions and scored in a healthier range on the SFI. Duff noted that a few families

who scored in the dysfunctional range at the beginning of the study also showed improvements.

This researcher conducted a partial replication of Duff's research to study the effects of play on families whose children were defined as "at-risk" for future school failure. Childless couples were not excluded from family play, provided they had "at-risk" characteristics relevant to the adult, such as unemployment, history of family problems or history of school difficulty, to name a few. Thus, the present research focused on families noted to have children or potential children "at-risk" and possibly more likely to pursue counseling intervention than families who did not have children who exhibited risk factors. Explicit to this research was the use of an instrument measuring reduction of stress for parents who engaged in structured play activities. The study examined participant responses on the SFI and PSI following participation in the study. Families in the experimental groups participated in seven structured play activities that occurred for 60 to 90 minutes once a week for 7 weeks.

### **Research Questions**

- 1. Does the experience of Group Family Play promote increased health/competence, style, and conflict resolution among family members who meet the at-risk criterion?**
- 2. Do parents see themselves as better able to cope with stress following participation in Group Family Play?**

### **Assumptions**

**The researcher assumed that the SFI and PSI were both reliable and valid measures of family health/competence and parenting stress, based on an existing knowledge base. It was also assumed that the nationwide norms for both the PSI and SFI could be useful for representing family members of all ages who participated in Group Family Play. The researcher made the assumption that the participants responded to the instruments in a careful and honest manner that reflected their own family experience and perspective.**

**A final assumption was that the trained instructors were able to engage families in the activities, without providing individual family therapy. Instructor training sessions served to make their role in the activities clear and concise.**

### **Rationale and Theoretical Framework**

**The history of the use of play for therapeutic purposes has been documented, starting with Freud and moving into present day therapy (Gil, 1994; Landreth, 1991, Miller, 1994; Zilbach, 1986). Therapeutic play is now a recognized discipline, and the International Association of Play provides credentials and regulated training worldwide (Gil, 1994). With the practice of Family Therapy expanding to include young children, an integration of the Play Therapy and Family Therapy fields has the support of many professionals (Ariel, Carel, & Tyano, 1985; Duff, 1995; Eaker, 1986; Gil, 1994; Shaefer & Carey, 1994).**

Following is a discussion of the history of Play Therapy and Family Therapy, which evaluates how the emerging technique of Family Play Therapy has been of interest to both. Similarities and differences of both Play Therapy and Family Therapy are addressed. Also, the benefits that current authors ascribe to the use of play in therapy are summarized, referring to the current technique of Family Play Therapy.

### **Play Therapy**

Like most therapeutic approaches of our time, Play Therapy had its roots in psychoanalytic theory. In 1928, Anna Freud began to use play as a way to lure children into treatment. She advocated play as a means of building a relationship. Melanie Klein considered play to be the child's natural medium of expression and proposed using play as a direct substitution for verbalization (Landreth, 1991; Schaefer & O'Connor, 1983). Erik Erikson (1963) later stated, "Play is a function of the ego, an attempt to synchronize the bodily and social processes with the self" (p. 211). He also stated, "[Play] is free from compulsions of a conscience and from impulses of irrationality" (p. 214).

### **Play Therapy Schools**

In the 1930s two schools of Play Therapy emerged. In Structured Play Therapy, the therapist sets up the play with a specific outcome in mind. An example would be using a Monopoly game to create competition among family members. The second school of Play Therapy, Relationship Play Therapy, allows the child to take

the lead and make choices about play. The therapist works with what the child presents in the therapy setting.

**Structured Play Therapy.** What is now known as Structured Play Therapy shares the commonalities of (a) a psychoanalytic framework, (b) a partial belief in the cathartic value of play, and (c) the therapist actively determining the course of therapy. Levy, Solomon, and Hambidge are a few of the founders of such directive play techniques (Schaefer & O'Connor, 1983). Solomon believed that helping a child to express rage and fear through play, without experiencing the feared negative consequences, would have an abreactive effect. Hambidge went further and facilitated the abreaction by directly recreating the life event in play (Gil, 1994).

**Relationship Therapy.** Relationship therapy emerged from the work of Otto Rank who de-emphasized the importance of past events and transference, but focused rather on the patient–therapist relationship and life in the here and now (Landreth, 1991). Ideas about relationships in therapy were further developed by therapists such as Taft, Allen, and Moustakas (Schaefer & O'Connor, 1983). Moustakas (1959) helped the child to individuate and to explore interpersonal situations while in a secure relationship with the therapist.

Using Carl Rogers' client-centered approach, Virginia Axline (1947) modified the rules for adult relationships and developed a credo for working with children. This approach further developed into what is known today as Nondirective Play Therapy. During Nondirective Play Therapy, the therapist follows the child's lead and trusts in



the child's ability to self-actualize. The child experiences growth " by playing out feelings as he or she brings them to the surface, faces them, learns to control them, or abandons them" (Guerney, 1983, p. 21).

### **Family Therapy**

The Family Therapy field evolved from traditional individual psychotherapy primarily due to clinical developments in the treatment of schizophrenics and juvenile delinquents that led to new views of the family as a living system, an organic whole. Hospital psychiatrists began to see that treatment was predicated on environmental stability. They also noted that a patient's progress sometimes resulted in the family becoming worse (Nichols & Schwartz, 1991). In the late 1940s and 1950s, clinicians such as Gregory Bateson, Don Jackson, John Weakland, Jay Haley, and later Virginia Satir of the Palo Alto Group, Murray Bowen and Lyman Wynne at the National Institute of Mental Health, and Theodore Lidz at Yale experienced frustration trying to apply conventional psychiatric principles to their work with schizophrenic individuals. Through their observations, writings, and scientific endeavors the focus turned to therapy with families. At the same time there were also concerns that applying conventional methods of therapy to the population of delinquent children was time consuming and ineffective (Gil, 1994). Thus, research began to look at the effects of therapy with families.

Three approaches advanced theories about family dynamics: Psychodynamic, Communication, and Structural. The uniting principle for all schools of Family

Therapy was the notion of focusing on the family system rather than on any one individual's pathology or inner world. Symptoms in the individual's life were proposed to be a result of processes in the family that resulted in stress for the individual. The result of individual processes, in turn, influenced the family. Family Therapy changed the focus of the diagnosis, the treatment relationship, and the means of intervention (Miller, 1994).

### **Psychodynamic Family Therapy**

The Psychodynamic approach focuses on the intrapsychic conflicts of each member of the family unit by application of individual psychotherapy techniques to family situations. The major goal of Psychodynamic Therapy is insight, because the individual's insight into problems is thought to evoke change (Okun & Rappaport, 1980).

### **Communication Theorists**

Communication and Structural approaches comprise much of Systems theory, and most therapists lean toward this systemic view of the family (Nichols & Schwartz, 1991; Okun & Rappaport, 1980). Communication theorists assume one learns about the family through study of both verbal and nonverbal communication patterns. This orientation was developed by Gregory Bateson at the Mental Research Institute, and was further explored by theorists such as Jay Hayley, Don Jackson, Paul Watzlawick, and John Weakland. They believe that all of a person's behavior is

communicative and occurs in both verbal and nonverbal interchanges. These interchanges can be equal, in which each person leads, or complementary, where one leads and one follows. Every communication has a content/report and a relationship command aspect, which is termed metacommunication. Relationships are defined by the command messages and depend on the punctuation of the communicational sequence between communication. These theorists believe one can best understand a relationship by analyzing the communicational and metacommunicational aspects of interaction (Nichols & Schwartz, 1991; Okun & Rappaport, 1980; Schaefer & Carey, 1994).

### **Structural Family Therapists**

Structural theorists focus on the ordering of the family system itself. David Kantor and Salvador Minuchin contributed to the structural theory. Although each describes a different emphasis, a commonality of structural practice includes diagnosis directed toward, and treatment predicted upon, a system's organizational dynamics. Of primary importance to structural theory is the creation, maintenance, and modification of boundaries (Nichols & Schwartz, 1991; Okun & Rappaport, 1980).

### **Current Perspectives Shaping Family Therapy**

**Feminist Perspective.** To date, the feminist movement has worked to integrate an understanding of biases into traditional psychoanalytic thought and systems theory. The movement has provided direction in getting therapists to assess how

psychoanalytic theory has shaped the nature of reality, normalcy, and psychopathology (Enns, 1993). Currently, feminist thought has addressed issues concerning traditional views about the family and the tendency to blame or pathologize family members, especially the mother. When therapists look through a gender lens, they can effectively stop blaming mothers and expecting them to do most of the changing (Enns, 1993, Nichols & Schwartz, 1991).

**Postmodern Perspective.** Constructionist and Social Constructionist thought have moved therapists toward a process of “externalization,” in which the problem is portrayed as something outside the family (Miller, 1994). By externalizing a problem, blame and infighting are decreased as the dispute over who is responsible for the problem is minimized. This increases the family members’ motivation to cooperate in a mutual struggle against the problem and its influence in their lives (Nichols & Schwartz, 1991).

Additionally, family theorists have developed stage theories to clarify the developmental issues facing different family members at different points in the lifespan. These theories have served to create an awareness of critical issues in the family life cycle and have related the importance of sociological, environmental, and biological stressors and crises that affect both family systems and the individuals in them (Carter & McGoldrick, 1989; Miller, 1994).

### **Family Play Therapy**

**Family Play Therapy, an eclectic technique combining elements from Family Therapy and Play Therapy, allows a therapist to work with family members in a preplanned play situation (Griff, 1983). For example, play can be used as a medium to promote assessment of family interaction patterns. The family puppet technique is one effective means of assessing parent-child and reciprocal interaction patterns in therapy (Ross, 1994). To illustrate, during a puppet interview, one father began to interrogate his child about her difficulties in nursery school. When the child stopped being an active participant in the play with him and made no reply, he tried again several times to get a response. Putting down the father puppet, he said he would be the preschool teacher instead. At several points the father was very intimidating in his play yet clearly did not perceive himself in that manner. Eventually the child left the play altogether stating, "I don't want to do this any more. I'm tired. I want to go to sleep," and retreated behind the therapist's desk. The technique allowed this family to clearly demonstrate their self-other interactions in a reciprocal way through joint participation. Verbal interviews prior to this time had not provided this information, and further therapy corroborated the inferences gained in the puppet interview as characteristic of the underlying issues which brought this family in for treatment (Ross, 1994). Although there are many types of play, the puppet interview is one example of the use of a Family Play Therapy technique.**

**These integrative play techniques resulted from a compromise between Play Therapists, who saw the need to include the child's family in treatment, and Family**

Therapists, who wished to include young children in family treatment (Wachtel, 1994). Both schools were uninformed as to the value of family play techniques until recently. Many therapists trained to specialize in young children have not been trained in family work, and limited citations are found in Family Therapy to address the needs of young children.

Family Play Therapy requires some understanding of psychodynamic principles as well as knowledge of Structural and Analytic Family Therapy (Zilbach & Gordetsky, 1994). The therapist must have a diversity of knowledge in child development; family development; and individual, family, and group process (Miller, 1994). Flexibility is also considered a priority (Griff, 1983). Incorporation of play in Family Therapy occurs when a therapist recognizes it is integral to work with the experiences of all family members, especially in helping older family members communicate and listen to younger children (Zilbach & Gordetsky, 1994).

### **Theoretical Differences Between Family Therapy and Play Therapy**

The most obvious difference between Play Therapy and Family Therapy is the focus of treatment. Play Therapy has an intrapsychic view, whereas Family Therapy attends to the system. Wachtel (1994) indicates that while Family Therapists believe Play Therapists pathologize children due to their focus on the individual child, Play Therapists would argue that Family Therapists oversimplify and ignore the needs of the children, working primarily with the adults. Still, Play Therapists recognize that parents are an integral part of their children's mental health and thus they work to

address a means of including parents in the therapy process. Papp (1986) pointed out that it is erroneous to suggest that children relieved of their role as mediator between adults will be symptom free as a result of individual treatment. Thus, although on opposite theoretical poles, both Family Therapy and Play Therapy recognize the need to service all family members.

Another theoretical difference between Play Therapy and Family Therapy concerns the directness of the therapist. Play Therapy, in its nondirective form, is led by the child, with the therapist taking cues from the child's directives, while Family Therapy is more directive, with the therapist having a plan of action (Axline, 1947; Nichols & Schwartz, 1991). In Play Therapy, the therapist follows the child's lead and moves to the areas and toys chosen by the child. The therapist comments on the play and activities, while questions are avoided (Landreth, 1991). Many forms of Family Therapy are directive, with the therapist setting up a situation that he or she believes will benefit the family. For example, Structural Family Therapists may deliberately provoke conflict or tension in their sessions, relying on their personal relationships with each family member to keep each individual engaged. Strategic therapists often rely on set strategies to minimize resistance or conflict while people change. It is the therapist's responsibility to develop and clearly describe specialized techniques for various problems and resistances, as well as the steps and stages of therapy (Nichols & Schwartz, 1991).

It has been suggested that Family Play Therapy should be more directive in nature as well. A directive approach can prevent family interactions from becoming

too chaotic, particularly for the family whose relationships easily go out of control. For example, if each family member chooses a different activity or direction, individuals might not learn from each other, and the therapist will need to expend a great deal of energy. Directive therapy also prevents family interactions from being too stilted for the family who is hesitant to participate (Chasin, 1994). For example, some families might choose to sit quietly and wait for the therapist's lead.

### **Alliances Between Play Therapy and Family Therapy**

With theoretical differences, it may be difficult to perceive that similarities exist between Play Therapy and Family Therapy. However, both are learned from experience, with theoretical structure serving as a platform for expanding the experience component of therapy. It is expected that therapists will later outgrow a technical approach to the work (Keith & Whitaker, 1994).

Both Family Therapy and Play Therapy acknowledge that problems are not a result of a single person's pathology, and both have identified power issues and biases that need to be addressed (Miller, 1994). Family Therapy has been instrumental in bringing women's issues to the field, while Play Therapy has recognized the needs of children. Both women and children have been misunderstood by the proponents of traditional schools of psychology.

The Play Therapy and Family Therapy fields recognize the importance of developmental issues with respect to the individual and the family (Miller, 1994). Development and maturation of children takes place within the context of the family,



and the identification of family stages of development by Family Therapists has been influential in shaping the theoretical tenants of Family Therapy (Carter & McGoldrick, 1989). Both schools recognize the child as a dependent who must rely on the immediate environment and the relationships within. Play Therapy and Family Therapy both attend to cognition and language development and currently acknowledge that a lack of words is not a detriment to treatment. In fact, children included in the therapy process might highlight undisclosed information important to Family Therapy (Lax, 1989). Some theorists believe fundamental family functioning tends to take place at the nonverbal level (Keith & Whitaker, 1994).

Another common link is the metaphorical nature of both Family Therapy and Play Therapy, because the concrete, metaphorical language of symbols is used to express content in a therapeutic setting. The symbolic or make-believe nature of play is conducive to both direct and indirect communication (Ariel et al., 1985). For example, a 6-year-old boy is not likely to tell his mother in therapy that he is afraid she may abandon him. He will not tell her that she is inconsistent in her treatment of him. However, he may make up a game in which he is the Little Prince and his mother is the Queen. In his story, the Queen treats the little boy sometimes with kindness and other times with anger, until one day she finally makes him leave the palace. This indirect expression facilitates complex communication (Ariel et al., 1985). Both Play Therapy and Family Therapy attempt to shift from what is real to “as if” situations, and continue to do so repeatedly throughout the course of therapy. The opportunity for multiple meanings to exist is a tenant of both fields.

### **Benefits of Play in Therapy**

**Play appears to be a means of engaging the family in effective therapeutic work (Gil, 1994). Current authors describing the use of therapeutic play techniques with families have noted several reasons why such techniques appear worthy of further study. Koback and Waters (1984) stated:**

**During play, the distinction between actuality and possibility becomes blurred and less obvious. The only reality the family experiences during play is action; the only time frame the present. In this way it mimics the most primitive sensory-motor learning of the young child. Each interaction during play calls forth a further interaction. Imagination and spontaneity take on concrete form as new moves, that bring forth new responses. (p. 96)**

**The following are some of the benefits of using play with families:**

- 1. Play serves to reduce anxiety among family members participating in therapy by providing the organization for initiation of emotional relationships and enabling social contacts. Children use play to master anxiety (Winnicott, 1980). Even for adults, the atmosphere of play can cushion the anxiety that families mobilize around the definition of their problems (Eaker, 1986). Once problems are defined, play can effect small changes that contribute to the overall goal of stress reduction (Ariel et al., 1985). Secondly, play allows creative channels for anxiety that accompanies change (Kobak & Waters, 1984).**

- 2. Play allows for the inclusion of all children in the family, even the very young. This addresses the concern that younger children are frequently excluded from Family Therapy due to their age and/or developmental level (Keith, 1986). When young children are excluded from the family therapy process, the experience and**

understanding of the total family is lost and children are discriminated against (Scharff, 1994). When families include young children in the therapy process, feelings associated with the changes that coincide with family development are often clearly communicated through their play (Zilbach, 1986).

3. Play allows the therapist and family members to observe family interaction patterns in a nonthreatening manner, as play is directly informative about everyday life (Chasin & White, 1989). Thus, engaging families in a play task affords the clinician the opportunity to observe how they organize themselves to participate; how they communicate; and how they negotiate fairness, limit-setting, boredom, and other potential difficulties. Even without therapeutic guidance, the families are capable of discussing the organizational patterns they see during a play activity (Duff, 1995). Both the therapist and family members can attend to attachment, relatedness, and other patterns of interaction, following engagement in a play activity (Gil, 1994).

4. During play, family secrets are shared in a nonthreatening manner, allowing taboo subjects to be open for discussion (Kobak & Waters, 1984). Because most young children have no vested interest in conscious or unconscious disguises, they have a keen ability to sense family problems (Gil, 1994). They are often helpful in bringing out issues that affect the family, which other family members would not choose to share. When, through play, family secrets are challenged, the attitudes of other members of the family seem to change in a positive manner (Eaker, 1986). Play creates enough emotional distance between family members that the truth can be

spoken, and the experience of play in therapy liberates ideas and behavior that have been bound or constrained by habit (Eaker, 1986; Kobak & Waters, 1984).

5. Relationships become more flexible in a play setting. Individuals experience new behavior and interaction styles provided through the play activity. Conjoint Play Therapy with families attempts to limit unrewarding conflictive patterns of interaction through modeling how to deal with conflict, supporting sublimations of behavior, and encouraging more direct expression of feelings (Safer, 1965). Play enhances the opportunity for emergence of new symbols and relationships. During play, family members are more likely to be themselves and may readjust their roles within the context of the family because the usual rules of consequence do not hold (Kobak & Waters, 1984). If behavior does not result in its usual consequences, the sense of freedom is increased and a family might be drawn to experiment with new possibilities. Freedom of expression allows parents to understand children as individuals with specific anxieties, attitudes, and coping styles, instead of being viewed just in terms of their role in the family (Wachtel, 1994). At the same time, the experience of learning through play allows parents to become flexible enough to prevent future conflict as they witness how they impact their children (Safer, 1965).

#### **Marriage of Family Therapy and Play Therapy: Family Play Therapy**

Using the beneficial qualities of play, Family Play Therapy could be described as the technique that combines Play Therapy techniques with Family Systems Therapy and offers the benefits of each (Eaker, 1986). This technique allows individuals of all

ages to participate in a therapy experience in which they can play out dreams and aspirations, and be and behave in ways they do not ordinarily experience. During play, the family is engaged in a form of enactment (Ariel et al., 1985). In defense of Family Play Therapy, Griff (1983) stated:

Family Play Therapy does not commit one to a specific technique that may or may not match a particular family and their problems. It is designed to be a conjunctive method; it is to be utilized at the therapist's discretion. Inherent in this model is a flexibility in use, location and mode. It, therefore, becomes a highly practical technique: short-term, flexible, and designed to remove families from their recurring cycles of failure and fear concerning change itself. (p. 75)

Family Play Therapy does not require a certain level of cognitive or verbal expression to produce effective outcomes. Adults who shy away from emotional issues, or who are not skilled in the art of communication, seem more comfortable during therapy when engaged in play (Bergman, 1982; Keith & Whitaker, 1994). Children, on the other hand, use make-believe play as their natural medium of expression and communication. They can perform complex social activities while engaged in the medium of play (Ariel et al., 1985). Thus, Family Play Therapy seems to provide a common ground for both children and adults to communicate concerning family issues.

### Delineation of the Research Problem

This study has investigated whether a significant difference exists in measures of health/competence, style, and conflict resolution (measured by the SFI) between at-risk families who participated in specified Group Family Play activities and at-risk

families who did not participate. The study further investigated the difference in parenting stress (measured by the PSI) between at-risk parents who participated in specified Group Family Play activities and at-risk parents who did not participate.

### **Hypotheses**

The hypotheses of this study were:

1. At-risk families participating in Group Family Play would score significantly lower (more optimal) as measured by the Health/Competence, Style/Cohesion, and Conflict Scales of the Beavers Self-Report Family Inventory than at-risk families not participating in family play.
2. At-risk parents participating in Group Family Play would exhibit less stress as measured by the Parenting Stress Index than at-risk parents not participating in Group Family Play.

### **Importance of This Study**

The importance of this study centered on the population that was serviced, as well as the invaluable resource that it provided families. The target population resided in a rural community where it has been determined that 40% of the population, on average, are at-risk for school failure based on income, family history, and other research factors. This rural community has limited resources, and most interventions are short-term in nature and necessitate that the family have the resources to participate. The opportunity to participate in a study that was free, nonthreatening,

and pleasurable was unique. This study also supported most families' desire to improve upon their relationships. Participation in the study afforded the family some positive time together. They had an opportunity to learn about themselves and leave with strategies they could implement on their own initiative. Families were also able to positively impact other families in the study and find a support network.

The value to the community was also a consideration, as the study was a support to various agency programs and agency staff currently engaged in family work. Leadership roles provided by various agency personnel not only promoted interagency interaction, but served to increase the knowledge base of Family Play Therapy techniques among various organizations. This study provided increased insight and skill for personnel involved in family work, or at times, suggested that other avenues needed to be explored in working with at-risk families. Either way, agency personnel learned something about themselves and the families with whom they worked, as well as various strategies they can tailor to fit the needs of the families on their caseload.

This study was also important because Family Play Therapy is suggested as a means of teaching techniques that change the family's response patterns and coping style, thus reducing the family's experience of stress. Because stress and crisis are not inherent in an event but are instead a function of the response by the distressed family, adjustment to stress depends in large part on the resources available to the family (Walsh, 1982). When a family is provided with coping techniques, vulnerability decreases, protective resources are strengthened, and stressor events are reduced.

The provision of coping techniques serves to actively influence the environment and change social circumstances. It is important to focus on the positive aspects of family coping rather than attending to dysfunction. A family that improved its functioning in one or a few areas was also likely to generalize improvement to other areas (Walsh, 1982). The current study investigated how teaching families to play and relate together might provide resources that impact health/competence, style (cohesion), conflict resolution, and level of parenting stress in current relationships.

The experience of play could be productive for both children and adults, and may result in significant changes for families. Research indicates that play is a valuable coping mechanism for children who are experiencing stress and anxiety, and that when allowed to “play out” their concerns, they are considerably less anxious (Barnett, 1984). Adults who exercise, engage in hobbies or activities, have a rich fantasy life, or enjoy humor tend to be more resilient (Quinn, 1994; Rubin, 1996; Werner & Smith, 1992). After noting the positive changes in functional families in Duff’s (1995) research, this researcher questioned whether similar effects would be noted in families considered at-risk for educational difficulties. The present research would have the potential to validate the use of Group Family Play with families identified as at-risk for educational difficulties and more likely to pursue counseling services.



## Definition of Terms

***Family:*** *Family* was defined as two or more individuals living in the same household, who shared emotional, physical, and financial responsibilities. Configurations included nuclear, single-parent, blended, multigenerational, or childless groupings of members.

***At-Risk Families:*** *At-risk families* were defined as families who met more than one criterion for having children or potential children at-risk for school failure, according to the guidelines of the Michigan School Readiness Program (MSRP). A list of 25 factors affecting children was used, which listed criteria such as low family income, nongraduating parent, low birth weight, teenage pregnancy, family history of alcoholism, and death of a parent, among others (Appendix A). Because rural location was one of the factors, and the majority of the residents in this study area fit this criterion, the researcher required at least one other criterion to qualify families for the study.

***Family Play Therapy:*** *Family Play Therapy* referred to a utilization of the family's innate creativity to facilitate communication, problem solving, and involvement (regardless of age, or verbal or cognitive ability) in the therapeutic process (Schaefer & Carey, 1994).

***Group Family Play:*** For the purpose of this study, *Group Family Play* involved the family's participation in a series of semistructured activities designed to utilize the family's creativity and to promote communication, problem solving, and growth in relationships. Approximately 40 individuals engaged in the semistructured

activities in a shared physical setting. During the sessions, each family always participated in an activity together. On some occasions, each family unit interacted with another family unit.

***Health/Competence:*** *Health/Competence* was defined as how well a family, as an interactional unit, performed the necessary and nurturing tasks of organization and management. The Health/Competence Scale of the SFI included an assessment of leadership, parental or other adult coalitions, and established generational boundaries. Also included was the ability of individuals in the family to develop autonomy, to communicate clearly and directly, and to have skills for resolving conflict.

***Conflict Resolution:*** *Conflict resolution* referred to the family's overall efficiency in negotiating problem solutions. The Conflict Scale on the SFI assesses how the family utilizes resources, personnel, and time to efficiently negotiate problem situations. Conflict resolution was used interchangeably with problem solving for purposes of this study.

***Style:*** *Style* refers to the degree of centripetal or centrifugal qualities in a family. A family may have a centripetal style, in which they seek satisfaction from within the family unit, or they may have a centrifugal style, where satisfaction is gained outside the family unit. The healthy family shows a flexible and blended family style such that they can adapt style as developmental, individual, and family needs change. The Cohesion Scale on the SFI measures style or family closeness.

***Stress:*** For the purpose of this study, *stress* was considered to be the many facets of the parent-child system that could lead to dysfunctional parenting, and intense and frequent behavioral and emotional difficulties among children. In looking at the system, the combination of child factors, parent factors, and life stress factors that impacted both the parenting experience and resulting child behavior and expression of emotion were addressed.

### Summary

This chapter outlines the benefits of play with children and the recent interest in using play with families. It defines the problem as the limited amount of research available to study the impact of play on the family unit. This is the rationale for the empirical study on Group Family Play. A theoretical framework documents the therapeutic benefits of play over time, and a brief discussion of Play Therapy and Family Therapy is included. A synthesis of ideas from these two schools has resulted in Family Play Therapy—play techniques that involve the entire family and promote communication. Some theoretical differences and alliances between Play Therapy and Family Therapy are discussed within this chapter, which lead to a statement of the research problem and hypotheses. It is hypothesized that individuals who engage in Group Family Play will show significant improvement in Health/Competence, Conflict Management and Style on the SFI, and they will report decreased stress on the PSI. The importance of the study is summarized for the reader and is followed by definitions of the terms to enable the reader to understand the present research.

## **CHAPTER II**

### **LITERATURE REVIEW**

#### **Play**

**Play, one of the earliest pleasurable experiences humankind engages in, is frequently misunderstood. Adults often see the world in terms of productivity and achievement of goals; thus, play becomes simply the fringe benefit of labor. A recent Gallup poll noted that the average American uses 13 annual vacation days (*Grand Rapids Press*, 1998), but that during vacation, a large percentage of individuals do not view themselves as free from work. They need to check e-mail, make telephone calls, or even leave vacation early to return to their work. Comments frequently made about play indicate that people do not assign serious value to it. For example, play is called a “break” or “recess” in academic settings, and children are dismissed to “go play.” Despite the peremptory dismissal, play is a subject that has been studied by many of the developmental theorists as the basic inalienable right of childhood (Zilbach, 1986).**

**A therapist who understands the importance of play as the means by which children communicate is more likely to understand the world of the child. On the other hand, therapists who demand that a child participate in an adult style of counseling sends a message that they are unwilling to enter the child’s world. It is**

crucial to understand the importance of play and its subsequent value for therapeutic work with children (Sweeney & Homeyer, 1999).

Several attributes of play make it a primary choice for therapeutic work with children. Play is voluntary by nature and it provides respite from everyday tensions. Play is also free from restrictions and rules. During play, children are safe to make mistakes, without failure and adult ridicule, since adults typically do not judge or analyze children's play. Fantasy and use of imagination are encouraged. In play, children can exercise the need for control without competition. In addition, play appears to attract the attention of children and they can easily become involved. Finally, play encourages social, physical, and mental development (Caplan & Caplan, 1974).

Although he did not frequently work with children, Sigmund Freud (1953) noted that play is very serious for children and takes a great deal of emotional energy. Through play, children create a world of their own and arrange things in order to please themselves. Freud noted that play is a loved and absorbing occupation in which children make use of their imaginative energy. In *War & Children*, A. Freud and Burlingham (1944) noted the differences between adults and children who were victims of war. While the adults expressed their reactions through frequent retelling of the experience, the children who suffered almost never spoke of their terror. The authors noted that the children were more apt to express their reactions by reenacting scenes with available toys and materials. This play would continue for a period of several weeks, after which the children adjusted.

Play can also be useful as a therapeutic tool for helping families adjust. Using play with adults helps them to communicate on an equal level with their children, for within them lies an “inner child,” as they were once children themselves (Eaker, 1986). The child’s connection with parents and siblings through play serves to develop one-on-one relationships with the family that will prepare the child “for every rejection, resistance or alliance present everywhere in his life” (Bowen, 1978 p. 368).

Ariel et al. (1985) makes this statement concerning the use of make-believe play with families:

This indirect mode of expression in which the content is conveyed by means of the concrete metaphorical language of symbols, facilitates the performance of complex communication tasks not only for children, but for adults who shy away from emotional issues or are not particularly skilled in the art of conversation. (p. 48)

This chapter will address the importance of play as a therapeutic tool for both children and adults by describing current literature on the use of Play Therapy techniques with families. The literature will address the contributions of both Play Therapy and Family Therapy as well as useful techniques of Family Play Therapy. Current research on Family Play Therapy will be discussed, although limited empirical research on this topic makes critique and comparison difficult.

### **Play Therapy History and Development**

Sigmund Freud was one of the first therapists to use play in therapy. In 1909, he attempted to uncover, through play, his client’s unconscious fears and concerns.

Twenty years later, Melanie Klein and Anna Freud simultaneously formulated the theory and practice of Psychoanalytic Play Therapy (Gil, 1994).

Psychoanalytic Play Therapy developed in the 1930s out of an attempt to work with children's issues. Melanie Klein (1932) was one of the first psychoanalysts to develop the use of play as an essential component in treating children. In addition, Anna Freud wrote concerning the use of play with children and emphasized the importance of a therapeutic relationship (Zilbach, 1986). While Freud used play as a means of developing a relationship with the child, Klein proposed using it as a direct substitute for verbalizations. Both proposed that play was a means of uncovering the child's unconscious desires and conflicts, and that play was a means of free-associating (Gil, 1994).

Based on the study of Freud and Klein's work with children, structured therapy developed in the late 1930s and took on a more goal-oriented approach. David Levy was instrumental in developing "release therapy" out of a belief that play was cathartic and that the therapist needed to determine the focus and course of therapy. His goal was for the child to re-enact a trauma over and over in order to assimilate the negative thoughts and feelings associated with it. He cautioned that a strong relationship with the child was necessary before engaging in this work (Gil, 1994; Schaefer & O'Connor, 1983). Hambidge and Solomon were also contributors to structured therapy, as they helped children express rage and fear through play (Gil, 1994).

In contrast to the structural therapists, Otto Rank and Carl Rogers were instrumental in developing a focus on the relationship and a nondirective approach to therapy. Influenced by their views, Virginia Axline in 1947 wrote *Play Therapy*, a classic book considering play as an actual modality for treating children. She wrote that Play Therapy was based upon the premise that play is the natural medium of a child's self-expression. In play there is an opportunity for the child to play out feelings and problems, just as in certain types of adult therapy an individual talks out problems (Axline, 1947). She articulated the benefits and desirability of a nondirective approach to Play Therapy in her book *Dibs in Search of Self* (1964).

Learning theorists provided further information about children and play in the late 1950s and early 1960s; however, their observations were not specific to therapy. Erik Erikson (1950, 1963) discussed observations on the interpersonal aspects of play resulting from his research with children. He emphasized interpersonal and cultural/social aspects of play as qualities that promote growth in young children. Erickson further noted that play is the most natural self-healing measure available to children. Observations of children by Piaget (1969) formed the basis for his theory of development. He concluded that children are not developmentally able to engage in abstract reasoning or thinking until approximately 11 years of age. He noted that children become problem solvers through the process of play. Although adults often do not understand the symbolism or unconscious process involved in play, Piaget noted that not interfering in the play allowed the children to find a solution that suited them best (Thomas, 1996).



Research concerning the use of Play Therapy with children was limited during the 1950s and early 1960s, but interest in Play Therapy as a means of treating children renewed in the late 1960s. D. W. Winnicott, another noted child therapist, was a master at using play in his treatment of children. He invented the “Squiggle” game as a way of interacting with children. He presented the child with a squiggly line and a marker, and they alternately added to the line until they had created something to discuss. Winnicott (1971) stated, “It is play that is universal, and that belongs to health; playing leads into group relationships; playing can be a form of communication in psychotherapy” (p. 41). In another study, Bow (1993) documented the use of fairy tales as a therapy intervention and used cartoon animals to reduce resistance in children. Bettelheim and Gardner used metaphor as an effective tool in therapy. Gardner, known for his “mutual story-telling” techniques (Duff, 1995), developed games such as “Talking, Feeling and Doing” and the “Ungame,” in which he makes a game out of storytelling.

Landreth (1991), a current expert in the field of Play Therapy and director of the Center for Play Therapy at the University of North Texas, made this statement:

Play is to the child what verbalization is to the adult. It is a medium for expressing feelings, exploring relationships and self-fulfillment. Given the opportunity, children will play out their feelings and needs in a manner or process of expression which is similar to that for adults. The dynamics for expression and vehicle for communication are different for children but the expressions are similar to that of adults. When viewed from this perspective, toys are used like words by children, and play is their language. (p. 14)

### **Play Materials**

Since toys appear to be the words used by children, it is important to have a variety of choices available for self-expression. Special consideration should be given as well to the materials considered for use with families (Duff, 1995). The materials provided should allow for exploration of life experience, expression of feelings, limit testing, exploration of play, nonverbal expression, and success without a prescribed structure (Landreth, 1991). Byron and Carol Norton (1997) suggest a basic list of toys for therapy and emphasize the metaphorical nature of play. They discuss the meanings associated with toys, animals, and the play environments created by children. The use of metaphor can assist in interweaving conscious, unconscious, and out-of-conscious sensory communication systems (Mills & Crowley, 1986). Many play techniques facilitate communication and problem-solving, as play makes use of auditory, visual , and kinesthetic means.

### **Beyond the Scope of Children**

Literature has suggested many ways in which adults and children can participate together in play with a therapeutic outcome. The idea of using adults in play with children originated with an initial attempt to involve parents in the therapy of their children, which opened doors for techniques that seemed to benefit the entire family unit. As a result of including parents in therapy, some child play techniques have been adapted for use with families. The following examples are not exhaustive, but are specific with respect to the Group Family Play study.

### **Parents as a Support to Children in Therapy**

**In their work with children, many therapists saw potential in using parents as therapists for their children (Furgeri, 1976; Gil, 1994; Guerney, 1964). Some therapists saw value in having parents take on a therapeutic role when playing with their children, while other therapists sought opportunity to meet the needs of the parents. All therapists observed that parental issues took precedence when they attempted to treat the child's symptoms.**

**In some instances, parents were genuinely interested in the outcome of their child's therapy, but when the therapist became more important than the family to the child, it was no longer therapeutic for the child (Fogarty, 1979). Guerney (1964) documented work by S. Freud, Moustakas, and Fuchs, describing promising results when parents conducted play sessions with their children in the home. The researchers observed that play sessions enriched the parents' relationship with their children as well as helped the children overcome the problems they had already developed.**

**Filial therapy, now referred to as child relationship enhancement (CRE) family therapy, was developed in the 1960s by Bernard and Louise Guerney to instruct parents in the techniques of Play Therapy. Parents are instructed through observation, mock play sessions, videotapes of themselves and other parents, and play sessions with their children. Following training, parents play with their children in the home, in addition to play sessions at the training site, and receive supervision (Schaefer & Carey, 1994). Research using the Guerneys' model showed positive changes in**

parents' perceptions of their children and in their attitudes resulting from training alone (Sywulak, 1977). Follow-up studies indicated that the therapeutic gains achieved as a result of this method were maintained for at least 3 years (Sensue, 1981).

The overall goals of filial therapy are (a) to eliminate the presenting problems at their source; (b) to develop positive interactions between parents and their children; and (c) to increase the family's communication, coping, and problem solving skills. Teaching parents these play skills promotes better handling of future difficulties (VanFleet, 1994). Although the Guerneys developed this technique for work with children 3 to 10 years of age, application of the technique was successfully extended to include adolescents (Gil, 1994). Other models have expanded upon and adapted the Guerneys' model, continuing to employ person-centered principles (Guerney & Guerney, 1994).

In a study on the effects of filial therapy on parent and child behavior, Rennie and Landreth (2000) indicate filial therapy positively affects parental acceptance of the child, self-esteem, empathy, and improvements in family environment. They also report positive effects on the child's adjustment and self-esteem while parent stress and the child's behavioral problems decrease. Their research also suggests filial therapy is effective with various parent populations including incarcerated mothers and fathers, single parents, and parents of different nationalities.

### **Parent Needs Exhibited**

Although the CRE approach has been successful, it has made therapists increasingly aware of the needs of the parents who bring their child for treatment. The CRE approach can teach parents how to “be with” their children; however, the way in which they engage their child in the playroom may be a reflection of the conflicts they experience as persons and spouses. Some therapists note the importance of discussing the parent’s own past and present experiences as part of the overall treatment program (Stollak, 1981).

Lena Furgeri (1976) supported inclusion of parents in Play Therapy after her experience with parents bringing their own issues into the child therapy setting. She wrote that frequently parents removed their children from therapy with the indication of progress. She observed that the children were really spokespersons for the parents, because the parents felt selfish in asking for help, yet they demanded the therapist’s time. Behind the problem child was a parent yearning for help but unable to ask for it directly, because of a cultural standard that implies the needs of the child should come first. When the child acted out the parent’s unconscious needs, treatment of the behavior resulted in a feeling of unconscious deprivation for the parent, and he or she would be strongly motivated to cancel the child’s treatment. Furgeri felt she could address the parents’ needs by including them in the therapy. By seeing both the child and related family members, an open therapeutic contract was established, aimed at educating and preparing the family to accept new behaviors via new means of communication.

Recognizing the importance of both the child and the family in making effective change, some therapists began to include parents and siblings in the play sessions of the identified child. They observed that some play techniques provided information about family dynamics that sometimes took much longer to discover in a formal talk therapy setting (Gil, 1994). Thus, experimentation with Family Play Therapy techniques began to be addressed in the literature.

### **Play Therapy Techniques for Families**

The literature currently documents many play techniques in Play and Family Therapy observed to improve relationships and promote growth among family members. Play could refer to a play of ideas, a play of words, or a play of metaphor. Techniques such as enactment, sculpting, and reframing can be used with families to create an enchanted time in which anything might happen (Kobak & Waters, 1984). Current case studies in the literature document the effectiveness of puppet play, artwork, sand tray, and psychodrama when working with the family unit. Following are some of the techniques to be explored by families participating in the Group Family Play study, along with a brief history of the technique, current writings, and available research findings.

### **Sandplay**

Sandplay as a therapeutic technique was first developed by Margaret Lowenfeld in the 1930s. Children who came to her institution were provided a half-

filled tray of sand and a variety of toys to use in the sand. Jungian analyst Dora Kalff further developed the approach in the 1960s, formulating theoretical principles for Sandplay, and training practitioners in the use and interpretation of the technique. This technique has since been extended to include adults, couples, and families. Today sand trays have specific dimensions, and hundreds of miniatures are available for individuals to choose those that are relevant to their work.

Sandplay provides children an opportunity to resolve trauma by externalizing fantasies and developing mastery and control over impulses (Allan & Berry, 1993). Most practitioners emphasize the value of unconditional positive regard and limited verbalizations by the therapist while clients construct their world in the sand. Carey (1994) noted the following five advantages of using Sandplay with families:

1. The tray serves to set limits when boundaries are an issue.
2. Family alliances are observed in the process of making a tray.
3. Unconscious contents are rapidly revealed, making discussion of patterns possible.
4. Sandplay appeals to the younger children.
5. The uniqueness of each family is observed.

After observing an example of family Sandplay conducted by Carey, this researcher noted that Sandplay helps the therapist visualize both the individual personalities and the interrelated family dynamics.

## **Art**

**The visual arts have been of interest to therapists because they represent a tool with which individuals can demonstrate their experience. Historically, the visual arts were viewed as an expression of the unconscious, and attempts were made to structure the use of drawings for intellectual and psychological assessment (Gil, 1994). Kramer (1971) suggested that the art process in itself is healing, and verbal reflection on the work is unnecessary. In a group setting, the use of art can encourage positive interaction among members, as well as promote self-perception and expression (Rhyne, 1973). Kwiatkowska (1967) noted that during a family art project, families are engaged in a simultaneous expressive activity, a task that is impossible during verbal communication. This informal situation serves to lessen defenses and controls, and uncovers ambivalent and confused attitudes. Using standardized procedures, Kwiatkowska reported case studies that demonstrate the application of family art techniques.**

**With respect to family art, Langarten (1980, 1987) noted its importance to the field of Family Therapy. Process and content are thought to be of value in assessing and treating families. She suggested that by observing the process through which a family creates a single piece of work, interaction patterns can be assessed. Content can be assessed from several perspectives and becomes visual evidence “that utilizes the sense of sight instead of the truth of sound” (Langarten, 1994, p. 224).**

**The Collaborative Drawing Technique (CDT) is an extension of Kinetic Family Drawing, in which individuals draw pictures of their family involved in an**



activity. Each family member is given a crayon and an allotted time (30 seconds) to draw, without talking, on one sheet of paper. As time is called, the paper is passed to the next person, until each member has participated. The process continues with the time limit progressively reduced, until time is called and the picture is completed. This activity produces a visible record of family interaction. The therapist attends to both the process and the product of the exercise (Smith, 1994).

Formats for using art with families are provided in work by Rubin and Magnussen (1974) and Wolfe and Wolfe (1983). These authors suggest variations of the use of Winnicott's scribble technique, family portraits, joint murals, construction paper families, and magazine collages as effective activities to promote awareness of feelings. Another format suggested by Gil (1998) has family members creating their own fish or flower and then working together to place them in an aquarium or floral arrangement. The use of art activities can be directed toward goals of establishing (a) generational boundaries, (b) new coalitions, (c) separation in enmeshed families, or (d) intimacy in families who are disengaged (Wolfe & Wolfe, 1983).

### **Puppet Interviews**

Family Puppet Interview is a technique developed to facilitate communication and interaction among family members. Family members may choose from an assortment of puppets, while the therapist observes the interaction and individual choices. Once selections are made, the remainder of the puppets are put away, and

the family members warm up by introducing their puppets. The following directions are then given:

Now I would like you to work together to make up a story using these puppets. I will go in the next room and watch through the window while you plan. Just try to decide how the story might begin. It is important that this be a made up story, not one you have seen or read. (Irwin & Malloy, 1994, p. 25)

In observing the process, the therapist may be able to determine family roles, alliances, and subgroups that may present themselves in the future. When the therapist returns to the room, the family performs its story. Facilitation is offered as necessary, and when the story is stopped or completed, the therapist can continue the interaction by talking directly with the puppet characters. In this way, the therapist can pursue conflict between puppets and explore significant themes (Irwin & Malloy, 1994). Gil (1994) suggested the following interactions after the production of a puppet story:

1. Determine the theme and reframe it in order to create meanings that might become helpful at a later point.
2. Create new interactions within the context of the family's metaphor.
3. Wonder out loud.
4. Pose questions.
5. Challenge belief systems portrayed in the story.
6. Postulate about the outcome as one might do in Mutual Story Telling developed by Gardner.
7. Comment on the story-telling system.

**8. Look for exceptions as proposed in Michael White's concept of narrative therapy.**

**Case studies presented by Irwin and Malloy (1979) and Gil (1994) demonstrate the effectiveness of these techniques in working with families. The metaphor of this technique "provides the needed distance and security to pursue a kind of self-disclosure perhaps only possible in this once-removed way" (Gil, 1994).**

### **Games**

**Games appear to be valuable tools for working with families, as they can encourage communication and expression of feelings. They can include board games, such as checkers or Monopoly, which provide rules and structure, or those that are designed to facilitate communication and story-telling. Game play can facilitate following directions and increase appropriate interaction, which can generalize to the home environment (Duff, 1995). Regarding the usefulness of games for the therapist, Capell (1968) noted the following four aspects:**

- 1. Games allow assessment of judgmental and perceptual disorders.**
- 2. The therapist might view the overemphasis placed on outcome.**
- 3. The therapist may observe and assess affective involvement that accompanies play.**
- 4. One might observe the intensity of fantasy and motor activities.**

**Games tend to free up blocked therapeutic transactions and reduce resistance to more verbal processing of problems and feelings. Also, they can be used as an**

adjunct to overall therapy, or they can be central to the therapeutic process (Nickerson & O'Laughlin, 1983).

### **Psychodrama, Kinetic Movement, and Experiential Activities**

The techniques of psychodrama and kinetic psychotherapy promote movement and game-like interactions. Psychodrama uses concrete situations constructed from life and carries them out in a dramatic narrative and then into group commentary (Simon, 1972). Kinetic psychotherapy uses a series of interactive games to facilitate and mobilize feelings (Schacter, 1994). Both methods use spontaneity and movement to warm up people in preparation for work with pertinent issues. Blatner (1994) and Schachter (1994) provide case study information that demonstrates effective use of these techniques. The use of such activities as a therapeutic modality can be less threatening and can promote a relaxed atmosphere where natural interactions occur (Raupp, 1978).

Sculpting, the arrangement of people and objects to express family relationships, demonstrates a "symbolic abstraction" of the family in a moment of time (Simon, 1972, p. 50). Simon noted that, in favorable circumstances, sculpting provides an atmosphere for confident relaxation. It also increases awareness of the uniqueness of the individual members that compose a family unit.

Gillis and Gas (1993) provided qualitative information concerning families who participated in therapeutic adventure experiences. These experiences are designed to attain specific treatment objectives. Often, exercises are processed using

three progressive questions: (1) What happened?, (2) So what?, and (3) Now what? Processing the experience in this manner can serve to transfer information to a new setting. The ability of families to transfer information and problem solve should help strengthen communication and reduce stress.

Family Play Therapy, a marriage between Play Therapy and Family Therapy, uses play techniques, such as those described above, to promote increased family health and competence. The idea of Family Play Therapy not only makes sense to the Play Therapist, but also has received support from Family Therapists. Current literature speaks to common premises that presuppose a union of Play Therapy and Family Therapy, with respect to the use of Family Play Therapy techniques. In order to understand Family Play Therapy, it is helpful to also understand the history and development of Family Therapy.

### **History and Development of Family Therapy**

Family Therapy developed out of dissatisfaction with traditional psychoanalytic theory in addressing factors not of an intrapersonal nature. The uniting focus of Family Therapy was the idea of treating the family as a whole system, rather than looking at individual dysfunction. The symptoms of any one person were viewed as the result of the process in the family system and the resulting stress upon the individual (Miller, 1994).

In the early 1950s, four groups began work on the concept of family treatment (Eaker, 1986; Gil, 1994; Zilbach, 1986).

1. Communication theorists (the Palo Alto group) consisted of Gregory Bateson, Don Jackson, John Weakland, Jay Haley, and later, Virginia Satir. They worked to define the concept of homeostasis, which suggested that if one member of a system begins to improve, it is likely that another member will deteriorate to maintain the system. They also worked with the “double-bind” phenomenon, which was described as a communication in which no response is acceptable and from which there is no escape (Nichols and Schwartz 1991).

2. At the same time, Murray Bowen and Lyman Wynn supported the inclusion of mothers in the treatment of children with schizophrenia. They found this to be an effective treatment. Bowen postulated that homeostasis is perpetuated by a series of interlocking triangles, and that family members are highly reactive to, or fused with, one another in an “undifferentiated ego mass.” He further believed that children were extensions of their parent issues in these families, and the children were prone to act out feelings the parents were not able to express. The goal of therapy would include differentiation of self (Nichols & Schwartz, 1991). Nathan Ackerman, who also worked at the National Institute of Mental Health with Bowen and Wynn, began to note the effects of unemployment on the families of coal miners. He occasionally began to see the family, as well as the miner, in the therapy session. By combining his child and family knowledge, Ackerman developed his skills and came to realize how important strategic play could be to a therapy session. Through the use of theatrical wit and humor, he was able to break down the families’ defenses and reduce resistance (Gil, 1994; Nichols & Schwartz, 1991). Ackerman wrote

concerning the positive results achieved through the appropriate use of play in Family Therapy. He noted that during play, small children revealed information about the family that might not otherwise be expressed (Ackerman, 1970).

3. From the Palo Alto group, Jay Haley continued to develop his position and began to view communication as a means of power and control. He became a leader in the strategic school of thought. This school was influenced by the work of Milton Erickson, the Palo Alto group, and the Milan group, resulting in a highly directive, behavioral approach to problem-oriented work. These strategic theorists worked to uncover the systemic maintenance of problems in the system (Nichols & Schwartz, 1991; Zilbach, 1986).

4. Structural Family Therapists, led by Salvador Minuchin, saw the task of family therapy as a restructuring of the family system. This school of thought saw the family as a hierarchical system with boundaries ranging from disengaged to enmeshed. Therapeutic goals were directed toward clarification of hierarchical relationships and establishment of healthy boundaries (Miller, 1994).

Today the feminist movement has assisted Family Therapists in the re-evaluation of former practice by seeking to redefine (a) family roles, (b) the causation of symptomatology, and (c) the understanding of how environment impacts individuals. Systems therapists have failed to understand how the larger social context affects the smaller family system, not unlike individual therapists who pull the individual out of the family context (Luepnitz, 1988). Miller (1994) recognized Michael White as an example of one therapist who was instrumental in a movement

to externalize the problem in the family. This concept decreases blame and infighting, while motivating the family to cooperate in a mutual struggle. Recently, a more intense examination of the stages of family development has helped to clarify the developmental issues facing different family members at different times in the lifecycle. This life stage focus recognizes the importance of sociological, environmental, and biological stressors and crises that affect both the family system and the individuals within the system (Carter & McGoldrick, 1989). Current therapists view their role as humble participants invited to share with the family, rather than to change or control it (Efran & Lukens, 1985).

### **Uniting Principles of Family Therapy With Play Therapy**

Therapists should have an understanding of the rationale for the synthesis of Family Therapy and Play Therapy that resulted in Family Play Therapy, another method of practicing therapy with adults and children. Literature in both Family Therapy and Play Therapy supports some common ideology regarding the use of play as a therapeutic technique. Some common ideas about play techniques, as discussed below, are derived from the theoretical frame described by Ariel et al. (1985), who proposed the following reasons for make-believe play in family therapy:

1. Make-believe play is a rich and flexible medium of expression and communication that enables the family to play out wishes and aspirations.
2. By participating in the family's play, the therapist is offered a variety of direct and indirect channels of communication.



**3. Make believe play is one of the best techniques to actively involve young children.**

**4. Engagement in play is a form of enactment in which families do not have to talk about their difficulties.**

**5. Make-believe play is paradoxical in nature. A player can pretend that something is the case, and at the same time deny that it is the case, as he or she is just playing. This type of play lends itself to paradoxical therapeutic techniques.**

### **The Medium of Play**

**Make-believe play is a rich and flexible medium of expression and communication, enabling family members to play out wishes and aspirations. During play, individuals can exist and behave in a manner that is not typical of ordinary interaction. For example, because it is inappropriate for a father to be aggressive in therapy, he will not display this behavior. However, in play, he may choose an aggressive toy, such as a lion or dinosaur, and act aggressively toward the toys chosen by other family members. Gil (1998) related an incident in which a man who had sexually abused his stepdaughter indicated that he was “cured.” During a puppet interaction, in which the stepdaughter chose a girl puppet and the stepfather chose a bumblebee, the girl puppet pleaded for the bee to leave her alone. The stepfather, however, was observed to be intrusive with his puppet and eventually used the bee to repeatedly sting his stepdaughter’s puppet. This provided insight to the observing**

therapists regarding the stepfather's ability to control his behavior. It also became the topic of therapeutic discussion within the context of the puppet interaction.

When ordinary activities are carried into the play frame, behavior may be reordered, a sequence may be interrupted, movement may be exaggerated, and role switching may occur. However, the most important change is that the ordinary function of the sequence is not realized. Play allows events to occur in a novel setting, without their usual consequences. This helps to redefine the meaning of interaction between family members (Kobak & Waters, 1984). In a play frame, the therapist can push the family to be real and honest: "A move away from the well-worn paths of existing family interactions into the less certain and less predictable territory associated with change" (Koback & Waters, 1984, p. 97).

Play can be broken down into properties for the purpose of therapeutic analysis. The properties of make-believe play can be used by therapists to (a) regulate emotion; (b) facilitate expression; (c) illustrate; (d) materialize wishes, plans, and potential states; (e) own new views and ideas; (f) alienate aspects of the immediate reality; (g) separate levels of expression; and (h) make signifier-signified distinctions (Ariel et al., 1985). Ariel et al. provided analysis of three clinical examples using these constructs from their theoretical model. Their work isolates variables and provides a context for empirical process and outcome research.

### **Direct and Indirect Communication**

**The therapist, by participating in the family's play, offers a variety of direct and indirect channels of communication. Participation of families on a play-based project can stimulate verbal and nonverbal communication, revealing how a family mobilizes itself toward a task or goal (Irwin & Malloy, 1994).**

**Children can be very direct; descriptive case studies indicate children can help to highlight previously undisclosed information through their play and innocuous remarks (Lax, 1989). Case studies and historical research document how children are often the vehicles through which family secrets are revealed. It is with the emergence of the family secrets that parents begin to see the connection between children's symptoms and family problems. Through observation of play, parents have an opportunity to observe how their children feel about the family (Eaker, 1986).**

**Children may bring troubles that are just brewing to the attention of helpers; otherwise, the first stages of problems may be ignored or unrecognized (Zilbach & Gordetsky, 1994). Bloch (1976) gives a demonstration of this in a case study where a 6-year-old, after creating mayhem in his office, asked the question, "What's a graveyard?" She answered her own question by stating, "I know. That's where they bury people and the flesh rots off them," which she illustrated by pulling at her cheek. Shortly after this scene, both parents disclosed they were survivors of concentration camps (p. 173). Symbolic representations through play can lead to a gradual and direct clarification of areas of conflict. The use of an indirect approach (play, art,**

drama, etc.) to gain information lessens defenses and controls in communication and provides impetus for discussion (Irwin & Malloy, 1994).

It is probable that fundamental family functioning occurs at a nonverbal level, and the inclusion of young children in therapy can serve to broaden therapeutic potential. Families can experience holistic therapy versus strictly a cognitive, language-based process. Body language and symbolic cues may provide a host of information to the therapist as the family is engaged in a play-based activity (Keith & Whitaker, 1981).

#### Inclusion of All Family Members in the Therapeutic Process

The Integrative approach of practicing therapy with children and adults can provide an experience of mutual acceptance and understanding, as well as the freedom to share feelings both through words and play. The goal of including both parents and children in sessions is to provide a healing, reparative experience for both generations together (Pare & Allan, 1996). The family is able to express its total experience, and the therapist is able to get a picture of the entire family. This is helpful in sharing insight with the family (Scharff, 1994).

In actual therapeutic practice, children are more often excluded than included in family therapy settings (Chasin & White, 1989). The rationale is that children need to be protected from adult material as well as a theoretical orientation focused on adults. The exclusion “usually occurs by default, inattention, or other unrecognized attitudes on the part of therapists” (Zilbach, 1986, p. 26). Ackerman (1970), an early

supporter of inclusion of children in family therapy, spoke of the difficulties associated with mobilizing the participation of children. He noted the importance of relating to both the parents and the children as persons. The quality of rapport in each case is different, as well as the language. Gaining rapport tends to be difficult for therapists who feel skilled in working only with a certain age group, but, nevertheless, it remains necessary. Ackerman stated:

A strange paradox marks the question of the participation of children in the family therapeutic interview. The central importance of the question is self-evident; without engaging the children in a meaningful exchange across the generations, there can be no family therapy. And yet, in the daily practice of this form of treatment, difficulties in mobilizing the participation of children are a common experience. (p. 403)

Ackerman offered further advice about working with young children and relating to them as persons. First, children must understand that they are wanted and important in their own right. They are perceptive and quick to discover the truth. The child's presence in family therapy affects the adults in a positive manner. Action-oriented techniques, often used when children are present in treatment, are helpful in breaking through some defenses of highly verbal adults. Several in the field have indicated that an approach that includes children seems to produce less anxiety in adults (Eaker, 1986; Keith & Whitaker, 1981; Shaefer & Carey, 1994). Concrete representations of family dynamics can also be helpful in providing new information to the parents and the therapist (Villeneuve, 1979).

### **Engagement as a Form of Enactment**

**Engagement is a form of enactment in which families are not required to verbalize their feelings, but rather have opportunity to play them out (Ariel et al., 1985). Minuchin felt that asking questions might yield a less accurate picture than allowing a family to generate a spontaneous picture. In his therapy sessions, Minuchin had families act out problematic sequences in order for him to provide insight for change. This enactment used by Minuchin in his early years allowed the therapist to directly observe the family's process and intervene directly in that process. The threefold purpose of the enactment was (1) to define or recognize a sequence, (2) to direct an enactment, and (3) to guide the family to modify the enactment by offering options for change (Nichols & Schwartz, 1991).**

**Play is an ideal form of enactment due to the emotional distance it creates, allowing family members to share the truth. Play serves as a buffer and makes it easier for the adult to accept the child's feelings (Ariel et al., 1985). For adults, play assists in the verbalization of feelings and uncovers fears and anxieties that operate at an unconscious level, a result of the adult's early childhood experience. In the recreation of childhood experiences, adults can begin to form new relationships with their own parents; this approach will serve to reduce judgment and blame of any individual family member. Play also serves as a cushion in sustaining families who are at risk of dropping out of treatment (Ariel et al., 1985).**

**During the enactment or play process, the therapist develops a position or role such as audience, director, or actor, depending on the goals of therapy. Ariel et al.**

(1985) described various roles a therapist might assume in order to help the family reach desired goals: observer, commentator, interpreter, critic, planner, organizer, designer, or generator of ideas. The following descriptions explain some positions or roles a therapist might assume in a therapeutic session.

With intervention as a reporter, the therapist provides a running commentary on the family's play, which may address the raw materials, semantics, and pragmatics. Also considered are the interpersonal relationships with respect to roles, distances, and dominance (Ariel et al., 1985). The role of the therapist might be compared to a sportscaster in which a play-by-play description is given of family interaction (Landreth, 1991).

In the role of involved audience, the therapist might choose to reinforce selected aspects of the play in a positive or negative manner. The therapist would accomplish this by pretending to be a member of the audience who responds to the family's interactions.

The therapist as "provoker" induces the family to play a game around a particular theme by providing the family with material and stimuli that would foster certain reactions. For example, if the therapist is interested in viewing an altercation, he or she might provide tools such as soldiers, weapons, and army vehicles. The therapist may then direct, organize, or serve as the generator of ideas.

Finally, the therapist as "stanislavsky" influences the course of the game by playing the role of actor-director, which induces family members to assume complimentary roles. For example, the therapist, as a police officer, may ask the

family to pretend that he or she has apprehended the father robbing the bank. Indirectly, the therapist is in the role of interpreter and critic; while directly, the therapist plans, organizes, and generates ideas.

As with enactment, make-believe play can provide many therapeutic opportunities. The therapist has opportunity to view the family as a whole (Pare & Allan, 1996). Regulation of emotional intensity and facilitation of expression are both provided through the medium of play. Play is also used to illustrate complex and difficult ideas and may allow families to inspect new ways of experiencing reality. Furthermore, the content of play provides a context in which ideas and behaviors can be owned and alienated at the same time (Ariel et al., 1985).

### **Paradoxical Nature of Play**

Parallels regarding the paradoxical nature of therapy are documented in both Play Therapy and Family Therapy. Paradox refers to a statement seemingly absurd or self-contradictory, but founded on truth in reality (Allee, 1984). Both Play Therapy and Family Therapy are learned from experience, provide content shifts from real to “as if,” and provide opportunity for multiple meanings (Keith & Whitaker, 1994). Gregory Bateson (1972), noted for his foundational insights into family therapy, observed the play of otters and described this communication process: “The playful nip denotes the bite, but it does not denote what would be denoted by the bite” (p. 25). Some premonitory signal says “this is play” and not for real. These animals were able to practice fundamental survival skills without the threat of personal injury.



Bateson believed that psychotherapy is viewed in the same way. Although all human emotion can be experienced in the therapy setting, it is infused with a quality that says this is not for real. Nevertheless, the feelings may have the same intensity that they would in a real situation (Keith & Whitaker, 1994).

Madanes (1981) also explained that pretending to have a symptom does not stand for that which the symptom stands for. For example, pretending to have a temper tantrum is not experienced the same way the child would experience an actual tantrum. Pretending tends to be less limiting and restrictive than actually having the symptom. Play allows the constituent acts of the individual to have a different sort of relevance and organization than they would have had in nonplay. The essence of play may lie in the partial denial of meaning that the same actions would have in other situations (Bateson, 1972). It may be that the essence of play lies in the provision of additional meanings or in the distortions that can occur as both family members and therapists are free to experiment with new realities (Keith & Whitaker, 1994).

### Summary of Common Ties

In reviewing the common ties of Play Therapy and Family Therapy, the reader may understand why Family Play Therapy techniques should be of interest to both schools of therapy. Play is conducive to flexibility and enables families to play out their dreams and aspirations. The use of play provides the therapist with a variety of channels for communication. Young children can be actively involved in therapy, because play is their language and adults gain insight into the child's world. Families

engaged in play do not have to talk about problems, as issues are enacted. Finally, play is paradoxical in nature, lending itself to paradoxical therapeutic techniques often employed by Family Therapist and Play Therapist alike. Though literature is lacking with respect to Family Play Therapy, a few studies address the value of employing these techniques with families.

### **Family Play Therapy**

Family Play Therapy has been referred to as the marriage between Family Therapy and Play Therapy because play techniques are integrated into family systems therapy, with the benefits of each (Eaker, 1986). Family Play Therapy is “the use of play techniques to actively engage children in the sessions and the development of creative and energetic techniques that might give adults and children a common ground by which to communicate and resolve their conflicts” (Gil, 1994, p. 31). To date, *Family Play Therapy*, by Charles Schaefer and Lois Carey, and *Play in Family Therapy*, by Eliana Gil, have attempted to familiarize therapists with the rationale for Family Play techniques.

### **Rationale for Family Play Therapy**

Family Play Therapy integrates Play Therapy techniques with a systemic approach to families. When the child is the identified patient, play helps to defer transference issues away from the therapist and onto family members. Transference

onto a family member helps to avoid the child's attachment to a therapist who must eventually end the relationship (Eaker, 1986).

In Family Play Therapy, children can see their value in the context of the family. Parents and children can learn to respond and cope with mutual reactivity in a positive way. Play can enter an element of humor in what might seem like a hopeless situation. A sense of space is created by play, in which a problem can be thought out and a solution found (Eaker, 1986).

Family members are not protected from each other in Family Play Therapy, and the confusion that can develop when more than one therapist and treatment modality are involved due to "generational" differences is eliminated. Through the child's play, the family can develop some awareness that a problem is not the responsibility of the child alone. As the child changes and homeostasis is upset, the therapist can deal with reactions to the change directly and reveal how problems are maintained in the family (Eaker, 1986).

Most parents have heavy emotional investments in their children, and Family Play Therapy can capitalize on that fact. Family Play Therapy offers the potential to re-establish the positive connection parents desire with their children (Eaker, 1986). Even when there are barriers, such as substance abuse, underlying the child's symptoms, this method of treatment seems especially strong in empowering resistant families to action (Stanton & Todd, 1982).

No language barriers are noted in Family Play Therapy. The parent is able to see, through the child's symbolic play, how the child feels about the family. The

children are not bored with the session, and the magical thinking of the child is considered. Play creates some emotional distance that allows the truth to be handled and assists in expression of otherwise difficult material. Adults are able to connect with their own childhood, as play elicits emotional memories. Fear and anxiety can be uncovered, and the expression of feelings is facilitated through the play format. By teaching parents to interact with their child in the way the child feels most comfortable, future problems may be prevented (Guerney, 1983).

Finally, play serves as a cushion to sustain resistant families in treatment, due to its satisfying and nonthreatening nature. Play provides a retreat when issues become too intense in the therapy setting. Family play can serve to ameliorate anxiety as it emerges (Eaker, 1986).

### **Empirical Study on Family Play Therapy**

Duff (1995) designed an empirical study to look at the effects of Group Family Play on relationships within the family. Using a Solomon Four Group Design, family units (134 individuals) were randomly assigned to one of the four experimental or control groups. Families were assigned individual numbers based on their registration time. Random sampling was accomplished by writing on a 4 × 20 table the names of families who volunteered. The independent variable was the Group Family Play intervention. The dependent variable was the scores of family members on the SFI. Through the utilization of a one-way ANOVA with multiple comparison, the study measured the variance in the means of the four groups.

Those families assigned to an experimental group attended seven 90-minute sessions of Group Family Play in which they participated in an activity designed to promote interaction. All of the play activities were research-based and shown to be effective techniques for working with families or groups of individuals. Activities were noncompetitive and promoted a spirit of cooperation and problem-solving. The researcher did not function as a therapist but facilitated the activities, which were believed to be instruments of change in themselves. The play activities were semidirected, with time provided for each family to process their interactions during each session. After each activity, the family was asked a set of questions covering individual observations, communication, roles, and decision-making. The family then compared their behavior during the activity with their behavior at home. This discussion took place among the individual family units. The researcher provided the questions and clarification but did not participate in the family discussions. One experimental group completed a pretest and posttest, while the other experimental group took only a posttest.

Families in the control groups took both a pretest and posttest, or only a posttest depending on which control group they were assigned. They did not receive any play intervention until the completion of the experiment. At that time, they were offered a chance to participate in the play activities in a 2-day retreat format.

Families participating in the study were representative of families nationwide with respect to norms on the SFI. Most of the volunteer families from area churches did not exhibit profiles indicative of families that exhibit clinical concerns; however

posttest scores indicated improvement across all areas measured on the SFI. The one family scoring in the clinically significant range exhibited improved scores as well.

Results of the ANOVA indicated there was one chance in a thousand that improvements noted in SFI scores would have occurred by chance; thus the results indicated the benefits of family play in enriching relationships. With a significance level set at  $p = .05$ , the critical value of  $F$  was established as 2.68,  $df = 3/130$ . Duff's computed  $F$ -ratio was 7.247, which was greater than both the critical values for the .05 and .01 levels of significance. An  $F$ -ratio of 7.247 had a probability of  $p = .0001$ , indicating that healthy families benefited from the intervention. Improved communication and problem-solving ability were also indicated on the SFI. Duff recommended further inquiry as to whether families who score in the clinically significant range could also benefit from the play intervention.

### Summary

This chapter noted how quality play at any level has the potential to be therapeutic for both children and families. Play Therapy has a fairly extensive history, beginning early in the 20th century. Today, workshops presented around the world deal with play and its benefits, not only for children, but for adults as well. The materials used in play are important in understanding the language of children, as toys are really the words they use to express themselves. In working to understand the nature of children's play and expression, therapists realized not only the benefit of first teaching parents to play, but that parent needs could also be met in a play

session. As a result, some play techniques for families have developed. Among them are Sandplay, art, puppet interviews, games, and psychodrama.

After recognizing the benefits of using play with families, some in the Family Therapy field have exhibited an interest in play. A review of the history and development of Family Therapy reveals both an interest in the use of play and paradox in therapy. Uniting principles that are shared by Play Therapy and Family Therapy include the use of play as a medium for therapy and the ability to use direct and indirect communication in play. Other uniting principles addressed in the literature include the ability to include all family members in a meaningful therapy session, the ability to engage families and allow enactment of problem situations, and the use of paradox to create change.

Family Play Therapy is not an adaptation of a theory, nor is it an extension of the theoretical base of either Play or Family Therapy (Pare & Allan, 1996). Rather, Family Play Therapy is the result of a synthesis of ideas from both Play Therapy and Family Therapy schools, resulting in a different method of practicing therapy with parents and children. This chapter discusses the rationale for Family Play Therapy and addresses empirical research supporting the use of play with families.

## **CHAPTER III**

### **METHODOLOGY**

#### **Overview**

**This chapter presents a description of the methodology used in the present study on Group Family Play with at-risk families. Included is a discussion of the research approach and design, the selection of subjects for the research, and the sampling process. This chapter also contains information regarding the instruments involved in the study, with data reported on both the Self-Report Family Inventory (SFI) and the Parenting Stress Index–3rd Edition (PSI). The procedures for conducting the Group Family Play and the training of the research assistants are discussed. Specific information regarding what took place in each of the seven groups, and a list of the discussion questions that were processed following each play activity are also provided. Data tabulation and data analysis are reviewed and followed by the limitations of the study.**

#### **Research Design**

**The Solomon Four Group Design was employed due to its ability to ensure the highest level of internal and external validity. This design was used by Duff (1995) in her original study, upon recommendation by Landreth (Play Therapy) and Hampton (Family Therapy), who were experts in their fields.**



The Solomon Four Group Design consists of four groups of subjects: two experimental (one pretested and one not pretested) and two control (one pretested and one not pretested) (Table 1). The subjects (a family unit) from the pool are randomly assigned to one of the four groups (Babbie, 1989). This design has the ability to eliminate the effects of testing (Krathwohl, 1993).

Table 1  
Solomon Four Group Design

| Administration | Group |   |   |   |
|----------------|-------|---|---|---|
|                | 1     | 2 | 3 | 4 |
| Pretest        | X     | X |   |   |
| Treatment      | X     |   | X |   |
| Posttest       | X     | X | X | X |

The Solomon Four Group Design was developed to involve a minimum of 30 subjects in each group, with the total design requiring a minimum of 120 subjects for one experiment (Babbie, 1989). For purposes of this study, 121 subjects capable of completing the SFI were sampled. Only the adult participants completed the PSI.

The independent variable in this study is Group Family Play intervention. The dependent variables are family members' scores on the SFI (Health/Competence Scale, Style/Cohesion Scale, and the Conflict Scale), and the PSI (stress level). Data on the demographic variables of age, sex, and family configuration were collected for purposes of describing the sample.

### **Selection of Subjects**

**The sample population for this study was selected from volunteer families who resided in four rural counties in central Michigan. Families met at least one risk factor in addition to rural residence as specified by the guidelines of the Michigan School Readiness Program (MSRP) (Appendix A). Guidelines include child factors such as low birth weight, development delays, sexual and/or physical abuse and neglect, nutritional deficiency, long term or chronic illness, a diagnosed disability, violent temper and destructive behavior, or speech and language delays. Family factors include low income, single-parent families, large number of family members, rural housing with few neighbors, families who speak a language other than English, teenage parents, and families who have nonreaders or nongraduates. Other factors include a history of family problems, unemployment, frequent moves due to housing conditions, alcoholism or substance abuse, delinquency, incarceration, chronic illness, or loss of parent or sibling through death or divorce. The MSRP program, public schools, area churches, and other public service agencies belonging to the Multi-Agency Consortium were selected to publicize this study. Participating agencies signed an agreement to participate (Appendix B). Agency personnel encouraged participation at one of the local elementary schools designated as host sites for the study. The multipurpose rooms were located at the following four host schools: (1) Velma Matson Upper Elementary School, Newaygo, Michigan; (2) Jack D. Jones Elementary School, White Cloud, Michigan; (3) Grant Primary Center, Grant, Michigan; and (4) Patricia St. Clair Elementary School, Hesperia, Michigan.**

Volunteer families were recruited through postings and personal invitation from several different area agencies known to participate in the Multi-Agency Consortium (MAC). Hesperia Elementary, Newaygo Elementary, Grant Primary, and White Cloud Elementary Schools supplied flyers for children as did the MSRP program at the Neway Center in Newaygo. Postings were placed at Community Mental Health, Family Independence Agency, and some of the Community Education programs in Newaygo County. Registration was open for a 2-week period. After choosing the host site that was most convenient, individual families self-registered by phone, or at the informational meeting. At the time of registration, the family unit was assigned a number that was used to randomly appoint them to one of the four groups in the design. Each family that volunteered for the study and met the “at-risk” criterion was included provided they were able to make a 7-week commitment. Although the participation of the total family was encouraged, it was not mandatory. Families in the experimental groups who missed more than two of the seven sessions were not included in the study and were dropped from data analysis. Several families who registered by phone never attended the informational meeting; however, only 3 families of the 43 who signed participation agreements did not complete the study.

### **Sampling**

Participating families were assigned to groups by time of registration. All families who volunteered and agreed to participate for seven weekly sessions and met one at-risk criterion in addition to rural residence were assigned to the study. Upon

registration, families were offered a choice of four locations for the Informational Meeting (Administration/Play Demonstration session) and the treatment intervention. Assignment of families into each of the four groups occurred following registration. Families were given a number as they registered based on the time or order of registration (the first family to register is assigned "1," etc.), and they were assigned to either an experimental or control group. Both the experimental and control groups attended the first session, in which they completed a participation consent form and participated in a demonstration of Group Family Play. Two groups (one experimental and one control) completed the SFI and PSI. The control groups were offered an opportunity to participate in the play intervention. However, to do so they waited 6 to 8 weeks until after the administration of the posttest at the end of Session 7. Control group intervention occurred in a weekend retreat format where all play activities were completed in 2 days (Friday evening 7:00 to 8:30 and Saturday 9:00 a.m. to 12:00p.m). It was explained at registration that due to the experimental nature of the play groups, some families had to wait up to 6 weeks to receive play intervention following the initial informational meeting. Families had the opportunity to decline participation when given this information.

### **Instruments**

#### **Self-Report Family Inventory (SFI)**

The SFI was developed by W. Robert Beavers and Robert B. Hampson at the Southwest Family Institute. The inventory is part of a comprehensive battery of tests

based on the Beavers Systems Model, which is a specific model of family functioning. It is a reasonable screening tool and the only part of the assessment battery completed by individual family members, allowing an insider perspective. The SFI measures competence and cohesion (an estimate of family style) for each family member based on his or her personal observation of what it is like to be a member of that family unit. Also measured are the individual's views on leadership, conflict, and emotional expressiveness. The SFI is norm-based and is nationally recognized as an assessment tool for measuring family competence and style (Beavers & Hampson, 1990). The SFI, a 36-item questionnaire, provides an overall measure of family health/competence. The SFI also provides a measure of style through the cohesion score, and a measure of conflict.

The SFI uses the continuum of Family Competence and a measure of Family Style to measure family functioning. The scores from these scales are plotted on horizontal and vertical axis with the intersection giving a total analysis of the family's views on its functioning. The intersecting score from the SFI can fall within one of five dimensions: Severely Dysfunctional (10–9), Borderline (8–7), Midrange (6–5), Adequate (4–3), and Optimal (2–1). Families considered healthy fall into the Midrange, Adequate, and Optimal styles. Statistical mean scores appear to lie in the Adequate to Midrange levels of Family Competence across groups (Beavers, 1982). The scores on the Health/Competence Scale, Style/Cohesion Scale, and Conflict Scale of each age eligible participant were used for purposes of this research.

In addition to its ability to assess individual family members' perceptions of health/competence, style/cohesion, and conflict, the SFI looks at two other related domains. It provides a scale to assess leadership and emotional expressiveness (Beavers, 1982). The questionnaire is fairly simple to complete, and children as young as 10 or 11 have little difficulty completing the instrument independently (Beavers & Hampson, 1990). Children even younger can successfully complete the SFI provided it is read to them and they are capable of understanding the items (Duff, 1995).

Cronbach's alpha for the SFI is between .84 and .88 with high test/retest reliability ( $p < .01$ ). The correlation between observation and self-report Competence scores are very high at the more dysfunctional end of the continuum. A moderate correlation (.62 canonical correlation) has been found between the SFI and ratings by trained observers. Further, the SFI discriminates between high and low functioning families (Beavers & Hampson, 1990). The developers report varying amounts of concurrent validity (.50 to .85) of the subscales on the SFI that correlate with the subscales of FACES-II, several factors of the Bloom Family Functioning Scale, and ratings of a clinical sample of 71 families (Beavers, Hampson, & Hulgus, 1990).

The Beavers model defines Competence as how well the family unit performs the necessary and nurturing tasks of organizing and managing. Competent families are more readily able to resolve conflict and communicate openly and directly. Competence is viewed along a progressive continuum to promote the view that observable and measurable growth and adaptation in families is possible. Families at similar competence levels may show different functional styles of relating and

interacting. The most competent families are able to shift their functional style as developmental changes occur, whereas rigidity in functional styles is noted in the most dysfunctional families. Test items measuring competence on the SFI are geared toward the family's ability to organize and manage itself, with some items covering communication skills, flexibility, and problem solving (Beavers & Hampson, 1990).

Family style refers to the degree of centripetal or centrifugal qualities in the family. Centripetal families seek satisfaction within the family and hold on to children longer. They are less likely to trust the outside world. Internalized disorders, such as anxiety and depression, are more often observed in these families because they tend to deny or repress any negative feelings. Centrifugal families, on the other hand, seek satisfaction outside their family unit. In centrifugal families, the children tend to leave the nest at earlier ages than considered the norm, because members trust activities and relationships outside the family more than those within. Members are wary of affectionate messages and are more comfortable with anger and hostility. Conduct and aggressive disorders are more common in these families (Beavers & Hampson 1990). Questions on the SFI addressing cohesion tend to look at closeness, togetherness, and whether the family enjoys time and activities together. However, concerns are reported that these questions do not measure style particularly well (Beavers & Hampson, 1990). Difficulties in measuring style may be a result of "levels of perception" in that interactional bonding patterns might be difficult to see from the insider perspective. Secondly, it is difficult to put therapeutic terms for style into a vocabulary that is easily understood by the general public. As a result of attempts to

define terminology, the individual might perceive questions differently than what the scale developer intended, causing some question with validity.

### **Parenting Stress Index (PSI)**

A second instrument used was the PSI (3rd edition) authored by Richard R. Abidin (1995). The PSI consists of a 101-item, self-scoring, 5-point Likert questionnaire, yielding a Child Domain score (six subscales), a Parent Domain score (seven subscales), and a Total Stress score (combined subscales). The instrument measures six stress factors related to child characteristics (the qualities that make it difficult and stressful for the parent to successfully engage in the parenting role). These measures include the four child temperament variables of mood, adaptability, demandingness, and distractibility/hyperactivity. Also included are parental perceptions related to acceptability and reinforcement of the child. The instrument also assesses stress from parent characteristics (sources of stress and potential difficulties that relate to dimensions of the parent's functioning within the parent role). These are the parent's sense of competence, depression, and attachment. Also measured is situational data concerning support of spouse, parent's health, role restriction, and social isolation. High scores (above the 85th percentile) are an indication of stress levels that require further investigation (Abidin, 1995).

The primary functions of the PSI are early identification, individual assessment, screening, and pre-post measures of intervention effectiveness (Abidin, 1995). Many studies document validity and reliability information (Abidin, 1995).



With respect to validity, 95% of the original PSI's items were related to at least one research study linking the attribute measured to parental stress (Impara & Plake, 1998). Several studies demonstrate that the relationship between PSI scores and theoretically relevant variables are quite robust with respect to behavior problems, childhood disabilities, at-risk families, and parent characteristics, to name a few (Kazdin & Mazurick, 1994; Krauss, 1993; Owen & Mulvihill, 1994; Volenski, 1995).

A weakness of the PSI tends to be in the standardization and normative data. The sample ( $N = 2,633$ ) used for normative purposes was not random and most of the subjects were from a similar geographic region. Also of concern is possible misuse of the PSI in making interpretations about families with respect to referral. Difficulties with factor analysis do not support statements concerning whether a family should or should not be referred. The PSI is believed to be more valid as a screening tool and is not recommended as a diagnostic tool without supporting information. Most preferable would be information from a family interview (Allison, 1998; Barnes & Stinnett, 1998).

The PSI manual reports strong reliability for each of the domain areas (.90 for the Child Domain, .93 for the Parent Domain, and .95 for the Total Scale), while subscale reliability coefficients are lower but thought to be acceptable. Test-retest reliability was noted to be .96 for a 1- to 3-month interval, and .65 for a 1-year interval (Allison, 1998; Barnes & Stinnett, 1998).

Studies conducted by Tam, Chan, and Wong (1994) supported reliability of the PSI with a Cronbach's alpha exceeding .90 and a small standard error of

measurement. The PSI was noted to have good concurrent validity through its correlation with those variables conceptually related to general stress. Several recent studies provide evidence for the construct and predictive validity of the PSI (Abidin, 1995).

### **Play Group Procedures**

#### **Research Assistants**

There were three to four research assistants per team at each site of the study. A minimum of two research assistants had a degree in a helping profession with training in play therapy, while the other one or two had a background or interest in a psychology, social work, or counseling field. The lead research assistant in each site had background and experience in group dynamics, play therapy, conflict resolution, and crisis management. Following is a list of the sites as well as Lead Research Assistant and Research Assistants who participated in the study:

Working in Location 1—Hesperia, Michigan at Patricia St. Clair Elementary—was Lead Assistant Ken Rooy M.Ed, Teacher Consultant, Infant Mental Health Specialist (background in group dynamics, emotional impairment, crisis intervention specialty, play therapy, and early childhood). Assisting Mr. Rooy, was Melissa Frendo, Elementary School Counselor, Licensed Professional Counselor (background in mental health, education, family, and group dynamics). Rebecca Frendo, psychology student at Central Michigan University, and Joseph Summerskill, high school psychology student at Hesperia High School completed the team.

**At Location 2—White Cloud, Michigan—was Lead Assistant Barb Liescheidt, MSW, CSW, Elementary School Counselor (background in crisis training, residential treatment of adolescents, and parent trainer for love and logic). Assisting was Julie Conati, Ed.S., PPI Teacher, School Psychologist (background in early childhood education, group dynamics and play therapy). Also part of the team were Heather Giese, B.A. (experience in criminal justice and crisis management) and Ezekiel Hernandez high school psychology student from Newaygo High School.**

**The team at Location 3—Newaygo, Michigan—consisted of Lead Assistant Mark King, Ed.S., School Psychologist (experience with individual and group therapy, 150+ hours play therapy training, 50+ hours in play therapy supervision, crisis management training and experience). Supporting Mark was Gloria Switzer, M.A., ZA-PPI endorsements, Teacher Consultant, Early Childhood Specialist (background and experience as a classroom teacher, consultant, and World Wide Marriage Encounter Presenter). Assisting was Colleen Myers, B.S., Early Childhood Specialist (9 years experience working with parents and children in early childhood programs), and high school psychology students Andrea Bergman and Kianna Longnecker, from Newaygo High School.**

**Making up the team at Location 4—Grant, Michigan—was Lead Assistant Barbara Krepps, CSW (18 years experience in Crisis Intervention /Prevention Training, Behavior Management Trainer, Positive Behavior Supports, Group Dynamics, and Play Therapy). Supporting her was Deborah Davis, MSW (5 years of training in Play Therapy, Group Dynamics training, and a current member of District**

Crisis Response Team). Other research assistants included Trish Lichon, B.S. in psychology (experience in families and prevention work), and Suzanne Portillo, BA in sociology, MSW intern.

The alternate for the research assistants was Coni Towersey, Infant Mental Health Specialist (experience in parent training, family work, crisis counseling, and certified CPR instructor).

### **Research Assistant Orientation**

Prior to conducting this study, all research assistants met with the researcher for a 5-hour orientation session. During orientation, the assistants received an orientation packet and learned about the instruments they would be required to administer. They also learned their role as research assistants throughout the seven sessions. Research assistants were instructed to stay away from offering advice or suggestions to families, but rather were to wonder aloud with the family about possible solutions. If a family was really stuck, assistants could ask them to observe or seek support from another family. Following an explanation of their role, research assistants formed into family groups and took turns participating in each of the play activities experienced by the families. Processing occurred at the end of each activity. During each activity, one group of assistants practiced working with the other family groups and responding appropriately to questions, concerns or impasses that arose. This type of training served to prepare the assistants for the actual study. Assistants

also understood that the researcher was available for consultation throughout the course of the intervention.

### **Setting**

Four multi-purpose rooms in Grant, Hesperia, Newaygo, and White Cloud Elementary Schools were chosen as host sites for the study. The rooms were able to comfortably accommodate 80 or more individuals. Permission was received from local school districts to use facilities. All participants met at their host site during the first week of the study for an informational meeting, and experimental groups continued to meet at that setting for the duration of the study. Retreats for control groups to participate in Group Family Play after completion of the research were held in a conference room at the centrally located Neway Center in Newaygo, Michigan. A snack was served at each session to encourage participation and to discourage attrition resulting from scheduling difficulties. Ice cream sundaes and trail mix appeared to be favorite snacks. The families in the experimental groups also received tickets for each session that they were in attendance. Two drawings occurred, in which tickets were drawn, and families were able to choose prizes from an assortment of family games, such as Chicken Soup for the Family, Twister, Uno, Skip-Bo, Disney Charades, Guesstures, and Sand Trays. One drawing occurred the 3rd week of the study and the final drawing occurred during the last session. Families from the control groups joined the experimental groups during the last session and all families that attended the last session to complete their paper work received a game for their

family. During the last session all children received simple prizes for participation such as bubbles, play dough, finger puppets, and water balls. Families seemed extremely excited about the drawings and based on comments heard from the participants, the research assistants believed that these incentives promoted attendance.

### **Participation Agreement**

Families who responded to the flyers to gain information or register for the informational meeting talked with the researcher, who followed the phone script (Appendix C). If they met the eligibility for being at-risk, they were invited to attend the informational meeting/ first session.

All families in the study were invited to attend the first session in which they were served ice cream sundaes and received an in depth explanation of Group Family Play. Sample activities were available for perusal. Confidentiality issues were discussed with respect to the assistants keeping all information confidential and the desire that families do so as well, due to the nature of living in a small community. After receiving an explanation of the study, individuals choosing to participate signed an agreement to participate. There were separate agreements for the adults (Appendix D) and the children (Appendix E). Children were taken to another area in the room, where an assent form was read to them that they were asked to sign. Children were instructed that if they chose not to participate they could sit quietly and wait for their family. They also had the right to pass on any items they choose not to answer.

Parents were instructed that it was not necessary to make their children participate. All individuals were told that they could drop from the study at any time without recourse. They also had the right not to participate or answer questions that made them uncomfortable. A research assistant orally read the agreement to ensure that all participants understood it, and questions were answered. Participants were informed that due to the nature of the experimental process, there were differences in paperwork and time of the study, but the same play intervention was offered to all participants.

Control groups were offered the opportunity to participate in a retreat format of Group Family Play following the 6-week intervention. This occurred on the first and third weekend of June at the Neway Center, a centrally located facility. Those participants who had to wait for treatment had their names entered in a drawing for prizes (puppet sets, sand-tray, games, etc.) to be picked up during the posttest session. All families who attended received a prize. They also received at least one call from the researcher during the wait time to check on the family.

Families in the experimental groups participated in six 90-minute sessions of Group Family Play over the next 6 weeks. These occurred on the same evening, at the same time and at the same location they first attended. Families were encouraged to attend all of the six sessions; however, they could miss up to two and still be a part of the project. If they knew in advance they would miss more than two sessions, they were discouraged from participating, but they still had the opportunity to participate without penalty.

### **Pretest and Posttest Schedules**

Following the signing of the participation agreement, families received their assignment to a group (name tags were colored coded with a sticker). Everyone participated in a play demonstration, followed by separation into color coded groups.

The research assistants meeting with individuals in Group 1 (red) administered the pretests (SFI for anyone 7 and over capable of completing the test [children could choose not to take the instrument] and the PSI for parents). Participants were advised that they could choose at any time not to answer a test item. Supervised child-care was provided in a separate area for children too young to complete the instrument or those who had finished with the SFI. The child-care for this session was provided by the assistants from Groups 3 and 4 who had dismissed their families. The attendance policy (must be present at a minimum of four sessions) and the setting for the following six sessions was reviewed. It was also explained that it would be necessary for individuals in Group 1 to take a posttest at the end of the study. Group 1 was given a schedule and excused.

Research assistants also met with Group 2 (blue) individuals to administer pretests and to explain to the members that their play intervention would begin in 6 weeks in a weekend format. Assistants informed participants that they could choose to refrain from answering any test items that made them uncomfortable. They were to participate on Friday evening, 7:00 p.m. to 8:30 p.m., and Saturday from 9:00 a.m. to 12:00 p.m., with breakfast and snacks provided. They could choose from two weekends. Group 2 members were informed of the prize drawing, the need to have



them complete posttests, and at least one call from the researcher to inquire about the family during the waiting period. Posttesting occurred at the end of session 7 or at an arranged time in the 2 weeks that followed session 7, prior to their participation in the retreat. They were given the dates, times and locations for the retreats. Group 2 members were excused.

Research assistants meeting with Group 3 (yellow) told them of the time, location, and attendance requirements for Group Family Play. It was also explained that they would be asked to complete a posttest during session 7 or at an arranged time in the two weeks that followed session 7. Group members were given a schedule of play sessions and were dismissed.

The research assistant meeting with Group 4 (green) explained to the members that their play intervention would begin in 6 weeks and would take place in a weekend format. Families were informed of the prize drawing and that they would receive at least one call from the researcher during the waiting period. They were informed of the need to complete some posttests administered during the latter part of session 7 or at an arranged time in the two weeks following session 7, prior to the retreat. The assistant also gave notice of retreat dates, times, and locations and they were dismissed.

### **Goals of Group Family Play Sessions**

The Group Family Play sessions were designed to stimulate communication and discussion through a series of questions that followed participation in each

activity. Although families may have had some difficulty during the initial sessions, they became increasingly familiar with discussion as the weeks progressed. The expected outcome was for them to be able to work together to understand their family dynamics and make appropriate adjustments independent of outside counsel.

### **Discussion Questions**

Discussion questions were designed to make families aware of patterns of interaction and communication that existed within their unit. The individual members' roles within the family were also discussed. Questions processed by each individual family unit were as follows:

1. What did you notice about your family during the activity?
2. How did each of you communicate (get across to the others) your feelings and thoughts?
3. What was each person's job, role, or major part in the activity?
4. How were decisions made (who made them or had a part in making them)?
5. How was the way your family interacted similar to what happens at home?

### **Nature of Play Group Activities**

The activities provided during the seven sessions were intended to bring families together as a unit. All family members present were required to participate in order to complete a task or activity. The nature of the play was designed to promote cooperation, and processing was intended to result in an increased understanding of

family dynamics. The activities involved physical movement, art, drama, sand play, and group initiatives designed to be fun and of interest to all ages. The following sections address the techniques and activities of Group Family Play.

### **Session 1—Administrative/Play Demonstration**

During the first session, participants formed groups of 8 to 10 members (two or three families per group) and selected a person to start a Nerf or sponge-ball juggling activity. The research assistants handed a ball to a member of the group (designated by the group), who tossed the ball to another person, who in turn chose another group member and passed the ball. A pattern was established and learned, with appropriate adjustments made for small children. Each ball was handed by the research assistant to the designated member (one ball for each member), who immediately threw it until all balls were in use.

**Goals.** The goal was for the group to keep all balls in the air. The exercise temporarily stopped when balls were dropping and group members problem-solved solutions for keeping all the balls aloft simultaneously. Ball-throwing practice alternated with problem solving until all balls remained in the air.

**Role of the Research Assistants.** The research assistants provided support as directed in the orientation session described above. The assistants joined the group in wondering what could be done differently. If a group was unable to continue the activity, the research assistants asked the group to observe another group or to talk to

group members who seemed to be having some success. Following the play activity, two research assistants administered the pretests to members of Groups 1 and 2, while two research assistants dismissed members of Groups 3 and 4. The two who dismissed members also supervised the younger members of Groups 1 and 2 who were not engaged in taking the pretests.

**Family Processing.** The processing that occurred during the introductory play session was group-directed and occurred within the confines of the small groups, which was different from the processing discussed earlier. The groups discussed ideas for successful task completion. Processing among individual families did not occur at the end of this introductory session, as families in the control groups needed to wait 6 weeks to receive their group play experience. It was noted in the original experiment that families struggled during the first few weeks with the processing activity, thus the researcher believed it would be helpful to postpone questions directed toward family dynamics and issues. The researcher was sensitive to the fact that some families had to wait for intervention.

### **Session 2—Family Sand Play**

Each individual family sat around a large tray of sand with various miniature figurines available. Together family members planned and built one picture (as opposed to a compilation of pictures) in the sand. Family members were encouraged to experiment and play, making several different pictures as time allowed, with some processing after each. Upon completion of their final picture, each individual chose an

item of particular interest. Individuals shared some aspect of the object that they liked, which they also liked about themselves, or some aspect of the object they did not like, which they also did not like about themselves. They could indicate one aspect of the object that they would like to emulate in their own lives, and make an accountability agreement with family members to work on it. Families could also choose items to represent each other as time allowed.

Goals. One goal of this exercise was to get each family to work together on a project and to promote dialogue. Another goal was for each individual family member to choose some aspect of himself or herself to improve upon, and to ask for family support.

Role of the Research Assistants. The research assistants introduced the activity, mingled among the families, and provided support to those who were struggling with the sand picture. When the pictures were finished, research assistants provided thought provoking questions regarding the choice of objects, and the families processed them within their individual units. Assistants mingled at that time, supporting the families who needed help getting started. Following the sharing time, research assistants introduced the five process questions and gave families a copy of the questions. They allowed 2 to 3 minutes for family discussion following each question. Larger family units required more time.

Family Processing. Two processing activities took place during this exercise. Family members spent time sharing what they liked or did not like about the object

that reminded them of themselves. After completing this sharing, families were introduced to the five process questions that followed each activity. Families were given some time to address each of the questions within the individual family unit. For closure, all families briefly reassembled. Some families chose to share their thoughts and feelings on the experience of sandplay.

### **Session 3—Overcoming Obstacle Challenge**

Families gathered into four groups of 8 to 10 individuals and formed a circle. They could divide into groups any way they desired, provided that all members of each family unit were in the same group. The first exercise was to pass a tennis ball around the circle as quickly as possible. A research assistant challenged group members to work at a faster pace until they met a set goal. The research assistant also helped the group to set a reasonable goal. Following this exercise, the groups were given three items (tennis ball, coffee can, and large cylinder block) which also had to travel around the circle. The rules for participation stated that no hands were used and that once a specific body part was used, it was not to be used again for another item. If an item was dropped, it was started once again from the beginning of the circle. The exercise was complete when all three objects had successfully traveled around the circle. Following successful completion of the activity, families were divided into their individual units to process questions.

**Goals.** The goals of the activity were to have families work together toward a common goal, to promote problem-solving and communication, and to provide input

from outside the family unit. The groups were responsible for setting their own goals and achieving them. If obstacles occurred, they had to work together to find a solution.

**Role of the Research Assistants.** The research assistants introduced the activity and provided support and encouragement to the group. They assisted some groups in setting reasonable goals. They also had the responsibility of timing the activity to determine if the group met its goal. If a group became frustrated, research assistants wandered aloud with the group and promoted discussion among the members. They also introduced the five process questions at the end of the task and allow 2–3 minutes for discussion.

**Family Processing.** Processing occurred throughout the exercise, directed by the research assistant if the group was not self-directed. When the exercise was completed, the families addressed the five questions that followed each session. Families were encouraged to continue to reflect on their interaction patterns and roles. Families also discussed if they had observed any differences since the last session in their roles and communication.

#### **Session 4—Family Aquarium**

After receiving various arts and crafts materials, each family member was to create and decorate a fish of his or her choice. Books on fish and various templates were available if family members chose to use them. Family members were asked to

arrange their completed fish in an aquarium (blue poster board) where they were most comfortable. Once they had negotiated placement in the aquarium and everyone was content, individuals shared why they chose that particular location for their fish. Family members also explained why they chose to be near a particular fish. Finally, they shared what they would change about the present arrangement, if anything.

**Goals.** The goal of this exercise was for individuals in the family unit to agree upon a configuration in the aquarium that included and felt comfortable to everyone. Secondary goals consisted of communication and problem-solving with regard to placement and arrangement.

**Role of the Research Assistants.** Research assistants introduced the exercise and assisted with supplies as necessary. They supported and encouraged families who had difficulty working on the task. Research assistants asked families to share their thoughts concerning placement, proximity, and change by providing individual copies of questions for the families who were self-directed and providing support for families struggling with the task. At the completion of the activity, the research assistants asked the families to consider the five process questions and also any changes that had occurred since the last session.

**Family Processing.** This exercise consisted of two processing activities. The family discussed the finished aquarium with respect to placement (bottom, top, half-out, behind a rock); proximity (close to mom's fish, far from older brother's fish); and wishes (next to Dad's fish, but the baby's fish is there). The family also processed



roles and communication style by answering the five process questions. The group could also discuss any changes in the family's play since the previous session.

### **Session 5—Frogs and Lily Pads**

Families were grouped into eight teams consisting of five to eight individuals, with each family participating on the same team, and each team having a distinct sticker. Equally numbered family teams faced each other on one log (2" × 6" × 8' boards placed securely end to end) with one empty space separating the two teams. For example, a family of six may face a family of two and a family of four. Only one person could move at a time and no one could pass his or her own team member-only members of the other team. If someone stepped off the log, the activity began all over again, with everyone back in the original position. Members with physical disabilities preventing this sort of movement acted as coaches to their team.

**Goals.** The goal was for each team to move to the opposite end of the log, through cooperation and teamwork. In this exercise, the family had to work with input from another social system or family in order to accomplish the task. Communication was especially important for the successful completion of this activity.

**Role of the Research Assistants.** Research assistants were responsible for introducing the task and providing support. Due to the nature of this activity, some families became frustrated and required more support. Research assistants were able

to comment empathically and wonder aloud about possible solutions. They also directed a frustrated group to another more successful group to gain some input. Following the exercise, the research assistants reviewed the five process questions, while allowing time for each family to process.

**Family Processing.** Processing occurred at the end of the activity with each family separating into its own unit. In addition to discussing the five process questions concerning roles and communication, the family was asked to share anything learned from the families with whom they worked. They could also indicate whether they had noticed any change in their interactions and roles since the previous session.

#### **Session 6—Puppet Stories**

From an assortment of puppets and without consulting other family members, each family member chose a puppet to use in a story. The family then told a story with a moral. The story had to be one that they have never seen or heard before. A guideline (Appendix F) presented examples for story development and covered the introduction of characters, setting, plot, and moral. This guideline provided support for families who needed help in creating a story. All family members had a role in the story in some capacity, and together they decided how to best present the story to the other families. Stories were shared in a total group setting, with feedback encouraged from the other families using “I statements.” When the exercise was complete, processing within the individual family concerning this exercise occurred.

**Goals.** A goal of this exercise was to promote communication and cooperation with all family members. Another goal was to allow families to observe what was happening in other families and to provide feedback and support. Families were also able to receive suggestions and support from others.

**Role of the Research Assistants.** The role of the research assistants was to introduce the activity and to ensure everyone has access to a puppet of choice. This sometimes required that one puppet be shared between families. Research assistants aided in negotiation. They also provided support to families as they worked on their stories. They used the guideline to ask questions that assist families in developing ideas. For example, “Do you have all the characters’ names and personalities?” Once the families were ready to share their stories, the research assistants assembled all the families to review the use of I statements when giving suggestions or feedback. They asked individual families to share, and they provided support and encouragement. They also asked other families for comments and feedback following each presentation. Families then spent a few minutes answering the process questions asked by the research assistants.

**Family Processing.** Total group processing and individual family processing were part of this exercise. Families received and gave information to other families following the story presentations. Individual family processing questions addressed roles and communication patterns. Families were asked to process whether interactions had changed since the previous session.

### **Session 7—Family Drawings and Posttests**

Each family unit worked separately on this activity. Pairs of crayons were distributed to family members, with no exchanging of colors allowed. One piece of poster-size paper was placed in front of each family. Without talking, the entire family unit drew one picture. Families then discussed the picture and discussed what occurred as a result of not being able to talk during the activity. Crayons were passed to the person on the right, and the procedure was repeated with new paper. Once again, no talking was allowed. Families discussed the picture and the results, and crayons were again passed to the right. Given the last sheet of paper, the family members drew a third picture, but this time they were allowed to talk. The family was asked to compare the pictures and to note the differences. The total group was then gathered so all families could display their pictures and tell what the activity was like for them as a family. Group members commented on the activity. Families then divided into individual units and processed the five questions concerning roles and communication style and also discussed what they learned during the play sessions. For closure, families reassembled with all participants to share thoughts and feelings about participation in the study. Following this discussion, all group members capable of completing the posttest did so. High school research assistants supervised the younger children, as well as the older children who had completed the SFI, in an area separate from the posttest administration. A drawing was held for prizes with all participants in attendance receiving a prize.

**Goals.** The goals of the activity were to help the family observe the results of communication and to learn from their experience and the experience of others. Some family members also began to realize that individuals can come together in a cooperative effort if they are able to communicate. Several individual drawings could be included in a single picture if the family was able to communicate and agree upon a common theme.

**Role of the Research Assistants.** Research assistants introduced the activity and enforced silence during the first two drawings. They assisted families who were having difficulty comparing the pictures and the process (nonverbal versus verbal) involved in creating them. The research assistants assembled the families for the sharing of pictures and reviewed the use of “I statements” when giving feedback. They invited families to share and provided necessary support and encouragement. Research assistants dismissed families to their individual units to cover the five process questions concerning roles and communication, and to discuss what they had learned. They gave the family adequate time to process the information. Finally, two research assistants administered the posttests, while two assistants supervised the younger children. Assistants were not responsible for scoring the instruments.

**Family Processing.** Processing was two-fold during this activity. Families were asked to compare and contrast the pictures they created. Were the pictures they drew while not talking different from the ones they drew when they were able to talk? If so, then why? Secondly, families were asked to process the five questions used during

each activity and address what they learned from the Group Family Play experience. Families were then given a brief opportunity to share their thoughts and feelings on the study with all the participants and were given a blank comment sheet to use if they desired to share any comments with the researcher.

### **Procedures**

The following procedures were utilized in collecting data for the study.

1. Each participating agency was notified by phone or in person of the actual dates set for the project. Flyers were provided to inform families of the study and to provide information regarding registration and the informational meeting (Appendix G). Some promotional work was accomplished in person, by the researcher, with visits to area schools to explain the study.

2. Sign-up for the study occurred via a phone call to this researcher from families wishing to participate, or from families attending the informational meeting. At this time it was explained to families that some would receive the Family Play Group intervention earlier than others, due to the nature of the study. Each family was screened to see if they met the at-risk criterion. Families who did not meet the criterion would have been invited to participate with the control groups at the conclusion of the 7 weeks. However, all families who called met the criterion. Personnel at participating schools also accepted registrations from families that met the criterion and returned them to the researcher, who assigned them a number.

3. From the lists of qualifying participants in each location, families were assigned to groups. Qualifying families were assigned a number based on the chronological time of registration. The first family that called for registration was assigned "1." The second family received "2," and so forth. Once all the families were given a number, the researcher assigned them to a group. "1" went to Group 1, "2" to Group 2, "3" to Group 3, "4" to Group 4 and the process was repeated. Families were given their group assignment during the first session, following an explanation of the study, signing of the participation agreement, and demonstration of Group Family Play. Families were informed that due to the nature of the experimental process there were differences in paperwork and time of study, but the same play intervention was offered to all participants.

A team of research assistants met with individuals in Group 1 to administer the pretests and review the time, attendance policy (must be present for at least four additional sessions), and setting for the following six sessions of Group Family Play. It was also explained that it would be necessary for them to complete a posttest. Group 1 members were given a schedule and then excused.

A team of research assistants also met with Group 2 individuals to administer pretests and to explain to the members that their play intervention would begin in 6 weeks in a weekend format (Friday evening, Saturday morning). Group 2 members were informed that the researcher would call once during the 6-week waiting period to inquire about the family and to ask them to complete some posttests. Posttesting occurred during session 7 or at an arranged time in the 2 weeks that followed session

**7. The researcher also gave notice of the retreat times and locations. The Group 2 members were excused.**

**Research assistant teams meeting with Group 3 told them of the time, location, and attendance requirements for Group Family Play. It was also explained that they would complete a posttest following session 7 or at an arranged time in the 2 weeks that followed session 7. Group members were given a schedule and dismissed.**

**A research assistant team met with individuals in Group 4 to explain to the members that their play intervention would begin in 6 weeks in a weekend format (Friday evening, Saturday morning). Group 4 members were informed that the researcher would call once during the 6-week waiting period to inquire about the family and to ask them to complete some posttests. Posttests were administered during the latter part of session seven or at an arranged time in the 2 weeks that followed session 7. The assistant also gave notice of the retreat times and locations.**

**Demographic data on each participant in the study was charted at the time of registration. Of interest was age, sex, family configuration, and number of individuals in the family unit. Also recorded were the at-risk factors (Appendix A) that made the family eligible for participation in the study. Risk factors included low income, diagnosed delays or disabilities, single parent, history of family problems, and a large number of family members, to name a few.**

**4. Training sessions took place to train volunteer research assistants (early childhood specialists, psychologists, social workers, and counselors and high school**



psychology students), who assisted the researcher. Each group consisted of at least two professionals who worked with children and families, and one or more student assistants. The role of the research assistants was to explain the play experience and support families in their endeavors to carry out each exercise. A training session was conducted by the researcher to train research assistants. The researcher was also available for consultation during the 7 weeks of the study, if questions arose. The goals of the training included administration of the SFI and PSI, review of content in family play sessions, and information concerning process questions. Research assistants physically participated in each play activity to experience the task the families would be given. This hands-on experience helped to clarify directions and allow the teams to resolve any misunderstandings that might arise while working with actual families. Allowing research assistants to struggle with the play exercises also increased empathy for families who struggled with some of the more difficult activities. Specific instructions were given concerning the kind and level of support that the research assistants could offer families. Research assistants were allowed to empathize with the families by making statements such as, "I see that you are really struggling with this activity." They wondered aloud with the family regarding ways to be more successful without recommending any solutions. "I wonder if anyone in the family has an idea about how we could do this better?" They directed a family to observe or ask for suggestions from others who appeared to be successful with a particular task. The research assistants did not offer suggestions, helpful hints, or advice. Each assistant practiced appropriate responses to struggling families via role-

play. Research assistants became familiar with the process questions that were unique to some play activities and the five common process questions that were discussed at the close of all but the first of the Group Family Play activities. This served to facilitate their understanding of the process activities and helped them to anticipate questions.

### **Data Collection**

The SFI (pretest) was administered during the initial session to each family member 7 years of age and older in Groups 1 and 2. Only the parents in Groups 1 and 2 took the PSI pretest during the first session. Parents completed the PSI on the child whom they found most difficult to deal with in their family. Those group members not required to complete test protocols during the first session were dismissed after further instructions. Children too young to participate (unable to understand the SFI when read to them) or children finished with the SFI were supervised in another area in the facility.

All family members (7 years of age and above) of all groups took the SFI (posttest) during the second half of Session 7 or at an arranged time in the 2 weeks that followed. Secondly, the PSI (posttest) was administered to each parent participating in the study during the seventh session or within the 2 weeks following completion of the study. Parents completed the PSI on the same child indicated in the pretest, or if they did not take a pretest, they completed the PSI on the child they found most difficult to parent. Families coded their protocols with their assigned

number received at registration for confidentiality purposes. Group administration of these instruments was provided to support younger children and nonreading adults. Participants who wished to complete the instruments on their own did so in a separate area. A research assistant read each of the test questions and responses and allowed appropriate response time following each question. Assistants who were not supervising young children circulated to answer questions that individuals had concerning the test.

### **Data Tabulation**

Demographic data were documented for each of the four groups based on registration information. At registration, the family was asked for names, family configuration (nuclear, single-parent, multigeneration, empty-nest, other), number of family members participating and each child's age and sex. Also, the registrar checked which of the 25 risk factors applied to the family, making them eligible for the study.

Each SFI was scored by the researcher using the Self-Report Inventory Score Sheet. These scores were plotted on the Diagram of Family Assessment Schema Reporting Form. Following the intervention, the researcher explained the completed diagram to each family unit desiring input in an individual interpretation session. The meeting was scheduled at the family's convenience in order to explain results. The researcher discussed differences in scores if the individuals in the family had taken both a pretest and posttest. The PSI protocols were scored by the researcher, with

results of these tests presented by the researcher in the meeting with individual family units.

The pretests were scored during the initial weeks of the intervention.

Contamination of results was not likely, since the researcher was not present at the administration of either the pretests or posttests. There were four exceptions. These four individuals met with the researcher to complete a posttest as they were absent during the last play session. All other absentees completed the tests at home and mailed them back. The posttests were scored in the 4 weeks that followed the last intervention session. Data were entered in a table for reporting scores.

Scores from the SFI were used to compute the one-way ANOVA with multiple comparisons. The critical value for this experiment was set at the .05 level of significance. Scores from the PSI were used to compute a *t* test. The critical value for this experiment was also set at the .05 level of significance. The results are reported in the Analysis of Data section.

### **Data Analysis**

The data from the SFI were analyzed using a one-way analysis of variance (ANOVA). One-way analysis of variance allows the researcher to test the hypothesis of multiple independent samples drawn from the same population. The ANOVA is generally viewed as one of the most important statistical techniques available to make comparisons of different treatments on four groups from one population (Krathwohl, 1993).

By comparing the variances of the sample groups, information was obtained as to the effectiveness of the methodology being studied. The comparison provides an analysis of the variance to determine if the variation is greater than would be anticipated from random sampling error. The critical value for this experiment was set at the .05 level of significance.

In a Solomon Four Group Design the observed  $F$ -ratio is only a partial solution to the research question. To determine which means in the Solomon Four Group Design were significantly different (thereby causing the significant  $F$ -ratio),  $t$  tests were applied. Two pairwise  $t$  tests were computed. The first compared the treatment groups to control groups to see if the differences were caused by chance. A second test compared posttest-only groups to the pre- and posttest groups. This indicated whether testing was a factor. Differences determined include maturation (individual psychological growth), testing (pretest affecting growth and not intervention), and whether family play produced changes in family health/competence, conflict, style/cohesion, and parenting stress levels.

A  $t$  test was computed to compare the treatment groups to the control groups on the PSI. One of the most common uses of the  $t$  test involves testing the means between two independent groups. Of importance was whether the difference between means was sufficiently large to justify the conclusion that the two samples were drawn from separate populations. A comparison of the computed  $t$ , with the critical value of  $t$  at the .05 level of significance, would result in accepting or rejecting the null hypothesis.

## Limitations

The population for this study resided in a rural area of Michigan and, as a result, services were not always easy to access. These rural residents lacked public transportation that might have made services more easily accessible. Transportation may have seriously impacted attendance. Morbidity may be a limitation to a 7-week study, as families who missed more than two sessions were dropped from the study.

As with any volunteer population, limitations existed in this project due to the composition of the persons involved. Although volunteer families were randomly assigned to a treatment group, because they were volunteers, they were not a random sample of the at-risk population, and results may not be generalized to all families considered at-risk.

Secondly, because the sample population was limited to a rural area in Michigan, results may not be readily generalized to populations of other geographic regions. A rural population may differ from an urban population due to isolation factors. Rural residents who are at-risk may have limited exposure to cultural activities and people in general. This may make family play more valuable than for populations who can easily access relationship experiences through the neighborhood or community.

Research assistants who ran the family play-groups had access to the same training procedures; however, individual differences could not be accounted for. The make-up of the research assistant teams could have impacted the outcome of the groups. In order to create balanced teams, the researcher placed at least two early

childhood specialists (i.e., counselors, social workers, psychologists, consultants) experienced with play and/or families on each team, as well as one or more high school psychology students. Members of both sexes were on all but one team. The assistants chosen exemplified good organizational and people skills. Team members enjoyed play. Still, personality variables were a factor within the context of this design.

Although researchers suggest the techniques used in Group Family Play have therapeutic value, this experience of Group Family Play was not considered therapy. Research assistant teams provided the families with questions to promote discussion but were not available to work with individual families on problems that arose, as a therapist would do. Positive changes and growth in behavior were attributed to the family and their play experience and not the joint work of the family and therapist. Results may not be generalized to the use of play techniques in a Family Therapy setting, where the therapist is involved in the treatment.

### Summary

Methodology of the study on Group Family Play is discussed within the contents of this chapter. Employment of a Solomon Four Group Design for purposes of the study ensures the highest level of internal and external validity. Selection of subjects is reviewed, as is the random assignment to either experimental or control groups. Instruments reviewed and chosen for use in the study are the SFI used in the original study by Duff (1995) and the PSI. The PSI was chosen by this researcher to

**assess the stress experienced by the parent–child dyad. Following the review of instrumentation, procedures for conducting the experiment are documented. Activities for seven play-group sessions are described, along with the goals, research assistant instructions, and processing questions to be addressed in the session. Finally addressed are the means of data tabulation and analysis, as well as the limitations and assumptions that affect this study.**



## **CHAPTER IV**

### **FINDINGS**

**Findings concerning the study on Group Family Play and its impact on families are discussed within this chapter. Information concerning the participants and demographics is reported, followed by the procedure for analyzing the data. Statistical findings are also stated, followed by a chapter summary.**

#### **Participants**

**This study was designed to look at the impact of family play on health/competence, style, conflict resolution and parenting stress. During the study, 174 family members from 43 families participated in Group Family Play. Families were randomly assigned to one of four groups (two experimental and two control) comprising the Solomon Four Group Design. From the four groups, 121 participants were able to complete all instrumentation necessary for the study. Of the 53 who did not complete testing, 40 were children under the age of 7 or children with developmental delays who did not understand the instrument. Five individuals who participated in the study did not complete posttesting because they were absent during the last session. Although the researcher attempted to get the data from these five, the protocols were not returned. Eight individuals from three families were**

dropped from the study because they did not attend beyond the first informational meeting. All other participants were present during five or more play activities.

It is difficult to accurately describe families on the Beavers scoring dimensions as the perceptions of each member over 7 was considered and scores varied within families. On the pretesting 13 families described themselves as falling in the Optimal and/or Adequate range, while six families described themselves as falling in the Midrange and/or Borderline area. Posttesting indicated that 30 families perceived themselves to be functioning in the Optimal to Adequate range, while 10 families fell in the Midrange to Borderline range. No families described themselves as severely dysfunctional.

Demographic data gathered from the families included family configuration, age of children, and factors that qualified them as being at-risk. All families had at least one risk factor in addition to rural residence. Most families in the study had two or more reported risk factors. This information was charted and is presented in Table 2. Information in the table refers only to the 121 participants who were able to complete test materials. It does not include participants who were either too young or too limited to complete the Self-Report Family Inventory (SFI). Forty children were either below the age of seven or unable to participate in testing due to a handicapping condition.

Each individual's SFI protocol was scored by the researcher using the Self-Report Inventory Score Sheet. Pretests were scored during the first few weeks of the study. Pretest and posttest forms were clipped together for families in Groups 1 and

**Table 2**  
**Demographic Data for Participants**

| <b>Group</b> | <b>Family Configuration</b> |                           |                  |                              |                | <b>Age</b>          |             |              |                      | <b># of Risk Factors</b> |                      |
|--------------|-----------------------------|---------------------------|------------------|------------------------------|----------------|---------------------|-------------|--------------|----------------------|--------------------------|----------------------|
|              | <b>Nuclear</b>              | <b>Single-<br/>Parent</b> | <b>Childless</b> | <b>Multi-<br/>Generation</b> | <b>Blended</b> | <b>Under<br/>12</b> | <b>Teen</b> | <b>Adult</b> | <b>Sr.<br/>Adult</b> | <b>2</b>                 | <b>3 or<br/>more</b> |
| <b>1</b>     | <b>5</b>                    | <b>3</b>                  | <b>0</b>         | <b>1</b>                     | <b>1</b>       | <b>11</b>           | <b>6</b>    | <b>13</b>    | <b>1</b>             | <b>2</b>                 | <b>29</b>            |
| <b>2</b>     | <b>7</b>                    | <b>3</b>                  | <b>1</b>         | <b>0</b>                     | <b>0</b>       | <b>6</b>            | <b>8</b>    | <b>16</b>    | <b>0</b>             | <b>17</b>                | <b>13</b>            |
| <b>3</b>     | <b>5</b>                    | <b>3</b>                  | <b>0</b>         | <b>0</b>                     | <b>2</b>       | <b>12</b>           | <b>4</b>    | <b>14</b>    | <b>0</b>             | <b>13</b>                | <b>17</b>            |
| <b>4</b>     | <b>5</b>                    | <b>3</b>                  | <b>0</b>         | <b>0</b>                     | <b>1</b>       | <b>10</b>           | <b>7</b>    | <b>13</b>    | <b>0</b>             | <b>2</b>                 | <b>28</b>            |

2. Posttests were scored in the 3 weeks following the study. Scores from the pretests and posttests were charted in a report format (Appendix H). Names and codes were removed from all data following a family conference and/or recording of scores.

### **Procedure for Analyzing Data**

The data in this study were analyzed using a one-way analysis of variance (ANOVA). One-way analysis of variance allows the researcher to test the hypothesis of multiple independent samples drawn from the same population of study. The ANOVA is viewed as one of the most utilized statistical techniques in psychological research (Howell, 1992). It is recommended for use in the comparison of differing treatments on four groups from the same population.

The ANOVA allows the researcher to deal with two or more independent variables simultaneously, asking not only about the individual effects of each variable separately but also about the interacting effects of two or more variables (Howell, 1992). Information is obtained on the effectiveness of the methodology being studied by comparison of the means of the sample groups. The comparison provides an analysis of the variance between means on the SFI to determine if the variation is greater than would be anticipated from fluctuation in random sampling. The critical value was set at the .05 level of significance.

The use of the null hypothesis results in an *F*-ratio; however, in the Solomon Four study, this is only a partial solution to the hypothesis. To determine which means in the Solomon Four Groups are significantly different, *t* tests are applied. This

allows the researcher to evaluate where the significant differences lie. Differences tested include maturation and whether the pretest resulted in change, instead of the Group Family Play intervention. Also evaluated is whether Group Family Play produced change in family Health/Competence, Conflict, and Style on the SFI.

The ANOVA was not applied to the data received on the PSI due to a limited parent sample ( $N = 49$ ). Instead, a two-tailed  $t$  test was applied to look at the difference between the mean scores of parents who participated in Group Family Play (Groups 1 and 3) and parents who did not participate in Group Family Play (Groups 2 and 4).

Reporting the Data

Table 3 reports the mean scores of the experimental and control groups on the SFI Health/Competence Scale. A copy of the complete data can be found in Appendix H. The two sets of statistics computed from the data in Table 3 were the analysis of variance and the  $t$  tests. The raw data in Table 3 were utilized in computing the one-way ANOVA.

Table 3  
Group Mean Scores for SFI (Health/Competence)

| Group 1  |      |       | Group 2  |      |      | Group 3  |       | Group 4  |       |
|----------|------|-------|----------|------|------|----------|-------|----------|-------|
| <i>N</i> | Pre  | Post  | <i>N</i> | Pre  | Post | <i>N</i> | Post  | <i>N</i> | Post  |
| 31       | 4.07 | 4.097 | 30       | 4.23 | 4.20 | 30       | 4.147 | 30       | 3.623 |

Table 4 reports the results of the one-way ANOVA. The first line is the independent variable, the intervention of Group Family Play. The study utilized four groups, thus the degrees of freedom (*df*) for the independent variable (between groups) is 3. Because 121 subjects participated, the total degrees of freedom equaled 120. The projected critical value (*cv*) for the study was determined by the use of the *F* table (Howell, 1992). Utilizing the degrees of freedom between and within groups and the designated .05 level of significance, the critical value was established at 2.68.

Table 4  
SFI Health/Competence ANOVA Results

| Source of Variation | Sum of Squares | Degrees of Freedom | Variance Estimate Mean Square | F-Ratio |
|---------------------|----------------|--------------------|-------------------------------|---------|
| Family Play         | 6.36           | 3                  | 2.12                          | 1.28    |
| Error               | 193.46         | 117                | 1.65                          |         |
| Total               | 199.81         | 120                |                               |         |

Testing the Hypotheses

The statements of the null hypotheses were the following:

$H_0$ : There will be no statistically significant differences in health/competence, style/cohesion, and conflict scores as measured by the SFI between at-risk family members age 7 and older who participate in Group Family Play and at-risk family members age 7 and older who do not participate in Group Family Play.

**H<sub>0</sub>: There will be no statistically significant differences in total stress scores as measured by the PSI between at-risk parents who participate in Group Family Play and at-risk parents who do not participate in Group Family Play.**

## **Results**

The first null hypothesis was tested with the use of one-way analysis of variance (ANOVA), which compared the means of the sample groups (Table 3). The raw data for the Health/Competence Scale on the SFI was entered into a STAT 101 computer program to obtain the calculated value, the  $F$ -ratio = 1.28 (Table 4). Next, this calculated  $F$ -ratio was compared against the one-tail critical value,  $cv = 2.68$ ,  $df = 3/117$ . This led the researcher to accept the null hypotheses, since in this case the  $F$ -ratio value of 1.28 was smaller than the tabled critical value of 2.68. On SFI measures of Health/Competence, there appeared to be no difference between at-risk family members age 7 and older who participated in Group Family Play and at-risk family members age 7 and older who did not participate in Group Family Play. The null hypothesis was accepted according to the ANOVA outcome.

Computer-generated tests also revealed that no difference existed between the treatment and control groups on the Conflict Scale of the SFI. The resulting  $F$ -ratio = 1.02 was compared to the one-tail critical value of 2.68,  $df = 3/117$ . This suggested no difference in the conflict ratings for family members who participated in Group Family Play and family members who did not participate (Table 5). The null hypothesis was accepted.

On the Style measure of the SFI, a computer-generated  $F$ -ratio = .68 was compared to the one-tailed  $cv = 2.68$ ,  $df = 3/117$ , in support of the null hypothesis. There was no difference on ratings of style between family members who participated in Group Family Play and family members who did not participate (Table 6).

**Table 5**  
**SFI Conflict (Raw Score) ANOVA Results**

| Source of Variation | Sum of Squares | Degrees of Freedom | Variance Estimate Mean Square | $F$ -Ratio |
|---------------------|----------------|--------------------|-------------------------------|------------|
| Family Play         | 188.6          | 3                  | 62.9                          | 1.02       |
| Error               | 7241.4         | 117                | 61.9                          |            |
| Total               | 7430.0         | 120                |                               |            |

**Table 6**  
**SFI Style ANOVA Results**

| Source of Variation | Sum of Squares | Degrees of Freedom | Variance Estimate Mean Square | $F$ -Ratio |
|---------------------|----------------|--------------------|-------------------------------|------------|
| Family Play         | 0.444          | 3                  | 0.148                         | .68        |
| Error               | 25.404         | 117                | 0.219                         |            |
| Total               | 25.848         | 120                |                               |            |

Pair-wise  $t$  tests indicated that pretest scores did not affect posttest scores on the SFI. The  $t = 1.0$  with a  $p = .32$  was not significant. This suggests that posttest scores were not influenced by pretest scores. The  $t$  test to compare treatment groups



to control groups resulted in  $t = .99$  with a  $p = .33$ . This value indicates that treatment groups participating in Group Family Play did not score significantly differently on the SFI than the control groups who did not participate in Group Family Play.

Testing of the second null hypothesis also resulted in its acceptance. The  $t$  test comparing treatment groups to control groups on the Parenting Stress Index (PSI) indicated no significant difference between the posttest means on the PSI (Total Score). The two-tailed  $t$  test compared 24 pairs of scores, thus there were 23 degrees of freedom ( $df$ ). Using the  $t$  table (Howell, 1992) it was found that for a two-tailed  $t$  test at the .05 level of significance, the critical value ( $cv$ ) for  $t$  was 2.069. The  $t = .88$  ( $p = .39$ ) was significantly below the reported  $cv$ ,  $t = 2.069$ . The mean of the sample of parents participating in Group Family Play was not significantly different from the mean of the sample of parents who did not participate in Group Family Play with respect to parenting stress.

### Summary

Demographic information was presented in this chapter, along with the procedures for analyzing the data collected in this Solomon Four Group Design. Following an explanation of procedures, the actual results obtained from running the statistics were provided, indicating no significant difference between the treatment and control groups on SFI and PSI measures. Also included in this chapter were appropriate tables reporting the statistical results.

## **CHAPTER V**

### **DISCUSSION OF FINDINGS AND RECOMMENDATIONS**

#### **Summary**

**This chapter presents discussion of the quantitative results of research studying the effect of Group Family Play on measures of family health/competence, style, conflict, and parenting stress, for families who have children or potential children considered “at-risk” for educational failure. Discussion occurs as to why results indicate there is not a significant difference on these measures between families who participated in Group Family Play and families who did not participate. Discussion is also provided concerning the discrepancy between the quantitative results and the written comments of participants. Research and therapeutic recommendations for future consideration are proposed, followed by a summary of the information contained within this chapter.**

**Proponents of Family Play Therapy believe that family play impacts family relationships (Gil, 1994; Schaefer & Carey 1994). A study by Duff (1995) indicated that church families who participated in Group Family Play showed significant improvement on the Health/Competence Scale of the Self Report Family Inventory (SFI). Most families in Duff’s study began the experiment scoring in the adequate and optimal ranges on the SFI, and Duff proposed that further investigation occur with families who scored in more clinically significant ranges.**

**This study partially replicated the study of Group Family Play (Duff, 1995) and studied the effect of play activities on family health/competence, conflict and style as measured by the SFI, for families who had children considered “at-risk.” In addition, the effect of Group Family Play on parenting stress was measured through the Parenting Stress Index- 3<sup>rd</sup> Edition (PSI). The population for this study was families with children or potential children considered to be “at-risk” for educational failure, according to the Michigan School Readiness Program (MSRP) guidelines. Participants included 174 family members from 43 families. Instrumentation was completed by 121 individuals, assigned to one of four groups (two experimental, and two control). Participants had to be seven or older to complete the SFI. Families in the experimental groups attended an informational meeting as well as six sessions of Group Family Play designed to promote communication and problem-solving through creative play-based activities.**

**The researcher used a Solomon Four Group Design to evaluate the impact of Group Family Play on Health/Competence, Conflict, and Style as measured by the SFI. This design allowed for the elimination of sampling error and chance error due to the random assignment of subjects and the utilization of inferential statistics. The Solomon Four Group Design enabled the researcher to challenge invalidity in testing and the risk of maturation, testing, and statistical regression if the null hypothesis had been rejected.**

**Results of the one-way analysis of variance (ANOVA) at the .05 level of significance yielded an *F*-ratio of 1.28 (cv 2.68) resulting in the acceptance of the null**

hypothesis, relative to the SFI Health/Competence Scale. There was not a significant difference in the mean scores on the SFI Health/Competence Scale between the individuals who participated in Group Family Play and the individuals who did not participate in Group Family Play. The ANOVA was applied to the Conflict Scale and the Style Scale on the SFI with similar results. The  $F$ -ratio 1.02 ( $cv$  2.68) on the Conflict Scale and the  $F$ -ratio .68 ( $cv$  2.68) on the Style Scale led to acceptance of the null hypothesis that there was not a significant difference between mean scores on the Conflict or Style Scales between individuals who participated in Group Family Play and individuals who did not participate in Group Family Play.

Due to sample size, the researcher was unable to use the one-way analysis of variance (ANOVA) to evaluate the effect of Group Family Play on parenting stress, as measured by the PSI. Therefore, a two tailed  $t$  test ( $N = 24$ ) was used to evaluate the difference between the means on the PSI of parents who participated in Group Family Play and parents who did not participate in Group Family Play. A  $t$  value of .88 ( $cv = 2.069$ ) indicated there was not a significant difference in the sampling distributions of the mean on the PSI between individuals who participated in Group Family Play and the individuals who did not participate in Group Family Play. This led to acceptance of the null hypothesis.

### Discussion

Through the use of a Solomon Four Group Design, an empirical contribution has been made to current knowledge in the field of Family Play Therapy. This study

adds sound empirical research to the limited research available on the study of Family Play Therapy and triggers questions concerning the use of play with “at-risk” families as a therapeutic entity apart from therapy. Though families verbally acknowledged their support of the Group Family Play project, statistical analysis suggest that “at-risk” families do not significantly increase communication and problem-solving skills through the use of play alone, as measured by the SFI and PSI.

In considering the difference between verbal support for Group Family Play and the non-supportive statistical results, considerations must be given to instrumentation. Instrumentation may not have been sensitive to the changes that occurred within the family unit as a result of the play experience. The PSI and the SFI may not have been the appropriate measures to assess changes in communication and problem solving skills.

Testing concerns were noted with the administration of the SFI. The SFI was not long or cumbersome to administer orally; however, the researchers observed that the reverse scoring was confusing. When this researcher completed testing with a few participants who missed the last session, it was often necessary to repeat reverse scored items. Participants easily adopted a strategy of marking “1” for the best response and “5” for the worst response after they had answered a few consecutive items that were weighted in this manner. When comparing the scoring on the pre- and posttests, the researcher observed that children and adults had opposite scores on some of the reverse score items. In reviewing the questions, the researcher believed

that this was a result of a misunderstanding rather than a dramatic change in family dynamics.

In addition, some problems were discussed regarding the administration of the PSI. Because of the oral presentation used in this study, the PSI was found to be lengthy and cumbersome during the pretest session. Research assistants noted that it took over 1 hour to complete this instrument due to its length and numerous individual questions. Parents may have given less thought to questions as time went on, and children were ready to leave. The amount of paper work was a complaint of one individual on the comment sheet and adults opted to complete the form independently for the posttest. Due to familiarity with both the length of the PSI and the questions, parents may have given more consideration to timely completion of the posttest and less consideration to accuracy.

Another consideration as to findings that Group Family Play did not impact families significantly may lie within the definition of the sample population. The use of the MSRP guidelines to define “at-risk” families accounts for a diverse group of individuals with diverse needs. Secondly, the label of “at-risk” can carry certain connotations that are not readily accepted by most individuals. Lastly, some subgroups of the sample population comprising this study may have had considerable impact on the results.

This study documents the effects of Group Family Play on families who have children identified as “at-risk” for educational failure. The study is the first to look at Group Family Play with families who meet a specific criterion for study, however

qualifying factors were quite diverse. There were 25 qualifying factors, of which each family needed two to be determined “at-risk.” Although individuals in the rural areas who participated are familiar with the MSRP guidelines, there are a wide variety of risk factors, many of which may not be a hindrance to an individual family’s health. Many of the families who participated may qualify under the guidelines set for this study, but still may not view themselves as having children “at-risk.” Qualifiers such as low income, single parenthood, many children, or rural residency may not be seen as barriers to family health by some participants, while for other families these qualifying factors may be a great source of stress. Some of the families participating in this study did so as a means of spending time with their children and began the study in the optimal or adequate range of functioning on the SFI. They did not view themselves as needing to improve a great deal. Other families rated themselves in the midrange or borderline range of functioning on the SFI and viewed themselves as needing more help.

Having a more defined population for study would have eliminated these differences. Using the SFI to delineate families who rate themselves as midrange, borderline, or severely dysfunctional prior to participation in Group Family Play would attend to the neediest population and may yield more useful results for individuals in the helping professions. Studies with defined populations, such as families with special needs children, adoptive families, or blended families is of interest, as some issues and concerns are specific to these populations.

**Instrumentation specific to the concerns of these populations should also be considered when conducting research.**

**Unique to this study is the significance of the identification of families as “at-risk,” unlike the original study by Duff (1995). Families in this study were asked to sign a participation agreement that identified them as “at-risk” prior to completion of the pretests. Having risk factors does not automatically mean a family will have limitations with respect to health and competence; however, individuals were singled out as being part of an “at-risk” group. It is not uncommon for participants who feel uncomfortable with this label to minimize difficulty on test instruments, especially if they are unclear about what the results will reveal. Even though initial reassurances were offered that individual families would not be “analyzed,” research assistants reported many comments throughout the study about increased comfort and ease with the study. This suggests that many participants were initially guarded and cautious, and they may have portrayed themselves on the subtests to be functioning more optimally.**

**Two large “at-risk” family subgroups and the teen participants warrant comment as they may have impacted the results of this study. Due to the researcher’s affiliation with Special Education in the county, several families with children who have been diagnosed with a developmental disability participated in the study. Several adoptive families also participated. One of the lead assistants had previously worked in adoption and had connections with many families whom she encouraged to participate.**



It is important to note the impact that participating families with children with diagnosed disabilities or significant learning disabilities may have on test results. Some of these families have daily stressors and concerns that may not change as a result of any intervention. The family members are frequently faced with some life-long circumstances that, in many ways, are beyond their control. Where most parents plan for their children to grow up and eventually leave home, these parents must concern themselves with who will look after their children when they are too old to take care of them. Group Family Play may have been fun; however, it may also have served to make developmental differences more visible. Watching families that could participate in activities with relative ease may escalate feelings of anger and stress for families who have to work around a disability. These families also report sensitivity to the reactions of others, thus feeling more self-conscious in a play group setting. Group Family Play may not have positively impacted these families, as it might families who do not have to cope with significant disabilities. A study by Kale (cited in Renny & Landreth, 2000) on the use of filial therapy with parents of children experiencing learning difficulties, found there was not a significant decrease in stress scores related to their children on the PSI. This was not typical of many of the other parent populations studied who benefited from filial therapy intervention by exhibiting decreased stress. Last of all, posttesting coincided with the end of the academic school year, when parents and siblings face increasing responsibility for provision of daily care, with less respite from the educational institution. The end of the academic year often creates more stress in these families as their support system decreases.

**Future research on Family Play for families with children diagnosed with developmental disabilities should be considered on an individual basis, or with other families who also share this unique experience. This eliminates the frustration sometimes experienced by families who report being misunderstood by many well meaning individuals, or the pain of watching others easily accomplish tasks that may be insurmountable to a family with a child with severe disabilities. It also offers a support network for families who share similar experiences.**

**A second subgroup of families participating in this study had adopted children. Because of their work with agencies, adoptive parents are frequently under a microscope and many times believe that they have to be more competent than other families. Some adoptive parents were observed to be uncomfortable with their children sharing information about issues such as discipline or feelings of isolation. It is possible that adoptive parents were more cautious about admitting concerns, thus impacting test results that assess family health and parenting stress.**

**A substantial number of teens participated in the study. Most teens in the study appeared to rate family health as worse following the intervention, while scores were mixed for children 7–12 years of age. Several observations in this area are noteworthy. First, teens may have looked at “playing” with their family as distasteful, although they appeared to be motivated once they started an activity. For example, one group with several teenagers quickly solved the Frog and Lily Pad exercise. They proceeded to make the game more challenging for themselves and ended up completing the task with their eyes closed. Still, it is an awkward age at which to be**

observed playing with one's parents, and individual family play, rather than a group situation, may be more appealing to this age group. Situations involving chaos, lack of leadership, disagreement, control, apathy, and other potential problems were visible not only to the family, but possibly to other families as well. Secondly, problem-solving and communication appear to be significantly difficult for many teens and parents. The activities made it difficult to avoid confronting these issues. In cases where awareness was increased and problems were not solved, teens may have reported that their family was less healthy and functional. A last observation is that many teens tend to live in the moment and may not have given thought to change in their family over time. All of these factors may have impacted scores on the SFI. Worthy of further investigation is the differences between latency age children and teenagers following participation in family play.

Some contrasts to the study by Duff (1995) in which families (the majority of whom began treatment in the optimal and adequate range of functioning on the SFI) were found to significantly improve following the Group Family Play intervention are worthy of mention. Contrasts such as a larger sample of individuals who fell outside the adequate and optimal range of functioning, minimization of researcher contamination, young participants, and involvement of multiple teams of research assistants may have affected the findings of the present study.

This research was specific to families who were identified as having children or potential children considered "at risk" for future educational failure. While some individuals fell in the adequate or optimal range on the SFI, many individuals

identified themselves as midrange or borderline. No families saw themselves as severely dysfunctional. This difference in sample population may account for the lack of significance not exhibited in the study on Group Family Play by Duff (1995) who mainly worked with families in the adequate and optimal range.

Unlike Duff (1995), who conducted her own play groups, this researcher did not participate in conducting the experimental play groups for fear of contaminating the results. The research assistants with therapeutic background in this study indicated that they had to work very hard not to intervene with some families. It is unlikely that a researcher invested in a study of this magnitude could remain totally neutral and uninvolved in the outcome.

Participants in this study had to be 7 or older to complete the SFI. Many of the children younger than seven were interested in completing the SFI, because the older children were participating. Those children under 7 who wanted to “do paperwork” were allowed to participate in the group administration of the test; however, results were not used. All but one of the younger children were confused by the test and did not complete it correctly, even with research assistant support. Duff indicated that sixteen 4-year-olds in her study completed the SFI, not to mention the 5- and 6-year-olds. Research assistants in this study reported that the SFI was complicated for children 7 and 8 years old, due to the reverse scoring. Even with the test being read individually to each child, the accuracy of results with children under 7 seems questionable, making the possibility of contamination more likely.

Due to the numerous groups that were offered as well as the time commitment involved, it was necessary to train 18 individuals to conduct the Group Family Play sessions. Although all research assistants attended an orientation session with the researcher, each team was comprised of different personalities, and group dynamics were unique. Some teams reported being more flexible than others with respect to directions for play activities and group process, sometimes out of necessity (families arriving late, children too young to complete the task, families in crisis). These decisions were expected; however, they created more variation in groups than would have occurred if one team had conducted the study. Because team differences may have impacted research outcomes, future researchers should consider conducting the study in one location, or using the same team of individuals to work with experimental groups.

Although the research suggests that family play does not have a significant impact on family health/competence and parenting stress, the researcher noted other evidence that strongly suggests that participants benefited from the experience. Factors considered included lack of attrition, written comments from participants concerning the study, and the observations and verbal comments of research assistants and participants.

Seven weeks was a lengthy period of time for families to commit themselves to a project, and yet no families dropped out following participation in the first play activity. The three families who dropped from the study did so following the

informational meeting. This lack of attrition suggests that the participants found value in the group play experience.

Written comments from family members suggest that, as a whole, families enjoyed the Group Family Play experience. Several comments indicated that the families “had fun.” Participation in the study enabled some family members to learn how to play with and enjoy their children, regardless of the perceived impact on health/competence. Positive statements were written concerning quality time with family members: “It [family play] allowed us to spend uninterrupted time together”; “My kids really looked forward to the time together”; “It was time well spent, especially for dad to interact so much with the kids”; “A great way to take time out to just sit and talk with my kids!”; “We got to spend more time together”; “We have found it easier to spend time together as a family. We find it easier to play a board game instead of escaping into the television.”

Many individual conferences indicated that families believed they had improved or grown even though statistical analyses did not support this. Written comments such as the following also suggested improvement: “We worked together”; “It was good for my child, even though he didn’t want to participate”; “We learned a lot about other members in the family”; “We began each activity with our own thoughts and goals, and by the time we were through, we were working together to accomplish the same goal”; “We have far fewer conflicts within our family structure, despite abnormally high levels of stress from outside the family since Group Family

**Play has begun”; “It helped us realize our strengths and weaknesses as a family”;  
“The questions after the activities were insightful and revealing.”**

**In contrast to most parent research that usually involves only the mother, many fathers participated in this study. Approximately 55% of the families who participated in the study were two-parent families, with a few of these blended families. Of the two-parent families in the experimental group, four participated without the father. Several of the men who participated commented that they enjoyed the play activities. A few spouses commented that they thought their husbands seemed to enjoy the play more than their children did. The lack of attrition and continued participation of fathers suggests that family play is a viable method for increasing the father’s involvement in parent child interaction.**

**Children who participated ranged in age from 11 months to 25 years of age. Both parents and research assistants suggested that young children were excited about coming to play group and often reminded parents about the group. Some reluctance on the part of teens was reported; however, they seemed to enjoy the activities once they began. No children declined participation, although this was an option. Research assistants noted that if families finished an exercise early, they often stayed around and visited. On occasion research assistants reported that it was difficult to get some families to leave at the end of the session.**

**Although some parents of young children did comment that they thought the processing questions would be more meaningful for older children, research assistants explained that each child gained from the experience what they were able to**

understand and process. It was natural for the younger children to be concrete in their processing. In fact, the nature of play allowed children to process life experiences with little, if any, cognitive realization of the attached concerns and feelings. According to research assistants, young children were most visibly excited about being part of a play group, and they readily bonded with other children outside their family.

Though frustration was expressed by some of the research assistants that the younger children sometimes were a distraction to family processing or required significant adaptations, this frustration was not as apparent for the participants. In each of these situations, the families appeared to adjust more readily than the assistants anticipated they would, which demonstrated the family's experience and resiliency. Families appeared to enjoy the play group experience despite complications that occasionally caused difficulty.

### **Recommendations**

Many recommendations need to be considered when conducting future research on Group Family Play. Due to the discrepancy between both research assistant and participant views concerning the value of Group Family Play and the resulting statistical analysis, questions arise as to whether the SFI and PSI were appropriate measures of change in family health that resulted from family play. Other recommendations concerning the use of play as a therapeutic entity are provided.



Also included in this section are recommendations concerning the instrumentation and demographics that are useful when considering future investigations.

Because of the quantitative statistical results, it would be easy to assume that “at-risk” families did not gain from this study; however, all families who participated in Group Family Play indicated that they “had fun.” A dictionary definition of *fun* is “pleasure” or “a source of merriment” (Allee, 1984). It is questionable whether the qualitative experience of Group Family Play could be effectively measured by test instruments.

Consideration should be given to qualitative research in the area of Group Family Play in order to define what families believe they gain as a result of participation in the play experience. Individual interviews following each play group experience might lead researchers to a clear insider perspective concerning the strengths and weaknesses of the activities and their impact on families. In looking at gender issues in play, it might be interesting to have a female researcher follow male participants and a male researcher follow female participants on a weekly basis throughout the study.

Other recommendations for future evaluation involve the consideration of different test instruments that might be more sensitive to what changes occur as a result of play. Instruments such as the Index of Family Relations Scale (IFR), Family Assessment Measure (FAM III), and the Family Function Scale (FFS) appear to be valid and reliable measures for assessing family functioning. They are also easy to use and have some degree of evidence for sensitivity to family diversity. Of concern to

this researcher is the fact that these tests are normed on an adult population. To date, the SFI appears to be one of the only instruments normed on the family unit (Pardeck, 2000). It is recommended that researchers consider the importance of the children in the family and consider creating instruments that are more appropriate in gaining the child's perspective.

Though this study looked at the concept of play being a therapeutic entity in itself, further investigation needs to take place concerning family play as a therapeutic technique used in a therapy setting. Research would indicate that play is a therapeutic entity for children (Bratton, Ray, Rhine, & Jones, 2000). Although play alone may be therapeutic for adults, some families who experience significant stress may need therapeutic guidance in bringing about change. Whereas some families were able to gain insight from the play and make necessary adjustments, other families seemed overwhelmed by what the play revealed. For example, a family may recognize that many of their joint play projects are chaotic, and though they wish to improve, they may not know how to minimize the chaos. In situations like this, the research assistants reported difficulty in not offering "therapeutic" intervention. The assistants believed that simple therapeutic interventions would have evoked positive change.

Investigation as to whether the play experience alone is sufficient to bring about change in the most needy families must still occur. However, because play is such a powerful tool and causes much covert material to become overt, it would also be helpful to study family play in conjunction with therapy for families who exhibit greater degrees of dysfunction. For example, a child in the midst of a custody battle

may choose to represent him/herself as a gun in the sand tray, in an unsupervised play activity. This sends a clear message to the parent that the child sees him/herself as the weapon or ammunition in the battle between parents. The parent is now confronted with the reality of this issue, despite any preparation or even any conscious thought on the parent's part about custody during the play activity. Parents have choices regarding how to deal with the information presented. They may choose to ignore any meaning associated with the play either consciously or unconsciously, or they may choose to put information on hold until they feel more capable of dealing with the issue. They may also choose to communicate and problem-solve concerning the information that is presented to them. In situations like this, the presence of a therapist can be of help to families as they maneuver through and make sense of disturbing information. The therapist can also serve as a sounding board and can help mediate conflict.

Therapists would continue to benefit from continued research on the impact of Group Family Play on stress and family health, especially when used in a therapeutic venue. In this study, research assistants reported that family dynamics were clearly recognizable; however, the dynamics were often avoided by the family or not discussed during the processing time. One concern was that participants who normally do not volunteer information in the family were usually silent during the processing time, and individuals who were controlling continued to dominate. The insightful play activities used in this study used at the discretion of the therapist could ensure that each person has a voice and is acknowledged. Therapeutic assistance

provided to families would enhance problem-solving and communication. The researcher believes that family play as a therapeutic intervention may result in even more families experiencing growth and change.

Researchers should consider working with a more defined population of study in the future. Research with families who have a few similar risk factors, rather than the variety of factors included in this study, might yield more conclusive results and be more applicable to special groups. Consideration to families with special needs children, single parents, adoptive parents, and blended families is recommended, as play can be a positive support to families who have multiple demands placed upon them.

Another suggestion would be to use an instrument or screener to identify families that meet a certain criterion prior to beginning the study. For example, only families who fall within the Midrange to Borderline range on the SFI would be asked to participate. This might be more applicable in a clinical or therapeutic setting in which families are presenting for therapy with mental health concerns.

Recommendations concerning future testing are also significant. If future researchers consider a pre-post test design, administration of the pretest should follow participation in one or two play activities (in addition to the play demonstration). This may yield a more accurate picture of family health, as participants become increasingly comfortable with the study and possibly more honest. It will also allow for exposure to the processing questions that are not introduced during the sample play activity. The processing questions will help family

members think about problem-solving and communication in relationships. Families might also be hooked into the study through the play activities prior to being faced with the lengthy paperwork process. The only families who dropped from the study did so after the informational session.

A larger sample of parents is necessary to study the effect of Group Family Play on parenting stress. It might be of further benefit to study how play affects the child (stress attributed to child characteristics) and parent domains (stress associated with parenting skills), as well as the various subscales. For example, in recording scores on the PSI, it was observed that all but a few male participants were above the 75th percentile on the Isolation and/or Attachment Scales, while this was not true for women. Future consideration should be given to the impact of family play on the father's perception of isolation and attachment. Also, it is recommended that the PSI not be group administered due to its length, as it proved frustrating for some of the parents. When offered a choice, all parents in this study chose to complete the posttest individually.

Differences between male and female adult participants warrant further investigation. Research assistants observed that the men were more comfortable with the play than the women; however, all but one female adult in the experimental group showed improvement on the posttest, whereas males did not show the same level of improvement. Male scores declined on the SFI posttest for both the experimental and control groups. Participation in Group Family Play may impact adult male scores negatively as a result of decreased isolation and heightened awareness of family

relationships. If most fathers feel isolated, the family play experience may have increased their awareness of relationships and dynamics, drawing attention to concerns they had not noticed. Increased communication and processing may have made fathers aware that there were more concerns in the family than they originally indicated on test measures. Concerns were not only discussed, but often were accompanied by a visual representation that can be more meaningful for some males.

Play is utilized by adults as a means of release or an escape from the day-to-day stress of life; however, women often have less time to play than men (Hochschild, 1989). This fact may shed light on differences in males and females. Although research assistants reported that women seemed to have more difficulty knowing “how to play” than men, the women were the ones who exhibited more growth on the posttests. It is possible that the men who participated in Group Family Play did not seek the opportunity to evaluate its therapeutic content; rather, they simply enjoyed the experience. It may be that the females were more observant and reflective, while the men and children simply enjoyed the experiential component of the activity. Future research to look at gender differences with respect to family play is warranted, as is a look at the number of fathers involved in parent studies that suggest play based interventions significantly impact family health.

### Conclusions

The present research studied the difference on measures of family health/competence, style, conflict, and parent stress, between families identified as

**“at-risk who engaged in Group Family Play and “at-risk” families who did not participate in Group Family Play. The study was a partial replication of any earlier study by Duff (1995) who found that families from various churches in Texas noted significant improvement in family health and competence following participation in Group Family Play.**

**Participants in the current study included 174 family members from 43 families. Data were collected from 121 participants. The Solomon Four Group Design was utilized and families were assigned to one of four groups. Groups 1 and 2 participated in an informational meeting and six sessions of Group Family Play, while Groups 2 and 4 (control groups) attended the informational meeting, but did not participate in Group Family Play until the completion of the study. Groups 1 and 2 took both pre- and posttests to determine differences in health/competence, style, conflict, and parenting stress, while Groups 3 and 4 took only the posttest.**

**A one-way Analysis of Variance (ANOVA) was computed to determine if there was a significant difference between the groups on the health/competence measure. The ANOVA did not detect a significant difference at the .05 level on health/competence, style or conflict scores between families who participated in Group Family Play and families who did not participate.**

**The ANOVA was not applied to the data received on the PSI due to a limited parent sample, but a two-tailed *t* test was computed to look at the difference between the mean scores of parents who participated in Group Family Play (Groups 1 and 3) and parents who did not participate in Group Family Play (Groups 2 and 4). The *t* test**

did not result in a significant difference at the .05 level in parenting stress between parents who participated in Group Family Play and parents who did not participate in Group Family Play.

Possible factors influencing significance included finding an instrument sensitive to changes resulting from the Group Family Play experience. Other factors included some concerns with the reverse scoring on the SFI and the administration of the PSI. The diversity of the sample population and the fact that individuals were noted to be “at-risk” was thought to have some influence on statistical significance. Within the sample population were two large subgroups of families, and a large number of teens that for various stated reasons may have had significant impact on test results. Lastly, some contrasts existed between this study and the earlier study by Duff (1995) that may account for the differences in significance.

Despite lack of statistical significance, it is important to note that families found the exercise to be “fun,” and most comments concerning the experience were extremely positive. There was little attrition following the introduction of the Group Family Play experiences even though families were required to attend five of the seven sessions. Verbal and written comments about the play experience were also supportive of Group Family Play. Family play appeared to appeal to both sexes, and all ages of individuals.

Further research is recommended to look at the use of different testing instruments to assess the impact of Group Family Play on family health. Other recommendations include the study of family play used with more specific



populations, or used in conjunction with therapy. Differences between adult males and females are of interest for further investigation with respect to perceptions of family health following a play intervention. Recommendations concerning future studies with regard to testing and sample size are also considered.

Family play does allow families to come together to participate in a mutual activity that is fun and non-threatening. The activities serve to create an environment that can open the door for communication and problem-solving. Additional research studying the effects of family play should serve to increase the body of knowledge concerning viable techniques for enhancing family relationships.

**Appendix A**  
**Guidelines for MSRP Eligibility**

## GUIDELINES FOR MSAP ELIGIBILITY

Child's Name: \_\_\_\_\_ Date: \_\_\_\_\_

| CHECK FACTORS AND SIGN STATEMENT AT BOTTOM OF FORM       | QUALIFYING FACTORS FOR MSAP (BUILDING BRIDGES PRESCHOOL) (NOTE: CHILD MUST BE 4 BY DECEMBER 1)                        | YES | NO |
|--|---|-----|----|
|  | 1. Low Birth Weight (5 $\frac{1}{2}$ pounds or under)   |     |    |
|  | 2. Child is behind in development (Language, Knowledge, Social Skills, Motor Skills, Etc.) *                          |     |    |
|  | 3. Child has been sexually or physically abused or neglected  |     |    |
|  | 4. Child has been on WIC program or has nutritional deficiency  |     |    |
|  | 5. Long term or chronic illness of child  |     |    |
|  | 6. A diagnosed disability (Physically Impaired, Hearing Impaired, Mentally Impaired, etc.)                            |     |    |
|  | 7. Family moves frequently due to housing conditions or is homeless   |     |    |
|  | 8. Child (or significant adult) has a violent temper and engages in destructive behaviors                             |     |    |
|  | 9. Family history of alcoholism, drug abuse, or other addiction (including adult's heavy smoking which affects child) |     |    |
|  | 10. Child has speech and language delays  |     |    |
|  | 11. Family speaks a language other than English   |     |    |
|  | 12. Family history of dropping out of school or doing poorly with school work   |     |    |
|  | 13. Family history of delinquent behavior (trouble with the law)  |     |    |
|  | 14. History of family problems (domestic violence, mental health issues, etc.)  |     |    |
|  | 15. Non-readers in family   |     |    |
|  | 16. Single parent family (no support of other adult in home)  |     |    |
|  | 17. Unemployed parent or parents  |     |    |
|  | 18. Family Income    1) Size of your family _____ 2) Your yearly Income _____   |     |    |
|  | 19. Large number of family members in home  |     |    |
|  | 20. Loss of parent or sibling through death or divorce  |     |    |
|  | 21. Teenage parent (19 or below when child or sibling born)   |     |    |
|  | 22. Chronically ill parent or sibling or received special education services  |     |    |
|  | 23. Parent is in jail   |     |    |
| 24. Housing is very rural, with very few or no neighbors |   |     |    |

\*This risk factor must be used in conjunction with another factor, if a standardized test score is being used as the sole factor in meeting Risk Factor #2.

| 2000-2001 INCOME ELIGIBILITY (Revised 5-8-00) |           |                     |           |
|---|-----------|---------------------|-----------|
| HEAD START ELIGIBLE                           |           | MSAP ELIGIBLE       |           |
| SIZE OF FAMILY UNIT                           | INCOME    | SIZE OF FAMILY UNIT | INCOME    |
| 1   | 8,356     | 1                   | 15,448    |
| 2   | 11,290    | 2                   | 21,143    |
| 3   | 14,190    | 3                   | 26,178    |
| 4   | 17,080    | 4                   | 31,843    |
| 5   | 19,950    | 5                   | 36,908    |
| 6   | 22,850    | 6                   | 42,273    |
| 7   | 25,750    | 7                   | 47,638    |
| 8   | 28,650    | 8                   | 53,003    |
| Each family member                            | add 2,900 | Each family member  | add 5,345 |

I verify that the income and factors that I have checked above are true and I understand that I must provide documentation of eligibility.

Parent/guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Appendix B**  
**Agency Agreement to Participate**

**Western Michigan University**  
**Department of Counselor Education and Counseling Psychology**  
**Principal Investigator: Suzanne Hedstrom, Ed.D.**  
**Research Associate: Carmen Baldus, Ed.S.**

The Grant Primary School has been selected to participate in Carmen Baldus' doctoral dissertation, "A Study of the Effect of Group Family Play on Family Relations for Families with Children Considered At-Risk For Educational Failure". Our perception is that this research is intended to study how playing together as a family affects their ability to communicate and problem solve. It will also consider how parenting stress is affected by family play.

Personal conversation and letter of intent which accompanied this form have provided insightful information regarding the nature and purpose of Ms. Baldus' research. Our agency will assist the researcher with subject identification and recruitment with regard to the following:

- Distributing flyers compiled by the researcher to potential families, requesting those who are interested to contact the researcher by phone.
- Designating someone from the school to act as the study coordinator, serving as a link between the school and the program.
- Forwarding all questions and inquiries about the study to the researcher

The school recognizes that all data collected by the researcher will be kept confidential. Once the data are collected and analyzed, the list of participants will be shredded. Data will be stored in a locked cabinet in the Principal Investigator's office for three years.

The school is aware that our contribution to this research will help in understanding how participation in noncompetitive play activities can impact family health/competence and parenting stress, in families who have children who are at-risk for educational failure.

Any concerns or questions we have about this research will be addressed to either Carmen Baldus as (231) 652-1299 or Dr. Suzanne Hedstrom at (616) 771-9913. The signature below indicates that the Grant Public Schools realize the purpose and requirements of this study and agrees to participate. The participant may also contact the Chair, Human Subjects Institutional Review Board (616) 387-8293 or the Vice President for Research (616) 387-8298 if questions or problems arise during the course of the study.

**SIGNATURE**

**DATE**

\_\_\_\_\_

\_\_\_\_\_

800 S. River Ridge Road  
 Newaygo, MI 49337  
 February 22, 2001

**To Whom It May Concern:**

My name is Carmen Baldus and I am a doctoral candidate in Counselor/Education Counseling Psychology at Western Michigan University. I am seeking help with my dissertation research, "A study of the Effect of Group Family Play on Family Relations for Families with Children Considered At-Risk For Educational Failure." The research is intended to study how playing together as a family affects parenting stress and the ability of family members to communicate and problem-solve.

The study may involve families completing two objective measures (the Self-Report Family Inventory, SFI; and the Parenting Stress Inventory –3<sup>rd</sup> edition, PSI), as well as participating in six sessions of Group Family Play. Control groups will be allowed to participate in a retreat format (Friday evening, all day Saturday), where the play activities are introduced in succession, following the six week intervention.

Subject selection criterion are families who have children who are at risk for educational failure. They must meet at least one of the Michigan School Readiness Program (MSRP) risk factors, other than rural residence. For a list of factors, see the attached sheet.

All data collected by the researcher will be kept confidential. Once the data is collected and analyzed, the list of participants will be shredded. Data will be stored in a locked cabinet in the Principal Investigator's office for three years.

I am enthusiastic about the information this study could generate and the potential impact it may have on a family's ability to problem solve and communicate. This research should also benefit professionals who work with families in either a school or agency setting, as it provides a unique means of helping families reduce stress and become healthier, in a non-threatening manner.

If you should choose to participate in recruitment of subjects I am asking assistance with the following:

- Distribution of flyers compiled by the researcher to potential families, requesting those who are interested to contact the researcher by phone.
- Designating someone to act as the study coordinator, serving as a link between the agency or school and the researcher.
- Forwarding all questions and inquiries about the study to the researcher

I appreciate your willingness to assist in the recruitment of subjects. Should you have questions, you may contact me at (231) 652-1299 or e-mail me at [cbaldus@neway.net](mailto:cbaldus@neway.net). You also may contact my major advisor, Suzanne Hedstrom, Ed.D. at (616) 387-8293. The participant may also contact the Chair, Human Subjects Institutional Review Board (616) 387-8293 or the Vice President for Research (616) 387-8298 if questions or problems arise during the course of the study.

Thank you for participating in my research.

Sincerely,

Carmen C. Baldus, Ed.S.

**Appendix C**  
**Script for Telephone Interview**

## **PHONE INTERVIEW**

**Caller:** I am interested in information on the Group Family Play sessions.

**Researcher:** I am glad you called. I have a few questions I need to ask you, and some information that I want to make sure is very clear.

What location are you interested in? (response)

Did you have a child attend the MECEP or MSRP (Michigan School Readiness Program)?

### **Scenario 1**

**Caller:** Yes

**Researcher:** What were their eligibility or qualifying factors?

**Caller:** My child had speech difficulties and we had a low income. (researcher records)

**Researcher:** Thank you. The fact that your child attended the program will allow you to participate in the study.

### **Scenario 2**

**Caller:** No or I don't know

**Researcher:** May I go through a list of 24 eligibility factors with you to see if any apply to you or any one of the children in your family? Many of them will not, so please bear with me. You have the right to not respond to any item. Researcher will read the checklist (Appendix A) beginning with item 1 and proceeding through item 24 by asking the caller to answer yes or no to each item.

**Caller:** Yes, go ahead.

**Researcher:** (Goes through items of Appendix B and checks the ones that apply.) I am sorry you do not meet any or the criterion for this study or These factors make it possible for you to participate in the study. Here is some information that I would like to make clear before inviting you to attend an informational meeting.



1. All families will attend an informational meeting and will be able to participate in play; however due to the random nature of the study you will not be able to choose whether you attend six sessions of play one evening each week, or whether you will have to wait six weeks following the informational meeting for a weekend retreat format. You will find out at the informational meeting what format you will participate in. Should I proceed?
2. All family members 7 or older will be asked to take some short assessments asking your views on your family. You may have to do this twice during the seven weeks. Should I continue?
3. If you decide to participate we would like to have you commit to attending all of the sessions, however you may miss two. Should I proceed?
4. It would be helpful to have all family members present, but it is not mandatory.
5. You will be participating in the activities with other families.
6. Would you like to register to attend the informational meeting?

Caller: Yes

Researcher: I need to fill out registration information. (Note time on registration sheet) What location would be best for your family? Who will be participating in the play? (record names, sex, and ages) Can you give me a phone number where you can be reached? (record) (From previous conversation note risk factors and family configuration.) Thank you very much I would like to confirm the informational meeting date and time. At that meeting you will be able to sign a consent form and get more information about the study.

**Appendix D**  
**Adult Agreement to Participate**

**Western Michigan University**  
**Department of Counselor Education and Counseling Psychology**  
**Principal Investigator: Suzanne Hedstrom Ed.D.**  
**Research Associate: Carmen Baldus, Ed.S.**

I have have been invited to participate in a study of the effect of Group Family Play on family relations. This study is part of Carmen Baldus' dissertation required for completion of her doctoral degree. This research is intended to study how playing together as a family affects our ability to communicate and problem solve. It will also consider how parenting stress is affected by family play. Participants will be asked to answer questions describing family health and parenting stress. Participants are free not to answer any question that may be asked.

I am agreeing to attend six sessions of Group Family Play (90 minutes one evening each week, for 6 weeks), or a Group Family Play retreat (2 hours Friday, 5 hours Saturday), following a six week waiting period. If I have to wait six weeks, the researcher will call at least once to check on my family. Due to the random nature of the study, I do not have a choice about the format to which I am assigned. Play groups will be held in the present site at this same time (Grant Primary Center Cafeteria Thursdays from 6:30-8:00, Hesperia Elementary Cafeteria Tuesdays from 7:00-8:30, Newaygo Upper Elementary Cafeteria Wednesdays from 7:00-8:30, or White Cloud Elementary Cafeteria Tuesdays from 7:00-8:30). Participants can miss sessions and still participate.

During the sessions my family will participate together in a semi-structured play activity that includes working with sand, puppets, art, and family and group initiatives, directed and supported by research assistants. Following the activities, I will be asked to process in my family unit concerning the play experience. During some groups, my family may be interacting with other families who are present. I am agreeing to complete some assessments asking my views on family health and parenting stress.

The benefits to participation include quality time with my family through participation in a play activity that is fun and non-threatening. I may have the opportunity to learn about myself and my interactions with others. As a participant my name will be entered in drawings for prizes such as games, sand trays, puppets, and certificates for family outings. My contribution to this research may help in understanding how participation in noncompetitive play activities can impact family health/competence and parenting stress.

Minimal risks exist in participating in the study. Processing of play activities may lead to some discomfort or conflict as I may express things that I haven't said before. I always have the right to pass during sharing times. I am aware that although the exercises have some therapeutic benefit, I am not in therapy. Although highly unlikely, a family crisis may occur. Although highly unlikely, a family crisis may occur. Individual or family therapy are alternatives I can explore to work on difficult family issues and pursued at my own cost. A list of agencies and individuals who do individual and/or family work will be provided upon request. I reserve the right to discontinue the study at any time without risk or penalty. As in all research, there may be unforeseen risks to the participant. If an accidental injury occurs

appropriate emergency measures will be taken; however, no compensation or treatment will be made available to subjects except as otherwise stated in this consent form.

All data collected by the researcher will be kept confidential. During the last session I may sign up to meet with the researcher individually to discuss test results prior to the link between my name and data being separated. If I choose not to know the results of our tests, the link between my name and the data will be immediately destroyed. Once the data are collected and analyzed, the list of participants will be shredded, and I will no longer be connected to the results. Data will be stored in a locked cabinet in (Principal Investigator) Suzanne Hedstrom's office for three years.

Any concerns or questions we have about this research can be addressed to either Carmen Baldus at (231) 652-1299 or Dr. Suzanne Hedstrom at (616) 771-9913. The signatures below indicate that our family members realize the purpose and requirements of this study and agree to participate. The participant may also contact the Chair, Human Subjects Institutional Review Board (616) 387-8293 or the Vice President for Research (616) 387-8298 if questions or problems arise during the course of the study.

As a parent(s), my signature affirms my permission for my children to participate in Group Family Play.

SIGNATURE(S)

DATE

\_\_\_\_\_  
\_\_\_\_\_

This consent document has been approved for use for one year by the Human Subjects Institutional Review Board (HSIRB) as indicated by the stamped date and signature of the board chair in the upper right corner. Subjects should not sign this document if the corner does not show a stamped date and signature.

**Appendix E**  
**Child Agreement to Participate**

**Western Michigan University**  
**Department of Counselor Education and Counseling Psychology**  
**Principal Investigator: Suzanne Hedstrom, Ed.D.**  
**Research Associate: Carmen Baldus, Ed.S.**

**I agree to participate in the Group Family Play activities with my family. When the family is talking about the activity, I will always be able to say that I pass or do not want to talk.**

**I agree to answer some questions about my family if I am 7 years of age or older.**

**If there is ever a time I do not want to participate, I may sit quietly and wait for my family to finish.**

**Name: \_\_\_\_\_**

**Date: \_\_\_\_\_**

**Appendix F**  
**Puppet Story Guide**

## **PUPPET STORY GUIDE**

**MORAL: MAKING A RIGHT CHOICE** (i.e. cheaters never win, don't judge a person by the outside, actions speak louder than words, soft words turn away anger.)

**Characters:**

**(What is the name, age, personality, likes, & dislikes?)**

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**Setting:** Where the story occurs. (i.e. picnic in the park, the beach, the house, a castle, a dungeon.)

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**Plot:** What happens to your characters. What is a problem and how do the others work together to solve it (i.e. the little brother runs away, and the family searches for him, an older sister is caught cheating at school and the family works out an appropriate punishment, someone feels left out and the family works hard to include them.)

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**The Moral:** What is it you want others to learn from the situation?

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**Appendix G**  
**Informational Flyer**

**FAMILY PLAY PROJECT**  
**FREE \*\*\* FUN \*\*\* PRIZES\*\*\*FOOD \*\*\***  
**APRIL 10- MAY 24**



**LOOKING FOR FAMILIES WITH CHILDREN OF  
ALL AGES WHO WISH TO**

- **IMPROVE COMMUNICATION**
- **PROBLEM SOLVE**
- **STRENGTHEN FAMILY BONDS**
- **ENJOY FAMILY TIME TOGETHER**

**INFORMATIONAL MEETING**

**Grant – Grant Primary Center (Thursday April 12, 6:30-8:00pm)**

**Hesperia – Hesperia Elementary (Tuesday April 10, 7:00-8:30pm)**

**Newaygo – Newaygo Upper El. (Wed. April 11, 7:00-8:30pm)**

**White Cloud- White Cloud El. (Tuesday April 10, 7:00-8:30 pm)**

My name is Carmen Baldus and I am a doctoral candidate in Counselor/Education Counseling Psychology at Western Michigan University. I am seeking help with my dissertation research which is intended to study how playing together as a family affects parenting stress and the ability of family members to communicate and problem-solve. Potential families must meet the MSRP criteria for risk before being invited to participate. Families will be asked to participate in the play activities and to complete surveys on family health and parenting stress. You may decide at the informational meeting whether or not you want to participate. All data collected by the researcher will be kept confidential. Once the data are collected and analyzed the list of participants will be shredded.

**THE PROJECT MAY INVOLVE A COMMITMENT OF SEVEN WEEKS (one evening each week for 90 minutes.) IN WHICH YOU AND YOUR FAMILY WILL PLAY TOGETHER WITH OTHER FAMILIES IN NONCOMPETITIVE ACTIVITIES OR A FRIDAY EVENING/SATURDAY RETREAT IN JUNE (2 hours on Fri, 5 hours on Sat.) YOU MAY CHOOSE THE LOCATION, HOWEVER DUE TO THE NATURE OF THE PROJECT YOU WILL BE ASSIGNED TO A GROUP THAT PARTICIPATES IN EITHER THE RETREAT OR WEEKLY GROUP EXPERIENCE FORMAT BASED ON REGISTRATION TIME. WEEKLY MEETINGS WILL BE HELD ON THE SAME DAYS AND TIMES AS THE INFORMATIONAL MEETING FOR THE NEXT 6 WEEKS.**

**TO REGISTER FOR THE INFORMATIONAL MEETING  
OR TO FIND OUT MORE CALL CARMEN  
AT (231) 652-1299.**

**Appendix H**  
**Pretest and Posttest Scores**

| CODE    | sex/age | risk fact. | pr3FI/HIC | po3FI/HIC | pr3FI/con | po3FI/con | pre3FI | po3FI | pr3FI/sty | po3FI/sty | pre3Fich | po3Fich |
|---------|---------|------------|-----------|-----------|-----------|-----------|--------|-------|-----------|-----------|----------|---------|
| R1-h1A  | F 8r A  | 6,22       | 43        | 34        | 27        | 31        | 4.5    | 3.6   | 2.84      | 2.1       | 14       | 9       |
| R2-h1C  | M 10    | 6,22       | 41        | 41        | 36        | 31        | 4      | 4     | 1.38      | 3.11      | 7        | 17      |
| R3-w1A  | M A     | 19,14      | 38        | 32        | 24        | 25        | 4      | 3.5   | 3.11      | 1.88      | 14       | 7       |
| R4-w1B  | F A     | 19,14      | 51        | 45        | 41        | 24        | 5.5    | 4.8   | 2.32      | 2.87      | 15       | 14      |
| R5-w5A  | F A     | 18,6       | 50        | 45        | 21        | 21        | 5.2    | 4.8   | 2.87      | 2.65      | 17       | 14      |
| R6-w1E  | M 11    | 19,14      | 32        | 34        | 16        | 22        | 3.5    | 3.6   | 4.26      | 2.9       | 14       | 11      |
| R7-w1D  | F 12    | 19,14      | 31        | 35        | 15        | 20        | 3.2    | 3.6   | 2.82      | 2.57      | 13       | 12      |
| R8-w5B  | F 13    | 19,6       | 40        | 44        | 16        | 23        | 4.2    | 4.6   | 3.04      | 3.2       | 13       | 12      |
| R9-g5A  | F A     | 16,20      | 56        | 46        | 29        | 23        | 5.8    | 4.8   | 3.44      | 3.14      | 19       | 15      |
| R10-g5C | M 12    | 16,20      | 56        | 60        | 28        | 24        | 6.1    | 6.2   | 3.99      | 3.08      | 20       | 20      |
| R11-g5B | F 15    | 16,20      | 50        | 56        | 23        | 23        | 5.2    | 5.8   | 3.17      | 3.91      | 17       | 23      |
| R12-q1A | M A     | 18,19      | 30        | 42        | 17        | 29        | 3.2    | 4.4   | 2.9       | 2.65      | 9        | 12      |
| R13-q1B | F A     | 18,19      | 35        | 37        | 25        | 24        | 3.6    | 3.8   | 2.65      | 2.65      | 10       | 11      |
| R14-q1C | M 8     | 18,19      | 32        | 50        | 21        | 31        | 3.5    | 5.2   | 2.45      | 3.2       | 12       | 12      |
| R15-w1C | F 13    | 19,14      | 34        | 49        | 21        | 30        | 3.6    | 5.1   | 2.65      | 2.92      | 13       | 14      |
| R16-n1b | M A     | 6,14,18    | 33        | 45        | 23        | 26        | 3.5    | 4.8   | 1.88      | 2.65      | 8        | 14      |
| R17-n1a | F A     | 6,14,18    | 33        | 42        | 23        | 23        | 3.5    | 4.4   | 1.88      | 2.65      | 8        | 12      |
| R18-n8b | F A     | 18,24      | 28        | 24        | 14        | 14        | 2.8    | 2.5   | 2.6       | 2.38      | 9        | 7       |
| R19-n9  | M A     | 18,24      | 25        | 32        | 13        | 17        | 2.6    | 3.5   | 2.38      | 2.6       | 6        | 10      |
| R20-h5C | M 14    | 6,18,19    | 37        | 40        | 30        | 32        | 3.8    | 4.2   | 2.15      | 2.51      | 9        | 14      |
| R21-h5B | M A     | 6,18,19    | 39        | 27        | 25        | 17        | 4.1    | 2.8   | 2.65      | 2.68      | 13       | 9       |
| R22-h5A | F A     | 6,18,19    | 37        | 31        | 23        | 20        | 3.8    | 3.2   | 2.9       | 2.68      | 11       | 7       |
| R23-h5E | F 9     | 6,18,19    | 34        | 35        | 22        | 27        | 3.6    | 3.6   | 3.2       | 1.9       | 13       | 13      |
| R24-h5D | F 14    | 6,18,19    | 63        | 67        | 44        | 36        | 6.6    | 7     | 3.44      | 1.93      | 15       | 17      |
| R25-h9C | M 7     | 14,16,18   | 23        | 20        | 28        | 16        | 2.4    | 2.1   | 1.38      | 2.38      | 5        | 7       |
| R26-h9B | M 8     | 14,16,18   | 29        | 20        | 28        | 16        | 3      | 2.4   | 2.48      | 2.38      | 11       | 7       |
| R27-h9A | F A     | 14,16,18   | 39        | 27        | 24        | 14        | 4.1    | 2.8   | 3.33      | 2.68      | 10       | 9       |
| R28-n5A | F A     | 6,9,16     | 35        | 35        | 27        | 22        | 3.7    | 3.7   | 1.88      | 2.13      | 5        | 9       |
| R29-n5B | M 11    | 6,9,16     | 36        | 39        | 22        | 29        | 3.8    | 4.1   | 3.09      | 1.82      | 13       | 12      |
| R30-n5C | M 13    | 6,9,16     | 40        | 39        | 37        | 32        | 4.2    | 4.1   | 2.79      | 3.04      | 14       | 14      |
| R31-q1D | F 7     | 18,19      | 53        | 40        | 36        | 22        | 5.6    | 4.2   | 2.92      | 3.22      | 13       | 15      |
|         |         |            | 1205      | 1213      | 779       | 744       |        |       | 84.84     | 82.46     | 370      | 379     |
|         |         |            | 75.3125   |           |           |           |        |       |           |           |          |         |

| preSFileD | poSFileD | preSFlex | poSFlex | preP3Ich | poP3Ich | preP3Ip | poP3Ip | preP3I to poP3I to | preIfeStr | polIfeStre |
|-----------|----------|----------|---------|----------|---------|---------|--------|--------------------|-----------|------------|
| 8         | 10       | 7        | 7       | 141      |         | 129     |        | 270                | 8         |            |
| 7         | 8        | 13       | 9       |          |         |         |        |                    |           |            |
| 7         | 7        | 10       | 10      | 143      | 133     | 123     | 118    | 286                | 251       | 10         |
| 10        | 7        | 9        | 16      | 131      | 137     | 136     | 128    | 287                | 285       | 20         |
| 10        | 6        | 15       | 15      | 165      | 171     | 137     | 136    | 302                | 307       | 10         |
| 4         | 3        | 9        | 11      |          |         |         |        |                    |           |            |
| 4         | 7        | 6        | 7       |          |         |         |        |                    |           |            |
| 11        | 11       | 13       | 12      |          |         |         |        |                    |           |            |
| 5         | 6        | 15       | 13      | 113      | 120     | 100     | 114    | 213                | 134       | 21         |
| 9         | 7        | 14       | 15      |          |         |         |        |                    |           |            |
| 10        | 5        | 15       | 17      |          |         |         |        |                    |           |            |
| 7         | 8        | 6        | 10      | 102      | 106     | 120     | 118    | 222                | 224       | 0          |
| 6         | 6        | 11       | 8       | 100      | 100     | 123     | 132    | 223                | 232       | 6          |
| 4         | 8        | 7        | 9       |          |         |         |        |                    |           |            |
| 6         | 9        | 5        | 13      |          |         |         |        |                    |           |            |
| 4         | 10       | 6        | 12      | 100      | 99      | 121     | 127    | 221                | 226       | 4          |
| 4         | 4        | 6        | 10      | 116      | 117     | 122     | 130    | 238                | 247       | 7          |
| 7         | 5        | 6        | 5       | 94       | 103     | 128     | 120    | 220                | 223       | 8          |
| 4         | 4        | 10       | 8       | 100      | 95      | 127     | 116    | 227                | 211       | 12         |
| 7         | 3        | 10       | 10      |          |         |         |        |                    |           |            |
| 6         | 7        | 9        | 6       | 100      | 101     | 117     | 116    | 217                | 217       | 10         |
| 5         | 5        | 6        | 6       | 98       | 87      | 114     | 108    | 212                | 195       | 6          |
| 8         | 10       | 8        | 8       |          |         |         |        |                    |           |            |
| 11        | 10       | 16       | 14      |          |         |         |        |                    |           |            |
| 9         | 7        | 5        | 5       |          |         |         |        |                    |           |            |
| 11        | 7        | 7        | 5       |          |         |         |        |                    |           |            |
| 10        | 6        | 7        | 5       | 108      | 79      | 134     | 93     | 242                | 172       | 18         |
| 10        | 7        | 7        | 7       | 99       |         | 125     |        | 224                |           | 0          |
| 7         | 5        | 9        | 10      |          |         |         |        |                    |           |            |
| 9         | 4        | 12       | 9       |          |         |         |        |                    |           |            |
| 9         | 3        | 13       | 8       |          |         |         |        |                    |           |            |
| 229       | 207      | 262      | 300     |          |         |         |        |                    |           |            |

| CODE     | SEX/AGE | RISK  | FCT | prSFI/HC | poSFI/HC | prSFI/con | poSFI/con | prSFI/cor | poSFI | prSFI/sty | poSFI/sty | prSFIch | poSFIch |
|----------|---------|-------|-----|----------|----------|-----------|-----------|-----------|-------|-----------|-----------|---------|---------|
| B1-q10A  | M A     |       | 6   | 28       | 33       | 16        | 17        | 2.9       | 3.5   | 2.82      | 2.8       | 9       | 14      |
| B2-q10B  | F A     |       | 6   | 30       | 31       | 19        | 18        | 3.1       | 3.2   | 2.38      | 2.6       | 8       | 11      |
| B3-q10C  | F 13    |       | 6   | 31       | 32       | 13        | 13        | 3.2       | 3.3   | 2.82      | 2.82      | 12      | 14      |
| B4-q10D  | F 11    |       | 6   | 35       | 34       | 18        | 24        | 3.7       | 3.6   | 3.42      | 2.29      | 13      | 15      |
| B5-q10E  | M 8     |       | 6   | 38       | 33       | 17        | 22        | 4         | 3.5   | 3.42      | 2.29      | 13      | 15      |
| B6-h10B  | F A     | 6,21  |     | 56       | 47       | 41        | 27        | 5.9       | 4.9   | 2.15      | 2.95      | 12      | 13      |
| B7-h10C  | M 15    | 6,21  |     | 56       | 53       | 41        | 32        | 5.9       | 5.6   | 2.89      | 3.17      | 17      | 14      |
| B8-q6C   | F 18    | 6,10  |     | 37       | 47       | 27        | 28        | 3.9       | 4.9   | 2.38      | 3.34      | 10      | 16      |
| B9-q6B   | M 16    | 6,10  |     | 50       | 47       | 37        | 32        | 5.2       | 4.9   | 2.65      | 3.17      | 13      | 11      |
| B10-q6A  | M A     | 6,10  |     | 29       | 31       | 26        | 21        | 3         | 3.2   | 2.9       | 2.65      | 9       | 8       |
| B11-q2B  | F A     | 2,24  |     | 35       | 46       | 13        | 16        | 3.7       | 4.8   | 2.43      | 3.12      | 13      | 16      |
| B12-n14C | F 15    | 14,18 |     | 66       | 67       | 38        | 33        | 6.9       | 7     | 2.81      | 3.14      | 23      | 22      |
| B13-n14B | F 25    | 14,19 |     | 85       | 83       | 50        | 48        | 8.9       | 8.7   | 3.16      | 3.46      | 25      | 25      |
| B14-n14A | F A     | 14,18 |     | 69       | 61       | 35        | 29        | 7.2       | 6.4   | 3.36      | 3.36      | 23      | 22      |
| B15-w2B  | F 15    | 16,18 |     | 68       | 64       | 42        | 43        | 7.1       | 6.7   | 2.92      | 2.67      | 19      | 16      |
| B16-w2C  | M 12    | 16,18 |     | 63       | 56       | 38        | 33        | 6.6       | 5.9   | 3.86      | 2.92      | 21      | 14      |
| B17-h2A  | M A     | 17,24 |     | 42       | 41       | 26        | 29        | 4.4       | 4.3   | 2.65      | 2.4       | 12      | 11      |
| B18-h2B  | F A     | 17,24 |     | 32       | 33       | 17        | 17        | 3.4       | 3.5   | 2.98      | 3.2       | 8       | 9       |
| B19-h6A  | F A     | 5,6   |     | 24       | 24       | 13        | 17        | 2.5       | 2.5   | 2.38      | 2.38      | 9       | 7       |
| B20-n2B  | M 14    |       | 16  | 28       | 27       | 14        | 16        | 2.9       | 2.8   | 2.35      | 2.6       | 13      | 12      |
| B21-n2A  | F A     |       | 16  | 33       | 27       | 20        | 12        | 3.5       | 2.8   | 2.68      | 2.9       | 11      | 10      |
| B22-n10A | M A     |       | 2   | 20       | 22       | 16        | 12        | 2.1       | 2.3   | 2.38      | 2.38      | 6       | 7       |
| B23-n10B | F A     |       | 2   | 20       | 19       | 12        | 18        | 2.1       | 2     | 2.38      | 1.38      | 6       | 5       |
| B24-n10C | M 7     |       | 2   | 31       | 31       | 18        | 18        | 3.2       | 3.2   | 2.6       | 2.6       | 9       | 9       |
| B25-h10A | M A     | 6,21  |     | 44       | 44       | 32        | 36        | 4.6       | 4.6   | 2.48      | 2.15      | 9       | 12      |
| B26-n6A  | F A     | 19,24 |     | 29       | 32       | 15        | 17        | 3         | 3.4   | 2.6       | 2.9       | 11      | 11      |
| B27-n6B  | F 14    | 19,24 |     | 30       | 29       | 15        | 15        | 3.1       | 3     | 2.9       | 2.9       | 11      | 12      |
| B28-n6C  | F 10    | 19,24 |     | 34       | 26       | 17        | 14        | 3.6       | 2.7   | 2.9       | 2.6       | 12      | 10      |
| B29-h6C  | F 7     | 5,6   |     | 30       | 36       | 14        | 15        | 3.1       | 3.8   | 2.16      | 3.12      | 14      | 15      |
| B30-q2A  | M A     | 2,24  |     | 40       | 47       | 20        | 27        | 4.2       | 4.9   | 2.9       | 2.65      | 10      | 14      |
| B31-w2A  | F A     | 16,18 |     | 54       |          | 33        |           | 5.7       |       | 3.22      |           | 16      |         |

| preSFld | posFld | preSFlex | posFlex | prePSich | posPSich | prePSlp | posPSlp | prePSl to | posPSl to | prelfest | polifeste |
|---------|--------|----------|---------|----------|----------|---------|---------|-----------|-----------|----------|-----------|
| 9       | 8      | 7        | 6       | 68       | 68       | 90      | 88      | 158       | 154       | 0        | 0         |
| 8       | 7      | 6        | 6       | 77       | 70       | 105     | 79      | 182       | 149       | 7        | 0         |
| 6       | 7      | 12       | 13      |          |          |         |         |           |           |          |           |
| 8       | 10     | 8        | 9       |          |          |         |         |           |           |          |           |
| 8       | 9      | 7        | 5       |          |          |         |         |           |           |          |           |
| 7       | 10     | 10       | 13      | 122      | 127      | 126     | 119     | 248       | 246       | 27       | 18        |
| 10      | 9      | 13       | 14      |          |          |         |         |           |           |          |           |
| 7       | 6      | 10       | 10      |          |          |         |         |           |           |          |           |
| 5       | 7      | 13       | 13      |          |          |         |         |           |           |          |           |
| 8       | 10     | 10       | 8       | 102      | 96       | 118     | 113     | 220       | 209       | 0        | 0         |
| 6       | 5      | 12       | 10      | 104      |          | 112     |         | 216       |           | 0        |           |
| 7       | 5      | 18       | 20      |          |          |         |         |           |           |          |           |
| 8       | 12     | 25       | 19      |          |          |         |         |           |           |          |           |
| 15      | 12     | 13       | 15      | 117      | 137      | 153     | 166     | 270       | 303       | 8        | 4         |
| 12      | 9      | 17       | 15      |          |          |         |         |           |           |          |           |
| 9       | 8      | 15       | 13      |          |          |         |         |           |           |          |           |
| 5       | 7      | 14       | 10      |          |          |         |         |           |           |          |           |
| 4       | 6      | 7        | 7       |          |          |         |         |           |           |          |           |
| 7       | 4      | 6        | 5       | 123      | 127      | 106     | 90      | 229       | 217       | 4        | 4         |
| 6       | 8      | 5        | 5       |          |          |         |         |           |           |          |           |
| 8       | 5      | 5        | 5       | 94       | 88       | 124     | 122     | 218       | 200       | 19       | 4         |
| 7       | 7      | 5        | 5       | 77       | 65       | 71      | 70      | 148       | 135       | 6        | 2         |
| 7       | 7      | 5        | 5       | 104      | 81       | 74      | 82      | 176       | 163       | 6        | 2         |
| 6       | 6      | 8        | 8       |          |          |         |         |           |           |          |           |
| 4       | 3      | 7        | 7       | 110      | 122      | 105     | 103     | 215       | 225       | 23       | 16        |
| 7       | 7      | 6        | 7       | 62       | 76       | 68      | 76      | 130       | 152       | 0        | 0         |
| 7       | 3      | 6        | 6       |          |          |         |         |           |           |          |           |
| 7       | 7      | 6        | 6       |          |          |         |         |           |           |          |           |
| 3       | 5      | 8        | 8       |          |          |         |         |           |           |          |           |
| 8       | 9      | 11       | 13      | 119      |          | 130     |         | 249       |           | 6        |           |
| 8       |        | 7        |         | 155      | 128      | 167     | 144     | 322       | 272       | 16       | 6         |

| CODE     | SEX/AGE | RISK FAC | prSF/HC | poSF/HC | prSF/con | poSF/con | preSF | poSF | prSF/sty | poSF/sty | preSF/co | poSF/co |
|----------|---------|----------|---------|---------|----------|----------|-------|------|----------|----------|----------|---------|
| Y1-h3A   | F A     | 6,19,20  |         | 28      | 19       |          |       | 2.9  |          | 2.38     |          | 8       |
| Y2-h3B   | M A     | 6,19,20  |         | 35      | 22       |          |       | 3.7  |          | 2.6      |          | 11      |
| Y3-h3C   | F 13    | 6,19,20  |         | 38      | 20       |          |       | 4    |          | 2.57     |          | 13      |
| Y4-N3B   | F A     | 6,24     |         | 22      | 12       |          |       | 2.3  |          | 2.38     |          | 7       |
| Y5-n7A   | F A     | 14,16,18 |         | 57      | 29       |          |       | 6    |          | 3.14     |          | 20      |
| Y6-w7B   | M 11    | 14,24    |         | 36      | 25       |          |       | 3.8  |          | 2.87     |          | 13      |
| Y7-w7C   | F 10    | 14,24    |         | 30      | 14       |          |       | 3.1  |          | 2.68     |          | 10      |
| Y8-n11B  | F A     | 2        |         | 40      | 22       |          |       | 4.2  |          | 2.65     |          | 10      |
| Y9-n11D  | F 17    | 2        |         | 56      | 24       |          |       | 5.9  |          | 3.64     |          | 21      |
| Y10-n11C | F 19    | 2        |         | 37      | 25       |          |       | 3.9  |          | 2.1      |          | 11      |
| Y11-n11A | M A     | 2        |         | 58      | 34       |          |       | 6.1  |          | 3.69     |          | 18      |
| Y12-w3B  | M 9     | 21, 24   |         | 30      | 16       |          |       | 3.1  |          | 3.58     |          | 12      |
| Y13-q7D  | M 9     | 16,18,19 |         | 47      | 26       |          |       | 4.9  |          | 2.87     |          | 14      |
| Y14-q3E  | F 7     | 18,19    |         | 24      | 17       |          |       | 2.5  |          | 2.38     |          | 10      |
| Y15-q3D  | M 9     | 18,19    |         | 27      | 32       |          |       | 2.8  |          | 2.38     |          | 8       |
| Y16-q3A  | F A     | 18,19    |         | 43      | 29       |          |       | 4.5  |          | 2.67     |          | 14      |
| Y17-q3C  | M 11    | 18,19    |         | 54      | 32       |          |       | 5.7  |          | 3.14     |          | 15      |
| Y18-q3B  | M A     | 18,19    |         | 36      | 24       |          |       | 3.8  |          | 2.98     |          | 10      |
| Y19-q7E  | M 7     | 16,18,19 |         | 43      | 27       |          |       | 4.5  |          | 2.18     |          | 11      |
| Y20-q7A  | F A     | 16,18,19 |         | 43      | 22       |          |       | 4.5  |          | 2.87     |          | 15      |
| Y21-q7C  | F 11    | 16,18,19 |         | 47      | 23       |          |       | 4.9  |          | 3.31     |          | 18      |
| Y22-q11A | F A     | 14,20    |         | 29      | 19       |          |       | 3    |          | 2.6      |          | 11      |
| Y23-q11D | M 12    | 14,20    |         | 46      | 38       |          |       | 4.8  |          | 1.88     |          | 11      |
| Y24-w3A  | F A     | 21,24    |         | 54      | 32       |          |       | 5.7  |          | 2.62     |          | 15      |
| Y25-w7A  | F A     | 14,24    |         | 48      | 32       |          |       | 5    |          | 2.7      |          | 13      |
| Y26-w7D  | M A     | 14,24    |         | 74      | 52       |          |       | 7.8  |          | 2.83     |          | 15      |
| Y27-n3A  | M A     | 6,24     |         | 23      | 14       |          |       | 2.4  |          | 2.38     |          | 6       |
| Y28-h3D  | M 7     | 6,19,20  |         | 32      | 30       |          |       | 3.4  |          | 1.63     |          | 10      |
| Y29-q7B  | F 14    | 16,18,19 |         | 27      | 20       |          |       | 2.8  |          | 2.9      |          | 8       |
| Y30-n3C  | F 7     | 6,24     |         | 32      | 15       |          |       | 3.4  |          | 3.42     |          | 12      |
| sum      |         |          |         |         |          |          |       |      |          |          |          |         |



| preSFile | poSFile | preSFlex | poSFlex | prePSich | poPSich | prePSip | poPSip | prePSI to | poPSI to | prelifestr | polifestr |
|----------|---------|----------|---------|----------|---------|---------|--------|-----------|----------|------------|-----------|
|          | 7       |          | 8       | 132      |         | 158     |        | 280       |          |            | 6         |
|          | 6       |          | 5       | 139      |         | 137     |        | 276       |          |            | 19        |
|          | 7       |          | 8       |          |         |         |        |           |          |            |           |
|          | 6       |          | 5       | 64       |         | 87      |        | 151       |          |            | 0         |
|          | 6       |          | 13      | 129      |         | 150     |        | 279       |          |            | 29        |
|          | 8       |          | 9       |          |         |         |        |           |          |            |           |
|          | 4       |          | 6       |          |         |         |        |           |          |            |           |
|          | 3       |          | 10      |          |         |         |        |           |          |            |           |
|          | 4       |          | 15      |          |         |         |        |           |          |            |           |
|          | 6       |          | 10      |          |         |         |        |           |          |            |           |
|          | 10      |          | 15      |          |         |         |        |           |          |            |           |
|          | 3       |          | 10      |          |         |         |        |           |          |            |           |
|          | 8       |          | 11      |          |         |         |        |           |          |            |           |
|          | 10      |          | 8       |          |         |         |        |           |          |            |           |
|          | 11      |          | 6       |          |         |         |        |           |          |            |           |
|          | 7       |          | 10      | 111      |         | 145     |        | 256       |          |            | 10        |
|          | 10      |          | 11      |          |         |         |        |           |          |            |           |
|          | 6       |          | 8       | 100      |         | 105     |        | 205       |          |            | 4         |
|          | 8       |          | 10      |          |         |         |        |           |          |            |           |
|          | 9       |          | 10      | 109      |         | 98      |        | 215       |          |            | 0         |
|          | 8       |          | 8       |          |         |         |        |           |          |            |           |
|          | 5       |          | 7       | 130      |         | 141     |        | 271       |          |            | 8         |
|          | 15      |          | 14      |          |         |         |        |           |          |            |           |
|          | 10      |          | 10      | 128      |         | 133     |        | 261       |          |            | 0         |
|          | 7       |          | 8       | 104      |         | 123     |        | 227       |          |            | 16        |
|          | 7       |          | 19      | 114      |         | 123     |        | 237       |          |            | 18        |
|          | 7       |          | 5       |          |         |         |        |           |          |            |           |
|          | 3       |          | 6       |          |         |         |        |           |          |            |           |
|          | 7       |          | 7       |          |         |         |        |           |          |            |           |
|          | 5       |          | 7       |          |         |         |        |           |          |            |           |
|          |         |          | 279     |          |         |         |        |           |          |            |           |

| CODE     | SEX/AGE | RISK | FAC     | pr3F/INC | po3F/INC | pr3F/con | po3F/con | pr3F/cor | po3F/cor | pr3Fi | po3Fi | pr3Fi/sty | po3Fi/sty | pr3Fich | po3Fich | pr3Fild |
|----------|---------|------|---------|----------|----------|----------|----------|----------|----------|-------|-------|-----------|-----------|---------|---------|---------|
| G1-mA    | F       | A    | 6,16,18 |          | 38       |          |          | 21       |          |       | 4     |           | 2.15      |         | 15      |         |
| G2-mB    | F       | 7    | 6,16,18 |          | 31       |          |          | 31       |          |       | 3.2   |           | 2.86      |         | 9       |         |
| G3-wB    | F       | 14   | 16,18   |          | 42       |          |          | 28       |          |       | 4.4   |           | 2.7       |         | 9       |         |
| G4-q8A   | F       | A    | 3,19    |          | 34       |          |          | 21       |          |       | 3.6   |           | 2.95      |         | 13      |         |
| G5-q8B   | M       | A    | 3,19    |          | 33       |          |          | 22       |          |       | 3.5   |           | 2.95      |         | 12      |         |
| G6-q8G   | F       | 8    | 3,19    |          | 37       |          |          | 23       |          |       | 4.2   |           | 2.87      |         | 12      |         |
| G7-q8D   | F       | 14   | 3,19    |          | 46       |          |          | 30       |          |       | 4.8   |           | 2.73      |         | 15      |         |
| G8-q8C   | F       | 15   | 3,19    |          | 35       |          |          | 27       |          |       | 3.7   |           | 2.73      |         | 9       |         |
| G9-q8E   | F       | 9    | 3,19    |          | 29       |          |          | 22       |          |       | 3     |           | 2.73      |         | 9       |         |
| G10-q8F  | M       | 11   | 3,19    |          | 26       |          |          | 22       |          |       | 2.7   |           | 2.13      |         | 7       |         |
| G11-q4A  | F       | A    | 12,18   |          | 38       |          |          | 22       |          |       | 4     |           | 3.12      |         | 13      |         |
| G12-q4B  | M       | A    | 12,18   |          | 38       |          |          | 18       |          |       | 4     |           | 2.68      |         | 12      |         |
| G13-w8B  | F       | A    | 3,18,19 |          | 49       |          |          | 21       |          |       | 5.1   |           | 3.12      |         | 16      |         |
| G14-w8A  | M       | A    | 3,18,19 |          | 50       |          |          | 27       |          |       | 5.2   |           | 3.09      |         | 17      |         |
| G15-n12B | M       | A    | 2,12    |          | 31       |          |          | 15       |          |       | 3.2   |           | 3.34      |         | 12      |         |
| G16-n12D | F       | 8    | 2,12    |          | 24       |          |          | 12       |          |       | 2.5   |           | 2.68      |         | 9       |         |
| G17-w8D  | F       | 13   | 3,18,19 |          | 45       |          |          | 32       |          |       | 4.7   |           | 2.87      |         | 14      |         |
| G18-n12C | M       | 10   | 2,12    |          | 23       |          |          | 13       |          |       | 2.4   |           | 2.38      |         | 9       |         |
| G19-n12A | M       | A    | 2,12    |          | 29       |          |          | 15       |          |       | 3     |           | 2.38      |         | 11      |         |
| G20-q4C  | M       | 7    | 12,18   |          | 34       |          |          | 12       |          |       | 3.6   |           | 4.24      |         | 15      |         |
| G21-w8C  | M       | 17   | 3,18,19 |          | 51       |          |          | 31       |          |       | 5.3   |           | 3.17      |         | 15      |         |
| G22-w8E  | F       | 11   | 3,18,19 |          | 49       |          |          | 32       |          |       | 5.1   |           | 2.87      |         | 15      |         |
| G23-m4C  | F       | 10   | 14,24   |          | 49       |          |          | 25       |          |       | 5.1   |           | 3.94      |         | 21      |         |
| G24-m4A  | F       | A    | 14,24   |          | 42       |          |          | 25       |          |       | 4.4   |           | 3.2       |         | 8       |         |
| G25-n8A  | M       | A    | 10,19   |          | 22       |          |          | 14       |          |       | 2.3   |           | 2.38      |         | 8       |         |
| G26-n8B  | F       | A    | 10,19   |          | 22       |          |          | 15       |          |       | 2.3   |           | 2.38      |         | 7       |         |
| G27-n8D  | F       | 18   | 10,19   |          | 22       |          |          | 14       |          |       | 2.3   |           | 2.68      |         | 7       |         |
| G28-n8E  | M       | 11   | 10,19   |          | 21       |          |          | 16       |          |       | 2.2   |           | 2.38      |         | 7       |         |
| G29-n8F  | F       | 10   | 10,19   |          | 22       |          |          | 15       |          |       | 2.3   |           | 2.68      |         | 7       |         |
| G30-n8C  | F       | 21   | 10,19   |          | 25       |          |          | 21       |          |       | 2.6   |           | 2.38      |         | 9       |         |
| mean     |         |      |         |          | 34.5667  |          |          | 21.3333  |          |       |       |           | 2.625333  |         |         |         |

| posFld | preSFlex | posSFlex | prePSlch | poPSlch | prePSlp | poPSlp | prePSl to | poPSl to | prelfeStr | polifeStr |
|--------|----------|----------|----------|---------|---------|--------|-----------|----------|-----------|-----------|
| 6      |          | 7        |          | 184     |         |        |           | 394      |           | 20        |
| 12     |          | 9        |          |         |         |        |           |          |           |           |
| 6      |          | 15       |          |         |         |        |           |          |           |           |
| 6      |          | 5        |          | 90      |         | 98     |           | 188      |           | 0         |
| 6      |          | 8        |          | 70      |         | 70     |           | 140      |           | 0         |
| 5      |          | 6        |          |         |         |        |           |          |           |           |
| 6      |          | 7        |          |         |         |        |           |          |           |           |
| 6      |          | 9        |          |         |         |        |           |          |           |           |
| 6      |          | 5        |          |         |         |        |           |          |           |           |
| 6      |          | 5        |          |         |         |        |           |          |           |           |
| 9      |          | 7        |          | 113     |         | 120    |           | 233      |           | 10        |
| 9      |          | 10       |          | 107     |         | 122    |           | 229      |           | 10        |
| 8      |          | 13       |          | 120     |         | 108    |           | 228      |           | 4         |
| 7      |          | 15       |          | 138     |         | 156    |           | 294      |           | 10        |
| 7      |          | 8        |          | 108     |         | 108    |           | 216      |           | 9         |
| 5      |          | 5        |          |         |         |        |           |          |           |           |
| 8      |          | 12       |          |         |         |        |           |          |           |           |
| 5      |          | 5        |          |         |         |        |           |          |           |           |
| 7      |          | 6        |          | 112     |         | 102    |           | 214      |           | 4         |
| 7      |          | 7        |          |         |         |        |           |          |           |           |
| 9      |          | 13       |          |         |         |        |           |          |           |           |
| 5      |          | 14       |          |         |         |        |           |          |           |           |
| 5      |          | 12       |          |         |         |        |           |          |           |           |
| 9      |          | 6        |          | 115     |         | 104    |           | 219      |           | 15        |
| 7      |          | 5        |          | 120     |         | 128    |           | 246      |           | 0         |
| 7      |          | 6        |          | 79      |         | 104    |           | 183      |           | 3         |
| 3      |          | 6        |          |         |         |        |           |          |           |           |
| 3      |          | 5        |          |         |         |        |           |          |           |           |
| 3      |          | 5        |          |         |         |        |           |          |           |           |
| 4      |          | 5        |          | 1356    |         |        |           |          |           |           |
|        |          |          |          | 113     |         |        |           |          |           |           |

**Appendix I**  
**Human Subjects Institutional Review Board**  
**Letter of Approval**

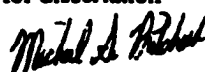
HSIRB Approval Form

Kalamazoo, Michigan 49008-5163  
815 367-5290

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**WESTERN MICHIGAN UNIVERSITY**

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**Date:** March 30, 2001**To:** Suzanne Hedstrom, Principal Investigator  
Carmen Baldus, Student Investigator for dissertation**From:** Michael S. Pritchard, Interim Chair**Re:** HSIRB Project Number 01-03-03

This letter will serve as confirmation that your research project entitled "A Study of the Effect of Group Family Play on Family Relations for Families with Children Considered At-Risk for Educational Failure" has been approved under the full category of review by the Human Subjects Institutional Review Board. The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the application.

Please note that you may only conduct this research exactly in the form it was approved. You must seek specific board approval for any changes in this project. You must also seek reapproval if the project extends beyond the termination date noted below. In addition if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

The Board wishes you success in the pursuit of your research goals.

**Approval Termination:** March 21, 2002

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