

1996

An extension of dyadic counseling to multi-family group training with application for Head Start families

Janet J. Zanetti

College of William & Mary - School of Education

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<https://dx.doi.org/doi:10.25774/w4-rww2-y374>

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AN EXTENSION OF
DYADIC COUNSELING
TO MULTI-FAMILY GROUP TRAINING
WITH APPLICATION FOR
HEAD START FAMILIES

A Proposal
Presented to
The Faculty of the School of Education
College of William and Mary
In Partial Fulfillment
Of the Requirements for the Degree
Doctor of Education

by
Janet J. Zanetti
April 22, 1996

UMI Number: 9703496

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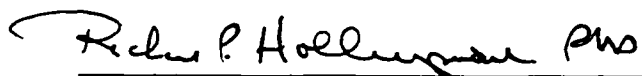
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ACKNOWLEDGEMENTS

I wish to express my sincere thanks to my committee chairman, Dr. Charles O. Matthews, and committee members, Dr. Sandra B. Ward and Dr. Richard P. Hollingsworth for their continued guidance and support, and to Dr. Susan Garvey, Clinical Consultant to Head Start, who made this research possible.

Special acknowledgment is due to Dr. Christine Philput and to Stephen Luke who helped sort out the statistical implications, to Terry Wells for putting it all into readable format, and to Martha Dennis and Robert Anderson who so skillfully edited the manuscript and video tapes.

Especially important to me was the encouragement and cooperation given by Virginia Beach school administrators, Linda Tanner and Michael Maloney. Deep gratitude is owed, as well, to Lawana Dowden, Director of Head Start, supervisors Eunice Eason and Renya Murray, the parents who shared their children, and the teachers who shared their space.

Special applause is due my facilitators, Martha Babcock and Janet Watson, for their youthful energy and optimism.

Deepest thanks go to my husband Allen for his unwavering support and to our children Lisa, Leslie, Susan, and Steven who never doubted that I would finish this study.

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AN EXTENSION OF
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ABSTRACT

The purpose of this study was to investigate the effects of one short-term training model, Parents and Children Together (PACT), on parent stress and child behavior for families enrolled in the Head Start program. PACT is a program of structured play activities designed to replicate the interactions between parents and children during the first developmental stage of life. PACT has been adapted, by the researcher, from a program called Theraplay developed for Head Start children by Ann Jernberg (1967).

Thirty families completed the study. Experimental and Control groups were formed from volunteer participants. Only Experimental subjects received training. Sessions were held weekly for one hour on site. Parents and children participated together for the first thirty minutes and parents met without children for the second thirty minutes.

Pre and post treatment assessment with Abidin's Parent

Stress Index/Short Form and the Connors' Parent Rating Scale-48 were administered to each group. The results of this study did not find statistical significance on measures of parent stress and child behavior; however, structured interviews with Experimental subjects indicated high satisfaction with the program.

This study offers an examination of one short term preventive model for community-based mental health services. Implications for multi-disciplinary service delivery are examined.

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CHAPTER 1

A. STATEMENT OF THE PROBLEM

The problem this research addresses is the maladaptive interaction between parents and children, which may be related to dysfunction in the first stage of life. This period, between birth and eighteen months of age, concerns the developmental tasks of attachment and separation which are critical for ego development and subsequent social adjustment (Bowlby, 1969).

Successful resolution of the attachment-separation stage of life depends upon the quality of the interaction between parent and child. When the caregiver's responses are appropriate to the infant's temperament and needs, secure attachment results (Ainsworth, 1978). Secure attachment involves more than the satisfaction of physiological needs. Consistent and responsive interaction in familiar rituals is also an important part of the attachment bond (Erikson, 1963). The infant who is securely attached establishes trust in the availability and consistency of the caregiver and will risk separation in order to explore his or her environment and to establish other relationships (Feiring, 1984). When responses of the caregiver create understimulation or overstimulation of the child, anxious or avoidant behavior may result. Developmental progress may be inhibited unless corrective emotional experiences, which address the tasks of this life-stage, are provided.

For many parents, the task of supportive interaction with their child is made more difficult by their own level of functioning (Hranitz, 1987). Parents who experienced difficulty in their early developmental progress, will find it difficult to assist their children through this same process (Bowen, 1976). Remediation of the parent dysfunction will be critical to the healthy development or remediation of the child (Nicholson, 1988).

A report by Senator Kassebaum (1994) describes the scope of the problem. She states that twenty-one percent of American children live in poverty, fifty percent of all marriages end in divorce, twenty five percent of all children live with a single parent, and twenty-five percent of all babies are born to unmarried mothers. According to Kassebaum, it is estimated that 100,000 children are homeless. Reports of child abuse are escalating. Infant mortality for 1988 was 10 deaths per 1,000, ranking the United States 20th in the world in this category.

Social-economic conditions of the family have profound effects on the children. Edlefsen and Baird (1994) report on changes they have observed in the disadvantaged pre-school population which they serve. "First, children are arriving with fewer intellectual, social, and emotional school-readiness skills. Second, preschool children have a precocious knowledge of life issues and experiences that they lack the emotional and cognitive ability to understand and integrate. Third, the inability of parents to show interest or participate in their

child's educational experience has become increasingly apparent" (p. 567). Major familial life stressors such as poverty, unemployment, domestic violence, substance abuse, medical problems, and inadequate social support can have destructive effects on parenting (Webster-Stratton, 1990). The accumulation of even minor stressors, associated with day-to-day living, can result in aversive maternal interactions when those stressors are chronic (Patterson, 1983).

Psychological characteristics of the parent or temperament of the child have been shown to impact familial stress levels as well. Webster-Stratton concludes, "Whether a family system will be disrupted by stressors appears to be affected not only by the number and relative weight of the stressors that the family has to cope with but also by the family's personal vulnerability or protective factors" (ibid p. 310).

The assumptions that (a) dysfunction within the first stage of life can affect all subsequent stages and that (b) parent dysfunction at any stage may inhibit the child in the same stage of development, raise important questions for treatment/training of families with young children. What are the methods for recapitulation and remediation of the early stages of development? Is there an optimal or critical time for effecting change? What are the implications for prevention?

B. JUSTIFICATION

Research and clinical experience over the past fifty years has demonstrated that effective intervention with young children must address the environment of the child. " Even in those cases where the child's problems seem to originate because of biological characteristics, such as difficult temperament, or neurological defects suspected in autistic, hyperactive, or developmentally impaired youngsters, many of the problem behaviors seem to be intensified by the interaction patterns between parent and child" (Eyberg, 1988 p.35).

Depending upon the orientation of the professional, intervention might be in the form of individual therapy of the parent or the child, family counseling, or a psycho-educational approach involving parent skills-training. Since the 1950s, a synthesis of these models has occurred. Parents may now be included in treatment as co-therapists for their children (Whitaker, 1981). Parents and children may be treated conjointly (Satir, 1967). Children may function as filial therapists for their parents (Guerney 1964, 1979). Extended family members, including siblings and grandparents, may be included in treatment/training. Delivery of care may take place in the office of the clinician, in the family home, or in the community educational center.

In many instances, however, parents most in need of services for themselves or their children are least likely to seek those services. Insufficient information about the availability of

services, lack of adequate resources to obtain services, or a failure of personal commitment to continue in services, all may keep families from the help they need.

Community programs which utilize an out-reach model of treatment/training and which involve a partnership of parents and professionals are needed to impact effectively the needs of today's disadvantaged populations. The goals of community-based mental health programs can be preventive or remedial.

Individuals who exhibit severe emotional problems or physical conditions requiring medication still will require individual care; however, group interventions can be effective in issues of socialization, self esteem, and behavior management (Edlefsen and Baird, 1994).

School based mental health services are currently in place for many elementary, middle, and high schools. Fewer services are available for pre-school programs. Treatment/training, delivered in the educational setting, provides the child with mental health support in an environment familiar to him/her and where participation of the parent is most apt to occur. A multi-disciplinary team approach is best able to provide the early intervention that minimizes or prevents the development of secondary emotional, social, and academic problems.

The purpose of this research is to investigate the effects of one training intervention, PACT (Parents and Children Together), on economically disadvantaged families. PACT is a structured intervention of play activities, designed to replicate

patterns of healthy interaction, between parents and children, during the first developmental stage of life. In this research study, PACT is intended as a preventive intervention for non-clinical parents and children.

C. THEORETICAL RATIONALE

Theoretical justification of the current research is based upon the eight stage psychosocial model of personality development proposed by Erik H. Erikson (1963, 1979, 1984). According to Erikson, the developmental stages of a person's life from birth to death are formed by social influences interacting with a physically and psychologically maturing organism. In Erikson's words, there is a "mutual fit of individual and environment - that is of the individual's capacity to relate to an ever expanding life space of people and institutions, on the one hand, and on the other, the readiness of these people and institutions to make him a part of an ongoing cultural concern" (1963, p. 102).

Erikson hypothesized that each of the eight developmental stages which he identified required the resolution of a crisis, a pivotal struggle between an individual's own needs and wishes and the needs and requirements of the community. Additionally, Erikson described six forms of ritualization related to the stages of development. Ritualization, in this model, referred to a patterned way of doing or experiencing things in daily interaction between individuals. According to Erikson, ritualization can help an individual relate to others in an

effective way, or the rituals can become rigid and perverted, preventing resolution of the psychosocial tensions of any particular stage. At each stage, the positive resolution of the psychosocial tension or crisis allows the "ascendence" of a basic strength such as Hope or Wisdom.

Unlike Freud, whose psychosexual stages implied a linear direction in growth of capacities from "lower" to "higher" stages of development, Erikson (1984) tried to make explicit an "epigenetic" scheme or life cycle which forces "a rounding out of the whole course of life which relates the last stage to the first both in the course of individual lives and in that of generations" (p. 157). Resolution of the crisis of each stage was not an "achievement" meant to show what we totally overcome, but what "can be renewed and mature at every further stage all the way up to the last stage" (ibid p. 159). Erikson explained that although a basic conflict dominates each particular stage, the crisis has been there in some rudimentary form before, and each will continue to mature during all the subsequent stages. This principle of renewing and previewing developmental tasks, which Erikson developed in his later years, proposes that reworking can be done simultaneously with achieving the task of a current life stage (Kivnick, 1985). This would seem to suggest that both parents and children might benefit from a recapitulation of the earliest life stage while perfecting the tasks of the current stage. The current study will examine a program designed to replicate the first psychosocial stage.

DEFINITION OF TERMS

The following definitions of terms are provided to clarify the major constructs of this study.

Independent Variable:

1. PACT (Parents and Children Together), refers to the intervention model developed, by the researcher, from Theraplay by Ann M. Jernberg (1967).

Dependent Variables:

2. Parent stress, refers to characteristics identified by objective measurement on the Parent Stress Index/Short Form (PSI/SF) developed by Richard R. Abidin (1990).
3. Child behavior, refers to the characteristics identified by objective measurement on the Connors' Parent Rating Scale-48 (CPRS-48) developed by C. Keith Connors (1989).

Related Terms:

4. Attachment refers to the interpersonal connection between infant and primary caregiver which develops in the first months of life. Attachment develops in the infant in relationship to the responses of the parent to the physical needs for protection and nurturing along with the emotional needs for warmth and consistency.

5. Bond refers to the interpersonal connection between parent and child which develops in relation to but not dependent on attachment. Bonding may be used interchangeably with attachment or in combination (attachment-bond) by other researchers.
6. Conjoint refers to the therapeutic approach involving spouses or parents and children in treatment simultaneously.
7. Family play refers to the specific interactions between family members which are used for diagnosis or treatment purposes by a mental health professional.
8. Filial therapy refers to the treatment/training approach that employs family members to treat other family members under the direction of a mental health professional.
9. Interactional therapy refers to treatment using specific behavioral or communicative skills between family members. Most often used to infer active interchange as in interactional play.
10. Reciprocal therapy refers to interaction between family members or other individuals from which each person receives benefits.

E. RESEARCH HYPOTHESES

The direction of the following hypotheses is suggested by the general literature on parent-child interactional play.

1. There will be a decrease in levels of stress in parents who participate, with their children, in the training program PACT.
2. There will be a decrease in negative behaviors of children who participate, with their parent, in the training program PACT.

F. DESCRIPTION OF STUDY

Population:

The target population, to whom the results of the study will apply, includes families of children enrolled in pre-school or child care centers in low economic environments. Daily life stressors, coupled with reduced social support systems, put family members in this population "at risk" for developing serious problems. Early preventive interventions can help to promote healthy development in children and effective coping strategies for adults.

The sample was drawn from families of pre-school children, ages 3 - 5 enrolled at four Head Start centers in Virginia Beach, Virginia. Programs such as Head Start are designed to address the physical health, developmental, social, educational, and emotional needs of children and to increase the capacity of parents to care for their children. The overall goal of the Head Start Program is to bring about a greater degree of social

competence in children and their families. Effective parent participation is a corner-stone of the program.

Treatment:

The training program, PACT (Parents and Children Together), is a structured intervention for parent-child dyads in a multi-family group model. Activities have been adapted, by the researcher, from a program called Theraplay developed for Head Start children by Ann Jernberg (1967). In both Theraplay and PACT, parent-child interactions, which emphasize the sensory-motor activities of the first stage of life, are reenacted. PACT focuses on four basic developmental needs identified by Jernberg: the need for Structuring or delineating time and space, Nurturing or the pleasure of contact, Intruding or stimulation and arousal, and Challenging or competitive confrontation. PACT is a six-week program which emphasizes activity rather than verbal communication. Like Theraplay, PACT is intended for families who are participating in the Head Start program.

G. LIMITATIONS OF THE STUDY

The design of this study utilized one treatment with pretest-posttest measures plus control group. External validity of this design may have been affected by the interaction of the pretest with the experimental treatment. Generalizability of the results of this study is limited due to the non-random selection and assignment of participants (Borg and Gall, 1983).

CHAPTER 2

REVIEW OF LITERATURE

A. Historical and Theoretical Development:

The current research study utilizes the theoretical position of Erik H. Erikson regarding personality development, in an examination of parent-child interactions. Erikson's psychosocial life-stage theory has been cited by scientific, clinical, and educational groups over several decades. Although Erikson did not employ extensive controlled experimentation, his psychosocial theory provides a source of research hypothesis which can be experimentally assessed.

Erikson's theory is based upon careful observation, in depth interviews, and extensive experience with typical and atypical populations. As a psychoanalytic practitioner, Erikson saw clients in a clinical setting. Additionally, he conducted field research with Native American children. Erikson also compiled psycho-historical studies of famous people and made generalizations about how their resolution of personal characteristics and life events served to influence others.

The purpose of isolating and operationalizing developmental stages and tasks for the psychosocial as well as other domains of human development is to suggest that there is a teachable moment when the organism is maximally receptive to specific stimuli. It is with Stage One, which Erikson called Trust vs Mistrust, that the current study is focused. This developmental stage, which occurs roughly between birth and 18 months of age, is primarily a

period of sensory-motor development. During this time, interactions between infant and caregiver revolve around familiar daily rituals which result in a sense of familiarity and trust. According to Erikson, this interaction forms the earliest basis for psychosocial identity. Interaction, which is responsive to the needs of the child, creates a positive ratio between trust and mistrust and permits the ascendance of "hope" or positive identification. Perversion of the rituals creates mistrust and can result in hero worship or idolism in later life.

Stage Two, labeled Autonomy vs Shame and Doubt, occurs approximately between 18 months and 3 years and involves the conflict between the child's striving for new and more activity-oriented experiences and the limitations which are placed upon the child by others. The virtue of "will" emerges from the proper ratio of autonomy vs shame and doubt. Rituals develop which help the child differentiate between right and wrong. Perverted ritualism involves legalism, the interest in application over intent of laws.

Stage Three, called Initiation vs Guilt, is an age of expanding mastery and responsibility occurring around 3 to 5 years of age. "Purpose" is the virtue that ascends in this stage. Dramatic play is a positive part of this ritual but impersonation can be a later perversion.

Stage Four is described as Industry vs Inferiority. It is the stage of formal education and involves the school-age child. "Competence" is the virtue to emerge, and rituals involve formal

operations. Perversion of the ritual can result in later repetition of meaningless formalities.

Stage Five is known as Identity vs Identity Confusion. It is an adolescent stage occurring at a time of transition from childhood to adulthood. Individual characteristics and vocational roles are examined. "Fidelity" is the virtue of this stage. Ideology is the ritual. Perversion of the ritual can create a preoccupation with rightness.

Stage Six involves Intimacy vs Isolation or the ability to seek relationships with others. This is the age of early adulthood. "Love" rises as a virtue of this stage and the ritualization is affiliation. Perversion of the ritual is elitism.

Stage Seven is called Generativity vs Stagnation and is characterized by concern for what is created or generated. A time of middle adulthood, "Care" is the virtue and the ritual is the transmission of values. Distortion of the ritual is authoritarianism.

Stage Eight is referred to as Integrity vs Despair and is the stage of old age, the organization of the previous seven stages. "Wisdom" is the virtue and the ritual is integration. Negative aspects of the ritual could be described as "the unwise pretense of being wise" (Erikson in Hall and Lindsey, 1978, p. 100).

Much of the recent research involving Erikson's theory of personality examines the period from adolescence to old age. Fewer studies investigate the early life stages; however, Hamachek (1985) reviewed the behavioral consequences of the first five psychosocial stages on ego development. He noted that the

self begins as an undifferentiated potential and grows through a series of key periods which reflect awareness of existence, "when young children begin to recognize the distinction between self and not-self, between their bodies and the remainder of their visible environment" (p. 138). Hamachek notes that when personal experience widens through increased motor development and intellectual functioning, the self differentiates further to self-as-object, having certain physical, social, emotional, and intellectual attributes (roughly translated into self-concept), and the self-as-doer, with certain perceiving, performing, thinking, and remembering functions in the outside world (roughly translated into self-esteem). According to Hamachek, the first stage, awareness of self, which occurs during infancy, is received through four primary input channels: auditory cues, physical sensations, body image cues, and personal memories.

Hranitz (1987) used the psychosocial theory to interpret parental needs and to understand the goals which parents set for themselves and their children. "The intensity of (a) priority may reflect unmet needs of one or both parents... and may not meet their children's needs" (p. 327). Helping parents understand children's developmental tasks will be important for finding a healthy balance in the family.

Kivnick (1985), participated in research conducted by Erikson and his wife, to examine intergenerational relations in the life cycle. "People participate, filially, in the contiguous intergenerational relationship of parenthood from the moment that

they are born, until the moment that their parents have died (Indeed, it may be argued that we remain psychodynamically involved with our parents until we, ourselves, have died)" (p. 94).

Attachment psychologists have investigated this early stage of development in great detail. Harlow (1962) was able to manipulate experimentally conditions between adult and infant monkeys that would not have been possible with human subjects. After creating two "surrogate" (or substitute) mothers, one wire and one cloth, and equipping each with a bottle for nursing, Harlow observed that young monkeys consistently chose the soft model. Even after the bottle was removed from the cloth surrogate but allowed to remain with the wire one, the young monkeys preferred the 'soft' mother. Harlow concluded that baby primates become more attached to a source of warmth than to a source of food. He also noted that the young monkeys, when frightened, would cling to the cloth mother for comfort while the monkeys raised with the wire mother would clutch themselves for comfort.

John Bowlby (1969) assessed the effects of separation on institutionalized children who were taken from their mothers at an early age. He concluded that what is essential for mental health is that the infant and young child should experience a warm, intimate and continuous relationship with his mother in which both find satisfaction and enjoyment. According to Bowlby, attachment is biologically rooted, evolving through a process of

natural selection because it yields a survival advantage. Bowlby believed that the infant is equipped, at birth, with a repertoire of species-characteristic behaviors that promote proximity to a caregiver. He described the infant behaviors which he believed constituted "attachment": clinging, visual tracking, and signaling with cries or movement by the infant to the mother, and concluded that when the mother is responsive to these behaviors, an attachment bond results. Bowlby's findings seemed to suggest that reciprocity of care-giver and child is a key ingredient of attachment and bonding, a more complex interaction than simply the fulfillment of physiological needs described by Freud. Within the first year of life, the infant gradually builds up expectations of regularities about what happens to him or her. Bowlby postulated that the infant begins to organize these expectations internally in what he has termed "working models" of the physical environment, attachment figures, and him/herself.

Alan Sroufe (1986) reexamined the central hypothesis in Bowlby's theory and cited supportive research for his position that the primary attachment relationship serves as a prototype for later social relationships. Sroufe concludes, "Individuals are not to be characterized by a collection of static traits which manifest themselves with constancy across time and situation. Rather, individual adaptation is an ongoing process in which the person reacts to and shapes his interpersonal environment in terms of inner working models of self and other...Early experience is of basic importance because each

successive adaptation is a product both of the new situation and of development to that point" (p.842).

Mary Ainsworth (1978) also was concerned with describing the characteristics of attachment. She used a sixteen-item measure to document infant response to the separation and return of the mother. Ainsworth identified three broad categories which she labeled (1) secure, (2) avoidant, and (3) ambivalent/resistant to describe infant behaviors. Ainsworth noted significant differences in the type and intensity of infant attachment, depending on the age of the child. She described the infant in the earliest months to be wholly "indiscriminate," by six months to prefer its mother, by one year to maintain attachment over distance, and by one to two years of age to foster separation by its own mobility. Additional studies by Ainsworth have extended her focus to attachments beyond infancy and to attachment characteristics in other cultures.

Goldberg (1991) suggests that recent developments in attachment theory and research have pointed to a fourth category for both children and adults. She describes this as "disorganized," a group which did not have a coherent strategy for coping. She notes, "It seems likely that disorganization of attachment may have implications for subsequent psychopathology" (p. 396). Goldberg discussed adult measures of attachment which have recently been developed.

Qualitative differences in parent-child interactions were identified by Crittenden (1981). She labeled mothers as abusing,

neglecting, problematic, or adequate and children as passive, cooperative, or difficult. Crittenden believes that when the maternal and infant patterns are considered together, the dynamics of an interaction became more clear. Likewise, Dorr and Friedenbergr (1983) utilized the concept of good-enough mothering developed by Winnicott to focus on how mother-infant bonding and separation influence the development of both persons.

An investigation of father attachment by Michael Lamb (1986) has demonstrated that infants seek out mother and father equally often during the first year unless in the presence of a stranger when mother is preferred over father. Later work prompted Lamb (1987) to suggest that the long-term predictive validity of attachment classifications "appear(s) significant only when there is continuity in caretaking conditions" (p. 823). Hay (1985) expanded attachment theory to include the human capacity to relate to others including peers.

Object relations theorists consider the infantile developmental stage to be the fixation point for various mental illnesses such as psychoses, character disorders and neuroses. Margaret Mahler (1975) described three stages of development which she called symbiosis, separation, and individuation. She believed these occurred during the same age as Erikson's Stage One. According to Mahler, even in infancy, individuals display one of three patterns of interaction which she has labeled moving toward, moving away, and moving against. Mahler theorized that these interactional patterns develop in response to the way in

which the infant's earliest needs for nourishment, warmth, and elimination are met. If it is to survive, the infant must realize immediate gratification of these needs. At this stage, the infant does not sense itself as separate from the primary care-giver. Gradually, as infant needs are not immediately met, this symbiotic union of mother and child is replaced by an awareness of separation. Anxiety results. Mediation of the anxiety is accomplished if the infant experiences consistent and familiar interactions with the caregiver and learns to form an inner referent of the object it desires. Called wish fulfillment or object constancy by others, it is the ability to visualize the object, to know that it exists even when out of sight, and to trust in its existence and recovery, which is so critical to normal development.

Barbara Nickolson (1988) has presented a synthesis of the concepts of object relations theory and developmental theory. She observes that "developmental object relations" can be a powerful tool to understanding where, and to what degree, deficits occurred. By designing a "corrective emotional experience," (p. 27) the therapist/mental health worker can create a new and different holding environment, within which the client will be able to rework earlier conflicts.

B. TREATMENT-REVIEW OF RESEARCH

For practitioners, intervention strategies are equally as important as causality in the discussion of dysfunctional parent-child interaction. In traditional analysis, parents and children are seen individually. When Freud (1909) first described his work with "Little Hans", assessment and treatment of the child was attempted through the parent. Freud is said to have worked from the father's reports of Hans's behavior rather than working directly with the child. Alfred Adler, a contemporary of Freud, worked with both the parent and child but in separate sessions. Nathan W. Ackermann is credited with being the first practitioner to see the parents and child in the same session (Johnson, Rasbury, Siegel, 1986).

Melanie Klein, (1979) a student of Freud, worked directly with the referred child and developed a technique utilizing play. Initially, Klein worked in the home of the referred child, but she came to believe that the presence of the parent hindered transference. Klein subsequently treated children individually in her office. Anna Freud, (1979) daughter of Sigmund, also treated children individually through play but she recognized the need for a cooperative approach with parents where "in the ideal case, we share our work with the persons who are actually bringing up the child" (p. 147). Anna Freud preferred a "home supervised by the children's analyst" or - less farfetched - a school where psychoanalytical principles predominate and the work is attuned to cooperation with the analyst" (ibid p. 148).

Virginia Axline, (1969) who is credited with developing "client-centered" play therapy, sometimes allowed the parents to observe her work from behind a one-way mirror or while sitting passively in the playroom.

During the 1960's some therapists made a shift in thinking away from viewing symptomatic behavior as residing within any one individual. Influenced by General Systems theory, (Bertalanffy, 1968) family theorists placed emphasis on the interrelatedness of the parts (individuals) within the whole (family). Family therapists began to include all members of a family in treatment sessions, believing that change in one member of the family could effect change in all other members of the family. Taken a step further, transgenerational family therapists recognized the need to include extended family members in treatment. Of particular interest to this study is Bowen's theory of multigenerational transmission of family patterns. One such pattern is what Bowen (1976) calls "relational distance." Bowen believes that families exhibit habitual patterns of interaction which he has labeled "disengaged" (distanced) and "enmeshed" (overinvolved). Families, whose members tolerate and facilitate attachment and separation (differentiation), are the most healthy; however, parents foster differentiation in their children to the extent that they (parents) have differentiated from their own family of origin. Family therapists also view the family as part of a larger system (community) which is part of a larger system (societal). Boszormenyi-Nagy (1986) proposed "the systemic

regulation of behavioral patterns of marriages, parent-child relationships, nuclear and extended families, and larger community networks." He believed that both constructive and destructive inputs have lasting transgenerational consequences.

Other models of family intervention began to emerge in the 1960s. "Encouraged by the emerging psychotherapy research findings indicating the importance of the facilitative conditions for psychotherapy outcome and spurred by an acute awareness of the shortages of mental health personnel, a growing number of workers began to train professional and lay helpers to enhance their interpersonal functioning in term of the facilitative conditions" (Levant, 1983 p. 29). The facilitative conditions became known as skills, and systematic skills-training programs emerged. Levant investigated several client-centered family skills-training programs including: 1. Relationship Enhancement (RE) developed at Pennsylvania State University under the leadership of Bernard Guerney, Jr., 2. Communication and Parenting Skills (CAPS) by D'Augelli and Weener, 3. Human Resource Development (HRD) programs developed under the leadership of Robert Carkhuff, 4. Microcounseling by Ivey, and 5. Parent Effectiveness Training (PET) developed by Thomas Gordon. Levant sums up the objectives of these programs as (1) training for treatment in which family members are trained in the application of a form of therapeutic intervention to be applied to another family member, (2) training as treatment in which the training of the family member is viewed as the treatment itself,

and (3) training for enhancement in which the aim is either preventing clinical problems or stimulating the development of family members through teaching interpersonal communication and other social skills. It has been shown that facilitative skills, particularly in play therapy skills, can produce positive results when applied by the parent to help a disturbed child. Parent-adolescent and marital relationships benefit as well. Follow-up studies indicate that skill levels and other gains held up over short-term and long-term follow-up periods. Comparative studies indicate that this approach is equivalent in outcome to a behavioral approach and superior in outcome to Gestalt and discussion group approaches" (ibid p. 42).

Relationship Enhancement (RE), also called Filial therapy, (B. and L. Guerney, 1964) was intended to train parents in small groups of six to eight to conduct play sessions with their emotionally disturbed young children at home. In the original model, parents were instructed in discussions with their therapist. Demonstration play sessions were conducted by the therapist using children other than those belonging to the parents in the group. Role-playing techniques were used. Referred children were not present in these sessions. Parents continued to meet weekly with the therapists while conducting their own play therapy at home. Filial therapy has been extended over time to include reciprocal therapy. Marshall (1993) describes his "filial" work with a family in which the referred

child "co-opted" the role of co-therapist in the treatment of his mother.

Professionals with a more behavioral orientation have utilized parent-skills training to instruct parents in the concepts of operant conditioning. Patterson (1971) developed a systematic training program for parents which included instruction in differential attention, reinforcement, and consequences. Hauf (1969) outlined a two-stage model in which she instructed the child's mother in operant behavior-management skills as well as coaching the mother and child together in the therapy session. Eyberg (1988) added to the work of Hauf by integrating the skills used by play therapists as well as behavior therapists. "It seemed that the most rapid and effective way to treat the psychological problems of young children would be to treat the parent-child dyad together, coaching parents directly in the established therapeutic skills used by play therapists and taught by behavior therapists" (p. 33). Eyberg's Parent-Child Interaction Therapy has the aim of establishing a warm, loving relationship between parent and child in order to teach desirable prosocial skills and to decrease inappropriate and maladaptive behaviors.

The presence of the parent in treatment/training sessions can help to strengthen the child's connection to the family and foster the relationship system that is so critical to the child's psychological well-being (Eaker, 1986). It can be reciprocally beneficial to adults and children. Parents can be coached to gain

particular skills and the family can experiment with changes in their interactional patterns within a safe setting (Scharff, 1989). Play can introduce an element of pleasure and humor into families who are experiencing high levels of stress.

Working with parents and children together can be particularly challenging for professionals who lack a developmental perspective. Early (1994) observes that some therapists have discouraged conjoint family therapy involving young children or unconsciously encouraged disengagement of families already in conjoint therapy "out of a sense of relief" (p. 119). Play can be an effective means of working with families with young children, according to Busby & Lufkin (1992), Stevenson, Leavitt, Thompson & Roach (1988), MacDonald & Parke (1984), and others.

A range of experiential options are available for use in family play. Vos (1988) defines 'experiential' as "any intervention which consists of something other than simple discussion or "talking about" (p. 116). She includes art-based techniques, family drawings and family sculpture, games and tasks, Gestalt-related techniques, guided imagery and fantasy, humor and cartoons, myth and metaphor, photographs, psychodrama and role play, and toys and puppets.

Theraplay, developed in 1967 by Ann Jernberg is an another approach which addresses the needs of both parent and child within the same session, utilizing the technique of play. Jernberg says that children at risk for emotional and behavioral

problems show substantial gains when exposed to a program of structured interaction. When expanded to include the parent, structured activities can offer the therapeutic aspects of play therapy and family therapy. Theraplay utilizes the touch and movement natural to early development. It is intended to promote attachment, self-esteem, trust in others, and joyful engagement. Theraplay differs from traditional play therapy in the degree to which the adult assumes responsibility for the activities. Each session is pre-planned and structured. Focus of this intervention is on the present but it offers a progression of activities along developmental lines.

In her model, Dr. Jernberg begins her work with an intake interview in which the parents share significant medical and social history about the child. Two observational sessions follow in which parent-child interactions are analyzed. Treatment begins between practitioner and child while the parent observes the activities from behind a one-way mirror. Another staff member remains with the parent and explains the purpose of the activities. Within one or two sessions, the parent is invited to join the therapist and the child in the play room. At this point, the clinician's role changes to one of coach.

Much of the Jernberg model includes techniques adapted from work by Des Lauiers (1967) and Brody (1978) in which body and eye contact and vigorous motor activities are a part of the program. Theraplay differs from these models in its emphasis on nurturing. Jernberg (1988) wrote about her work with two long-term patients,

one adult woman and one male adolescent who received Theraplay as part of their clinical visits.

Golden (1986) reviewed Theraplay as a therapeutic modality to facilitate the development of healthy narcissism in both child and parent. "In the context of the Theraplay sessions, and while observing their child in the Theraplay sessions, parents are helped in developing their own healthy narcissism. They are helped and given permission to feel powerful, important, significant, impactful, and understood" (p. 104).

Robbins (1987) has utilized Theraplay with parent groups to "enhance the parents capacity to accept and practice healthy self-nourishing behaviors." In this instance, parents participated without their children, using one another as objects of discovery and play. The adults exhibited the same growth in degree of intimacy, trust, and nurturing as is seen in parent-child interactional groups. Playpartners, is another adaptation developed by Robbins (1990) for parents and children utilizing the Nurturing component of the original model. Dance is incorporated in this program.

Rubin and Tregay (1989) developed Theraplay groups for special education classes, using the classroom teacher, other professionals and peers as primary objects of play. Their book, Play With Them - Theraplay Groups in the Classroom, has influenced others to organize groups in regular pre-school and primary classes (Martin, 1995) (Lovejoy, 1995). Rubin (1995) has written most recently about her use of Theraplay with mothers and

children in a shelter for the homeless.

Several additional Theraplay models have been reported in the Theraplay Institute Newsletter (1995). Talen (1995) integrated Theraplay techniques into her work in a community-based primary health care project. "Because attachment is a basic need for healthy development, primary health care for young children should address the attachment issues and relationship qualities between children and their care givers" (ibid, p. 1). Talen used a multi-disciplinary approach that included teachers, nurses, and students in training. A variety of opportunities were provided for parents and staff to broaden the understanding of health to include interaction aspects. Bostrom (1995) describes a pre-school curriculum based on Theraplay which provides a way to help parents understand the needs of their child and to look at their own life and needs as well.

Bostrom (1995) has used group Theraplay to foster attachment in post-institutionalized adopted children. Theraplay has also been utilized with children impacted by HIV (Chambers, 1995).

Objective assessment of many Theraplay programs has not been reported; however, the Marschak Interaction Method (MIM) was developed at the Theraplay Institute for diagnosis and evaluation of single dyads. The MIM involves assessment of verbal and non-verbal interactions between two people as they perform a series of structured tasks.

REVIEW OF POPULATION:

Head Start is a community-based early childhood program for children aged 3 - 5 from economically disadvantaged families. Funding for the program has come primarily from the Federal government. The project was developed in 1965 by a planning committee of 14 professionals in medicine, early education, and mental health. Since that time, Head Start has served over 13 million children and their families.

Treatment centers are established within the communities they serve and are run by local staff from the community. Nearly all families enrolled in the Head Start program can be characterized as having low income or receiving public assistance, as mandated by Head Start legislation. The stressors which impact these families go beyond the poverty that Head Start was designed to address. Piotrkowski (1994) cites a survey of 117 Head Start programs, conducted by the Office of the Inspector General, to identify the challenges of serving families with multiple needs. This study found that substance abuse, lack of parenting skills, child abuse, domestic violence, and inadequate housing were the families' most frequently identified problems. Another study, referenced by Piotrkowski, by the U.S. Congress, Office of Technology Assessment noted that across age groups, almost 20 percent of all children might benefit from some specialized mental health intervention; yet, Head Start Program Information Report shows only 2 percent of children were referred for treatment.

CHAPTER 3

A. SAMPLE

The sample size for this study was thirty-two families. Participants were drawn from families participating in the Head Start program in Virginia Beach, Virginia. Parents were given general information about the PACT program in a presentation by the researcher, during the regularly scheduled monthly parent meetings. Written notices were sent home with each child at the Centers identified for PACT play groups. One additional orientation meeting was held for parents who indicated an interest in PACT. During the orientation meetings, parents who could commit to daytime sessions were assigned to the Experimental groups. Parents who indicated an interest in PACT, by attending the orientation meetings or by written response, but could not commit to daytime sessions were assigned to the Control group. Fifteen families were contained in each group; however, two Experimental families included twins and these families were counted twice bringing the number of families in the training groups to 17. Control families who wished to participate actively in the PACT program were offered a place in the next group. Post-assessment data from this study will constitute the pre-assessment data for those families.

B. RESEARCH DESIGN

The current study utilized a pre-test, post-test, time-control group design. Experimental and Control groups were formed from a

pool of volunteer families. Random assignment of participants was not possible due to the limited number of volunteers at each Center. All groups were measured before training and again six weeks later at completion of training. Only the Experimental groups received training in PACT. At the conclusion of the study, Control subjects were offered the opportunity to join a play training group.

C. DESCRIPTION OF INTERVENTION

The program PACT has been adapted by the researcher, from Theraplay (Jernberg, 1967). In the current research study, PACT differs from the Jernberg model in several important ways:

1. Dyads consist of parent and child instead of clinician and child.
2. Sessions include multi-family dyads.
3. Treatment techniques are not individualized; i.e., all dyads participate in Structuring, Nurturing, Intruding, and Challenging activities.
4. Treatment is time-limited to six weeks.

Before beginning training, a pilot study was conducted, under supervision, to assess the effectiveness of PACT as small group training. The activities were formalized into a training package which included video and written representation of the activities.

Meetings were held between the researcher and the Head Start administrators, supervisors, and teachers to review the concepts and activities for PACT. Written agreements, outlining the responsibilities of the Head Start staff and of the researcher, were obtained. Centers which could provide adequate space and privacy were identified.

Facilitators, with B.S. degrees in counseling and experience in family service delivery, were recruited and trained by the researcher. Training included written instructions of the PACT program and a review of video segments of the pilot group.

PACT groups were scheduled at four different Head Start Centers. One orientation meeting was held for interested parents. During these meetings, participants were fully informed of their right to refuse to answer specific questions on the assessment instruments or to withdraw from the study at any time without penalty of losing their child's place in Head Start. Informed consents were obtained from participating parents.

Training program sessions were held on site, during school hours, to maximize parent and child participation. A total of five training groups were conducted over a period of one year. Sessions were conducted weekly for six weeks. Each session lasted approximately 60 minutes. Parents and children participated in play activities for the first 30 minutes. Following play, parents had an additional 30 minutes, without children, for discussion. Children were supervised by Head Start staff for the last 30 minutes.

Overview of Weekly Activities:

PACT parent-child play sessions have a distinct beginning, middle, and end routine. Activities are pre-planned and introduced by the facilitator. Activities alternate boisterous and calming experiences. No specific rules are established except that participants must remain in the room. Each weekly session includes facilitator-led activities and child-led activities.

Week 1

Participants begin by sitting together in a large circle (nest) which has been outlined on the floor with chalk or tape. The session begins with a greeting (song). Parents and children are introduced to Structuring activities (protective holding) and are encouraged to return to this position between activities. Nurturing activities (feeding) are introduced. Eye contact and touch are encouraged. Session concludes with the children assuming responsibility for teaching Head Start activities to parents.

Week 2

Greeting (song), Structuring (protective holding), and Nurturing (feeding) are reviewed. Intruding (lotion) activities are introduced. Closing routine (child-led games) is the same.

Week 3

Greeting (song), Structuring (holding), Nurturing (feeding), and Intruding (lotion) activities are reviewed. Challenging activities (crawling, hopping, skipping) are introduced. Closing routine (child-led games) is the same.

Week 4

Greeting (song), Structuring (holding), Nurturing (feeding), Intruding (lotion) activities are reviewed. Challenging (wheelbarrow and balancing races) activities introduced. Closing routine (child-led games) is the same.

Week 5

Greeting (song), Structuring (holding), Nurturing (feeding), Intruding (lotion), and Challenging (tug-of-war) activities are reviewed. Concept of growing up is introduced through weighing and measuring activities. Termination is addressed. Closing routine (child-led games) is the same.

Week 6

Greeting (song), short review of Structuring (holding), Nurturing (feeding), Intruding (lotion), and Challenging (relay races) activities are reviewed. Cooperative play with parent is encouraged to produce a permanent memory of the play group (clay or wood chips). Termination is addressed. Closing routine (child-led games) is the same.

D. INSTRUMENTATION

A. Test One - The Parent Stress Index/Short Form (PSI/SF)

The PSI/SF (1990) is a direct derivative of the Parent Stress Index full-length test. All items on the short form are contained on the long form with identical wording. The PSI, developed by Richard R. Abidin (1986), is a self-report instrument designed to measure the degree of stress experienced

in a parent-child system. It has been used with parents of children 10 years old or younger. Three major source domains, child characteristics, mother characteristics, and demographic-life stress, are defined and assessed.

The PSI/SF contains 36 items, which are rated by the primary caregiver on a 1 - 5 Likert-type scale. It is intended for situations where limited time is available to identify families most in need of follow-up services. Each of the three domains to be assessed on the PSI/SF contain 12 items. Scores are reported in raw scores. Percentile ranks for the Total Score, Parent Distress, Parent-Child Dysfunctional Interaction, and Difficult Child are computed. An additional category, Defensive Responding, assesses bias of the subject to present the most favorable picture of himself or herself.

The PSI was standardized on 534 parents who visited small group pediatric clinics in central Virginia. The normative sample was 92% white and 6% black consisting of mothers whose ages ranged from 18 to 61 years (mean age = 29.8 years). Adequate internal consistency and stability coefficients are reported (Wantz, 1989 p. 602). Evidence indicating content, concurrent, construct, discriminant, and factorial validity is provided. The PSI was also used successfully to discriminate between physically abusive and nonabusive mothers, amount of husband support and single and married mothers. Adequate internal consistency and stability coefficients are reported. Alpha reliability coefficients of .95 are reported for the Total Stress Score.

Test-retest reliability coefficients ranging from .55 to .82 for the Child Domain, .70 to .71 for the Parent Domain, and .69 to .96 for the Total Stress Score are cited. At the present time the empirical validity of the PSI/SF has not been fully established; however, a correlational analysis of the PSI/SF with the full-length PSI shows concurrent validity for Total Stress ($R = .94$), Parent Distress to Parent Domain ($R = .92$), and Difficult Child to Child Domain ($R = .87$). Parent Child Dysfunctional Interaction which contains items from both the Child Domain and the Parent Domain on the PSI correlated to PSI CD ($R = .73$) and to PSI PD ($R = .50$) (Abidin, 1990 p. 16).

Conners' Parent Rating Scale-48 (CPRS-48)

The Conners' Parent Rating Scale-48 by C. Keith Conners is designed to evaluate reported problem behavior of children. It has been used with populations of children ages 3 - 17 years. Four instruments comprise the Conners' Rating Scales: two teacher-rating scales and two parent-rating scales. Each pair of measures consists of a long and short form. All scales contain a 10 item Hyperactivity Index in addition to the Hyperactivity subscale.

Items are rated using a common four point scale (Not at All, Just a Little, Pretty Much, Very Much). Profiles are separated by sex and age of the child.

After 20 years of use, extensive reliability and validity evidence has been collected in support of the Conners' Rating

Scales. Although the data does not differentiate between long and short forms, results obtained across studies have been similar.

Generally speaking, test-retest reliability for the scales is high to moderate range (.91 to .93) with intervals ranging from 2 weeks to 1 year. Interrater reliability has been evaluated among teacher, parents, and teachers and parents. Moderate to high correlations (range = .23 - .94) are reported.

Validity evidence for the Conners' is substantial.

It can be classified into the following categories: (a) sensitivity to changes in behavior resulting from drug therapy, (b) correlations with other rating scales, independent observations, and peer ratings (c) ability to discriminate among various diagnostic groups and (d) correlations with measure of childhood pathology including depression and coronary-prone Type A behavior (Martens, 1992 p. 233).

E. SPECIFIC HYPOTHESES

1. It was hypothesized that there would be a decrease in levels of stress, as measured on the PSI/SF, in parents who participated with their child in the program PACT.
2. It was hypothesized that there would be a decrease in negative behavior, as measured on the CPRS-48, in children who participated with their parent in the program PACT.

F. DATA GATHERING

Assessment included objective measures, observations, and structured interviews. Objective assessment of adult stress on the PSI/SF, and of children's behavior on the CPRS-48 was conducted prior to treatment and at the conclusion of the six week training. Adults in Experimental and Control groups completed both assessments at both intervals. Observation from video tapes of training sessions was reviewed weekly for planning and informal evaluation of parent-child interactions. Structured interviews were conducted, by the researcher, with Experimental group participants following training. (See Appendix)

G. DATA ANALYSIS

The statistical method of data analysis used in this 2 (group) x 2 (time) research design was the MANOVA, which tests for treatment group differences on two or more dependent variables considered simultaneously. Measurement of attitude and behavior before and after training/treatment is most dependable when the measurements are also analyzed for interaction effects (Borg & Gall, 1983).

Analysis of variance (ANOVA) followed by the Tukey HSD test on each dependent variable was used to clarify which of the variables were statistically significant and contributing to the overall MANOVA F.

H. COMMITTEE ON HUMAN SUBJECTS RESEARCH CRITERIA

Research studies which examine human behavior demand safeguards to insure protection of the subjects. The probability of aversive effects on the human subjects of this study is minimal; however, pre-screening of clients is indicated.

Families are excluded for the following reasons.

- a. No parent or designated care-taker is available.
- b. Either adult or child is in crisis or recovering from crisis such as death, divorce, or physical trauma.
- c. Either adult or child is exhibiting psychotic, organic, or drug related symptoms.

Parents not excluded from the study are informed of the general purpose of the study at one pre-training orientation. The following points are reviewed.

- a. Participation in the study is voluntary.
- b. Consent forms must be signed.
- c. Weekly attendance and follow-up appointments are required.
- d. Confidentiality of objective measures is assured.
- e. Permission to video tape is necessary to assure equal training between groups.
- f. Subjects have the option to leave the research study at any time without losing the opportunity for their child in Head Start.

CHAPTER 4

Analysis of Results

The purpose of this research study was to investigate the effects of PACT, a six-week program of structured play activities, on the levels of stress in parents and the behavior of children.

Description of the sample

Preliminary analyses were conducted to determine if the training group and the comparison group were significantly different from one another on the demographic variables or on pre test scores. Analysis of demographic information between groups, using Fisher's Exact Test (2 tail) showed the Experimental and the Control groups to have no significant difference for age, gender, marital status, number of children, level of education, level of income, racial background, religious preference, age of children, or sex of children. The use of Fisher's Exact Test (2-tail), rather than Chi-Square, is indicated due to the large number of cells and the small number of subjects. A break-out of the demographic information, by group, is contained on Table 1 in the Appendix.

Demographic Analysis

Age: Families who remained in this research study had a range of parent age from 19 to 42 years. Participants between 21 and 30 years constituted 68.8% of the sample. Parents between 31

and 40 years made up 28.1% of the sample. Parents who were over 40 years of age comprised only 3.1% of the sample.

Sex: All but one of the subjects (96.9%) who completed this study were female. One male (3.1%) in the Experimental group completed the training, and one male attended but did not complete assessments and was not counted.

Marital Status: Participants who listed themselves as married once (34.4%) or married twice (12.5%) constituted a total number (46.9%) of married subjects. Participants who listed themselves as single (31.3%), or divorced/separated (21.9%), when combined, represented a total number of non-married participants (53.2%). Some confusion may have existed concerning the interpretation of these terms. Single was intended to mean never married but may have been chosen by some parents to indicate not currently married due to divorce or separation.

Number of Children: The largest percentage of families (62.5%) in this research study had 2-3 children. The remaining families listed one child (21.9%) or more than four children (15.6%).

Educational levels: Nearly equal numbers of participants completed high school (40.6%) as completed one year of college (43.8%). Considerably fewer subjects (15.3%) had 11 or less years of school.

Income: Annual income levels for the total sample showed a range from under \$5,000 to over \$20,000. Three participants did not respond to this question. Better than one third of the sample fell in the lowest category. Analysis showed:

\$5,000 or less	37.9%
\$5,000 - \$9,500	13.8%
\$10,000 - \$14,500	20.7%
\$15,000 - \$20,000	17.2%
\$20,000 & over	10.3%

Ethnic: Racial representation was 65.6% African American, 31.3% Caucasian, and 3.1% Hispanic. One parent listed herself as Native American but when interviewed said she meant only that she was born in this country. She was Caucasian.

Religious Affiliation: A surprising number (64.5%) of respondents listed "other." On further inquiry by the researcher, some of these respondents meant to designate specific denominations which are considered Protestant.

Children's Age - The range of age for children was narrow, due to the pre-school program in which they were enrolled. Age three constituted 12.5%, age four made up the largest segment or 53.1%, and age five was 34.4 %.

Children's Sex - Males made up 62.5% of the sample and Females accounted for 37.5%.

Analysis of Objective Measures

Multivariate Analysis of Variance (MANOVA) was performed on objective measures to determine differences between pre and post assessments for the Experimental and Control groups. Results of the MANOVA indicated that there were no significant differences for time and no interaction. Results did indicate a significant difference between groups ($F(22,39) = 2.6595, p = .0037$).

Analysis of Variance (ANOVA) was conducted, followed by Tukey's HSD test, to compare Mean values between groups. The Parent Stress Index/SF yielded the following information. Total Stress $F(1,63) = 12.39, p = .0008$, Parent Distress $F(1,63) = 12.71, p = .0028$, Parent Child $F(1,63) = 12.71, p = .0007$, Difficult Child $F(1,63), p = .0101$ and Responding $F(1,63) = 8.37, p = .0053$.

Chart 1

PARENT STRESS INDEX/SF

GROUP MEANS

DOMAIN	MEAN X		STANDARD DEVIATION	
	EXPERIMENTAL	CONTROL	EXPERIMENTAL	CONTROL
Total Stress	76.50	61.03	21.36	11.20
Parent Distress	26.70	21.40	8.01	4.98
Parent/child Dysfunction	21.50	16.87	5.93	4.03
Difficult Child	28.26	22.80	10.07	5.12
Responding(inverse sig.)	16.47	13.30	5.12	3.31

Results of the MANOVA on the Connors' Parent Rating Scale-48 showed no significant differences for time and no interaction for Experimental or Control groups. Significant differences were found between groups on Psychosomatic $F(1,63) = 10.70$, $p = 0.0018$, Anxiety $F(1,63) = 4.08$, $p = 0.0479$, and Hyperactivity Index $F(1,63) = 4.51$, $p = 0.0377$.

Chart 2
CONNERS PARENT RATING SCALE-48

DOMAIN	MEAN X		STANDARD DEVIATION	
	EXPERIMENTAL	CONTROL	EXPERIMENTAL	CONTROL
Conduct Problem	5.35	3.83	4.90	2.15
Learning Problem	2.91	1.90	2.82	1.54
PsychoSomatic	0.85	0.10	1.21	0.31
Impulse-Hyperactivity	4.94	4.07	3.15	2.82
Anxiety	2.82	1.77	2.17	1.99
Hyperactivity Index	9.71	6.40	7.59	4.05

Summary of Hypothesis Testing

The findings of this research study were intended to test two principal hypotheses:

1. Levels of stress, as measured on the PSI/SF, will decrease significantly in parents who participate with their child in the training program PACT.

Results of this study did not reach statistical significance for differences and cannot be used to reject the null hypothesis.

2. Behavior problems, as measured on the PRS-48, will decrease significantly in children who participate with their parents in the training program PACT.

Research results confirmed a null hypothesis.

Chapter 5

Conclusions

The purpose of this research was to investigate the effects of PACT, a structured program of play activities for parent and child dyads. PACT is designed to replicate the healthy interactions which occur between parents and children during the early developmental period of 1 to 18 months of age. The developmental tasks of this life stage are identified to be attachment and separation. PACT, in this study, was intended as a preventive intervention with a non-clinical population of families enrolled in the Head Start program.

Although a great deal of research had been done concerning the characteristics of attachment in infants, less attention has been given to investigating this connection between older children and their parents. The absence of reliable methodology for assessing attachment beyond infancy coupled with the lack of intervention strategies for strengthening attachment have left professionals with few options. Interventions are needed which encourage parents and children to "revisit" this stage, to "renew" primary attachment, and to "preview" the tasks of autonomy and industry described in Erikson's psychosocial model.

Individual therapy, family counseling, or cognitive skill training programs for parents have been utilized most frequently to remediate family problems. More recently, reciprocal or interactive models utilizing play in combination with behavioral

training have been tried for clinical populations. Few programs offer non-clinical families the opportunity for preventive parent-child interventions. PACT provides families with a method to develop the positive interactions which strengthen attachment and foster autonomy in children.

Review:

A sample of forty families from the Head Start program volunteered to investigate PACT, a program of structured play activities designed to replicate early developmental activities. Of the original forty families, thirty families completed the six-week program. Participants who did not complete the program included three families in the Experimental group: one family left the Head Start program; one family changed Head Start Centers; and one parent did not agree with the concepts of PACT. In the Control group, five families were dropped from the study: one returned incomplete assessments; one returned assessments too late to be included; and three families failed to maintain contact. Two of the Experimental families who completed the training but did not agree to fill out the questionnaires were not counted in either group, giving the study an attrition rate of approximately twenty-five per cent. Fifteen families were assigned to the Experimental group and fifteen families were placed in the Control group. Two Experimental families included twins and these families were counted twice bringing the number of families in the training groups to 17.

Parent-child dyads in the training (play) groups met weekly for six weeks, on site, for one hour of play and discussion. Inconsistency of attendance may have affected the outcome measures of this study. Only three subjects (17.6%) were present at every session. Eight subjects (47.1%) attended five of the six sessions. Four subjects (23.5%) attended four of the six sessions. One subject (5.9%) attended three sessions. One subject (5.9%) joined late and attended two sessions. Attrition in this study was only slightly higher than average but inconsistency in attendance could negate gains in a short-term program.

Objective measures of parent stress, using the Parent Stress Index/SF, and child behavior, using the Connors' Parent Rating Scale-48, was given to all adult subjects before training and again following the six-week training. Groups were found to be equivalent for demographics but significantly different for levels of stress and some child behaviors. The following response trends should be noted.

A. On the PSI/SF, Experimental subjects assigned higher levels of stress (mid-range) to themselves than did the Control subjects (low-range) on both pre and post measures. Control subjects rated themselves in the low-range of stress on all but one subscale, the pre Total Stress which was mid-range. One explanation of the differences between groups may be responder attitude. The Parent Stress Index/SF includes a Defensive Responding scale, which assesses the extent to which a respondent

approaches the questionnaire with a strong bias to present the most favorable picture of her/himself and to minimize indication of problems or stress in the parent-child relationship. Control subjects fell into the critical range for Defensive Responding on pre assessment. Reasons for scores in the critical range are suggested by Abidin (1990).

1. Parent is trying to portray the image of a very competent individual who is free from stress normally associated with parenting.
2. Parent is not invested in the role of parenting and therefore is not experiencing the usual stress associated with caring for a child.
3. Parent is a very competent individual.

Another factor which may have influenced assessment outcomes was test sophistication. Experimental group subjects may have been better informed about test procedures than the Control subjects. Experimental subjects received verbal instructions from the researcher and completed pre assessments on site. Control group subjects completed all assessments at home from written instructions.

It is important to note that change in levels of stress for Experimental subjects was in the hypothesized direction (decrease) on all but one subscale. Parent-Child Dysfunctional Interaction remained the same. Change in stress levels for Control group subjects was in the reverse direction (increased)

on all but one subscale. Difficult Child variable showed a slight drop for Controls. Further study with larger samples will be needed to establish significance for these trends.

B. Examination of response patterns on the Connors' Parent Rating Scale/48 indicates that parents in both Experimental and Control groups tended to rate their children (T-score 40 - 44) in the lower half of the scale for behavior problems. It is helpful to keep in mind that children from a "low base-rate" group, such as children without behavior problems, need a much higher criterion score (T-score 66 - 70) to infer clinical problems, according to the test developer (Connors', 1989). Even mid-range levels of behavior rating would be non significant for this sample. It would appear from this data that families in this study did not perceive their children's behavior to be problematic, even before training.

It should be considered that the measures of parent stress (PSI/48) and child behavior (CPRS-48) may not adequately assess change in families as a result of interactional training. Much research which attempts to evaluate parent-child interaction uses coded analysis of observational or video data. Accurate coding of interactions involves special training as well as an adequate position from which to observe the interactions. Head Start centers frequently lack the appropriate space for unobtrusive live-observation or video coverage.

Structured interviews were conducted with training group participants at the completion of the program. All Experimental subjects were interested in continuing in play groups. Six of the fifteen control group members expressed the intention to join groups. Twelve of the Experimental subjects noted improvement in child behavior; one felt that the play group had made the child worse; and two parents did not see any difference in their child or themselves.

Many parents in the Experimental group described their decision to participate with their child in the play group as a reaction against their own childhood.

Question: Why did you decide to join the Play Group?

A single mother who participated in PACT twice, once for her son and once for her daughter, talked about her own childhood.

" There was a lot of...not abuse but neglect. My parents were separated when I was coming up and I always said that I had a mother and a father but not parents. I missed out on a lot....I didn't do the normal things that little girls did (sic). I didn't play with dolls or I didn't learn to jump rope and I still don't know how to ride a bike. I promised myself when I had children of my own that it would be different."

A foster father, with a six year old biological son, came with his three year old foster son. Dad talked about his family of origin.

"I was real needy too. My own brother was a bully and I lived in fear."

Mother of twins, who were the youngest of her five children, talked about her early years in Haiti.

"My Mother had ten kids. I had to help raise them. I never felt close to my Mother. I cry when I think of her."

Grandmother who came to PACT with her granddaughter and nephew recalled her experience as a young mother.

" When I was thirteen, I asked for a baby-doll for Christmas but my Daddy said I would have my own baby in a few months so I didn't get it."

Many parents expressed the opinion that they had changed as a result of being in the group.

Question: What do you think you gained from the Play Group?

Single mother of three children explained how she benefited.

" I took it (training) for myself too. It guided me. It hasn't been that long but it took me back too to when they were babies."

Older mother of single child explained that she had lost her first child.

"I was very sick when A. was born and I don't remember much about those early months. I just want to spend time with J. now. I think every Center should have a group like this."

Second mother of twins, who has older and younger children, talked about her motivation for coming to PACT.

"It gave me a chance to spend time with just one of them (children). They need to know they are loved."

Single mother recalled her own difficult and rebellious years.

"I did it for B and I did it for me. He is the best thing that ever happened to me. He is my anchor. It is important to spend time with him."

Other Findings

The results of this research yielded the following practical knowledge concerning the delivery of community-based mental health services to families in economically disadvantaged circumstances.

A. Attracting and keeping subjects in programs can be challenging. Ways to improve volunteer response to this study included (Borg & Gall, 1983):

1. Making the initial appeal as interesting as possible.
2. Stating how the study would specifically benefit subjects.
3. Recruiting persons known and respected by subjects.
4. Offering courtesy gifts for participation.
5. Keeping frequent contact by telephone and written notice.

B. Pre and post assessment tools for volunteer populations need to measure strengths as well as deficits. Assessments should be non-threatening in tone and not burdensome to the subject in terms of response time. Confidentiality must be assured often. Clear directions, given in simple language, should to be given to all participants.

C. Multi-disciplinary approaches require that professionals be willing to plan carefully in advance, be flexible, relinquish "private" space, and respect the goals of other program components. Frequent exchange of information between the professionals is needed to assure optimal service to families.

Limitations of the Study

There were several limitations to this study. Caution should be applied in interpreting and generalizing outcomes for the following reasons (Borg & Gall, 1983):

1. Sample size was small. Although the size of this sample was within the limits for experimental research, it does not

allow firm predictions. Larger samples protect against Type II error which is the failure to reject the null hypothesis when it is false. Larger samples help to equalize the impact of outliers.

2. Subjects were non randomly assigned to Experimental or Control groups, due to the limited number of volunteers at each Center. Since random assignment is the best technique for assuring initial equivalence between different groups, it can be said that non random assignment may create groups that are non equivalent (Glass & Hopkins, 1970). In this study, demographic data supported the initial equivalency of the Experimental and Control groups; however, pre assessments demonstrated significant differences between the groups.

3. Both Experimental and Control groups consisted of volunteer families. Responses may be different for subjects who self-select than for the target population, many of whom would not volunteer. Personal characteristics of volunteers which may have affected the research outcomes are, the tendency to be better educated; to have a greater need for social contact and social approval; to be more arousal seeking; and to be more self-disclosing.

4. Time between pre and post assessment may have affected outcomes for some subjects. Training groups employed an open-enrollment policy which precluded strict adherence to recommended test re-test schedules for two subjects who entered late.

Implications for Further Study

The need for continued investigation of treatment/training models which are effective with families of young children and which can be delivered in non-traditional settings is clear. It is not enough simply to describe the personal characteristics of parents and children or to predict the future behavior which is inferred from these characteristics. Much more challenging work must be done to develop and evaluate programs which address both preventive and remedial needs.

Ziegler (1994), a former director of Head Start, had said that it is probably the most extensively evaluated social program in American history. "A program that was that was state-of-the-art in the 1960s could not be expected to meet the needs of today's economically disadvantaged families...The need for empirical guidance is acute not only to inform program improvements but because the population served by Head Start has changed over time" (p. 129).

The current study attempted to examine objectively the effects of one time-limited training program, delivered on site, to a small sample of subjects. Continued examination of this model with larger samples, drawn from other populations, and conducted for longer periods of time will be necessary before a full assessment of the effectiveness of the program can be determined.

Outcome measures which are sensitive to dyadic interactions

need to be developed and explored. Comparisons of outcomes from self reports, coded observations, and structured interviews are indicated. Utilization of teacher assessments in combination with parent assessment is strongly recommended for other researchers. Input from the child should be included to strengthen future studies.

Investigation of group delivery is needed. Many questions remain to be answered. Are individual, small group, or whole classrooms equally effective? Can a few well-trained adults in daily interaction with larger numbers of children produce the same changes as structured interaction with a parent once a week? Would daily intervention with a parent for a shorter total period of time be equal in outcome to once-a-week intervention over a longer period of time?

Follow up studies are indicated as well. What long-term benefits can be identified? Does an intervention between parent and child generalize to other family members or to the classroom? What are the implications for parent growth?

Finally, are there specific facilitator skills that promote spontaneity and exploration in group participants? Is modeling more effective when parents and facilitator share a common ethnic background? Is it possible to support attachment between parent and child concurrently with promoting social support?

While there are many questions still to be answered, the results of this study should be of interest to both educators and clinicians for several reasons. Change is promoted through

healthy parent-child interactions which pose no risk to the participants. Group members learn by observing one another as well as by modeling facilitator actions. Needs of the parent and needs of the child are addressed simultaneously and may promote benefits which are reciprocal in nature. On-site training is most likely to be utilized by the families who most need it. Professional resources are maximized in a service delivery which addresses several families at once. Time-limited interventions, which focus on a specific task and are concluded when that task has been mastered, fit the current fiscal demands.

Questions about this study may be addressed to:

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Licensed Professional Counselor
1113 North Inlynnview Road
Virginia Beach, VA 23454
804-481-1067

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APPENDIX

BREAKOUT OF DEMOGRAPHICS

	<u>Experimental</u>		<u>Control</u>	
	<u>Raw</u>	<u>Percentage</u>	<u>Raw</u>	<u>Percentage</u>
<u>Parent Age</u>				
21-30 years	11	64.7	11	73.3
31-40 years	5	29.4	4	26.7
41-50 years	1	5.9		
<u>Parent Sex</u>				
Male	1	5.9		
Female	16	94.1	15	100.0
<u>Marital Status</u>				
Single	4	23.5	6	40.0
Married	8	47.1	3	20.0
Div./Separated	3	17.6	4	26.7
Remarried	2	11.8	2	13.3
<u>Children at Home</u>				
One	3	17.6	4	26.7
Two-Three	10	58.8	10	66.7
Four plus	4	23.5	1	6.7
<u>Education</u>				
9 - 11	4	23.5	1	6.7
High School	5	29.4	8	53.3
College	8	47.1	6	40.0
<u>Income * (3 non response)</u>				
< \$5,000	6	37.5	5	38.5
\$5,000-9,500	2	12.5	2	15.4
\$10,000-14,500	4	25.0	2	15.4
\$15,000-20,000	1	6.3	4	30.8
> \$20,000	3	18.8		

	<u>Experimental</u>		<u>Control</u>	
	<u>Raw</u>	<u>Percentage</u>	<u>Raw</u>	<u>Percentage</u>
<u>Ethnic</u>				
African American	9	52.9	12	80.0
Caucasian	8	47.1	2	13.3
Hispanic			1	6.7
<u>Religion</u>				
Catholic	4	25.0	2	13.3
Protestant	1	6.3	2	13.3
Other	10	62.5	10	66.7
None	1	6.3	1	6.7
<u>Child Age</u>				
3	1	5.9	3	20.0
4	10	58.8	7	46.7
5	6	35.3	5	33.3
<u>Child Sex</u>				
Male	9	52.9	11	73.3
Female	8	47.1	4	26.7

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March 28, 1996

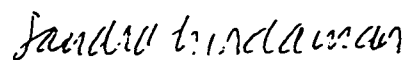
Janet J. Zanetti EdS, LPC
1113 North Inlynnview Rd.
Virginia Beach, VA 23454

Dear Ms. Zanetti:

As we discussed, you have the permission of The Theraplay Institute to use the Theraplay® terms Structuring, Nurturing, Intruding and Challenging to describe the activities in your dissertation research groups as long as you credit the original idea to the creator of Theraplay, Ann M. Jernberg, Ph.D.

We are pleased that you have found the concepts of Theraplay so powerful and effective and look forward to further discussions of your findings.

Sincerely,



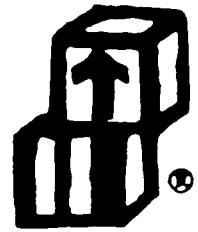
Sandra Lindaman, M.A.
Executive Director



The STOP Organization

HEAD START PROGRAM

2551 ALMEDA AVENUE • NORFOLK, VIRGINIA 23513 • 858-1375 or 858-1376



February 9, 1995

Ms. Janet Zannetti, Eds.
1113 N. Inlynnview Road
Virginia Beach, Virginia 23454

Dear Ms. Zannetti:

Following our brief meeting and my subsequent discussions with Mrs. Picot, the STOP Organization Head Start Program is pleased to enter into an agreement to provide children and families an opportunity to participate in developmentally appropriate training sessions called PACT.

It is my understanding that the program is to begin as soon as it is reviewed by the College of William & Mary and that you will be working closely with Mrs. Picot, the Health/Mental Health Specialist to administer the program and collect research data.

Sincerely,

Lawanna M. Dowden
Head Start Director

LMD/smb

A COMMUNITY SERVICE ORGANIZATION

for CHESAPEAKE, FRANKLIN, ISLE OF WIGHT COUNTY, NORFOLK, PORTSMOUTH, SUFFOLK, SOUTHAMPTON COUNTY
AND VIRGINIA BEACH, VIRGINIA

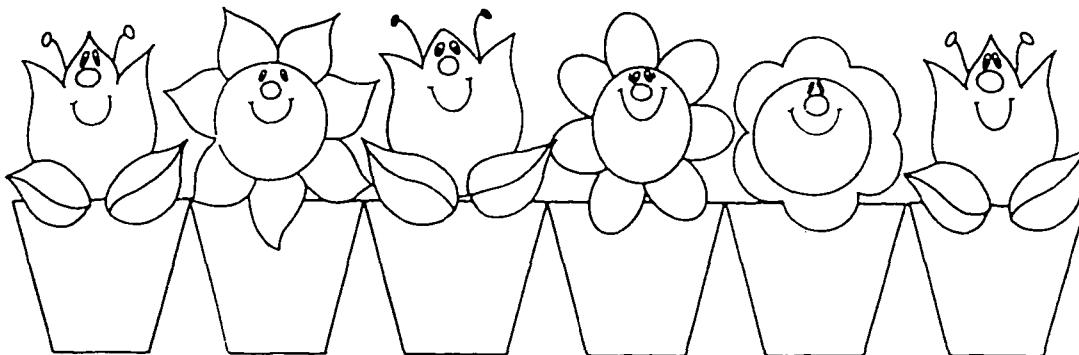


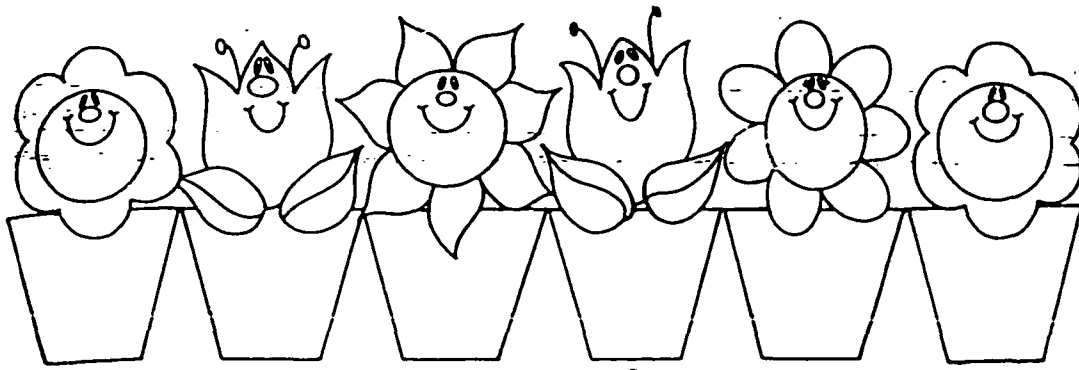
COME JOIN THE FUN

Parents and Children Together (PACT) is a play activity group offered to families in the Head Start program. It is intended to provide time for parents to join their children at the Head Start Center, once a week, for fun and refreshments.

Our first meeting will be on:

Please come and hear more about this program. Refreshments and prizes will be offered.





YOU ARE IMPORTANT

Please help us. Your opinions are important to Head Start. We need families at each Head Start Center to volunteer to help us evaluate a program of Play Activities. Some parents have volunteered to come to the Center each week to participate in the Play Activities with their children. We need other parents, who can not come to the Center, to fill out two short questionnaires at home. All parents can be part of the study, either at home or at the Center, by answering the questionnaires.

Your answers to the questions will be confidential. You do not need to sign your name because you will be given a number to use on your form. We will ask you to do this again in six weeks. Please sign below if you are willing to help. Also mark the box if you are interested in the Play Activities the next time they are offered. Return this paper to the Center with your child tomorrow and we will send you the questions to answer at home.

Thank you for your help.

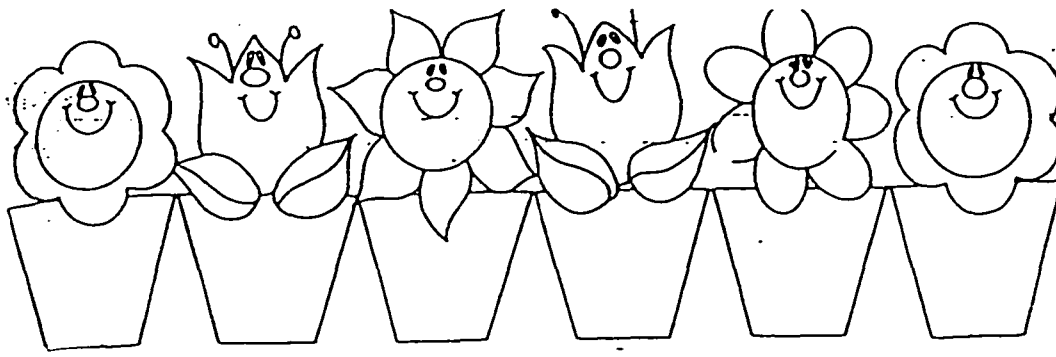
Name _____

Address _____

Phone _____

Names and Ages of Children _____

I am interested in being part of the next Play Activity Group.



Dear Parents,

Thank you for agreeing to help Head Start with this project to evaluate a program of play activities for parents and children. The group provided an important experience for your child and your comments were very helpful to me. The last requirement will be to fill out the following questionnaires and return them, in the enclosed stamped envelop.

As before, your answers will be confidential. You do not need to sign the questionnaires but please remember to fill in the age and sex of your child. Please take a few minutes and do this today. I appreciate your cooperation very much.

This study is will help the Head Start staff to plan programs which will be of benefit to you and your child. Thank you again. Please feel free to call me if you have questions.

Janet J. Zanetti

Janet J. Zanetti

Researcher

481-1067

CONSENT FORM

The purpose of this research study is to evaluate a program of play activities designed for parents and children. The program, called Parents and Children Together, (PACT), consists of 30 minutes of play between parents and children, and 30 minutes of discussion for parents only. PACT will be offered weekly, for six weeks, at the Head Start Center. There is no cost for the program.

The program, PACT, utilizes typical play activities between parents and children. Activities are introduced and demonstrated by the group leader. There is no risk to participants. Parents who volunteer to participate in the study will benefit by learning ways to help their children increase in self-esteem and trust in others. Additionally, parent discussion time will offer the opportunity for adults to address questions about child development.

Participation in the study is strictly voluntary. Head Start families who choose to participate will be randomly assigned to one of two groups. One group will receive the six week training program PACT immediately. The second group will receive PACT in follow-up training (six weeks later).

Parents who volunteer to participate with their child in the training program PACT will be asked to complete two short questionnaires: one regarding the child's behavior and another concerning parent feelings of stress. Questionnaires will be

completed before beginning the program PACT and again at completion of the six week program. Completion of the questionnaires will take approximately 30 minutes. Participants may choose not to answer a specific question. Results of the questionnaires will be coded by number for analysis to protect the privacy of participants. All data will be analyzed in group form so that no individual can be identified. Both groups will complete the questionnaires directly before and directly after the first training program.

Each session of the training programs will be video-taped to insure equal training opportunities between groups. Participants will receive a voucher each time they attend a training session. Vouchers can be exchanged for children's play materials, at the end of the six week training program.

Head Start families who do not wish to participate will not be penalized. Participants have the right to withdraw from PACT at any time without penalty.

The current study will provide useful information for the families who participate and for Head Start staff responsible for program planning. Similar programs are in place in other Head Start centers and pre-school day care centers throughout the U.S. and abroad. If you are willing to participate in this study, please sign the attached consent form. Thank you.

CONSENT

I am willing to participate in the study described to me in
in this paper. I understand that my participation is
voluntary and that precautions will be taken to protect the
confidentiality of my responses on the questionnaires. I give
permission for the use of video-taping of the training sessions
to insure equal training for each group.

Signature: _____

Date: _____

Address: _____

Phone: _____

Questions about this study may be of directed to the
researcher:

Janet J. Zanetti EdS, LPC
1113 North Inlynnview Road
Virginia Beach, Virginia 23454
Tel. 804-481-1067

Researcher qualifications: Doctoral candidate at College of
William and Mary. 15 years experience in agency and school
counseling. Licensure by state of Virginia as Licensed
Professional Counselor (LPC). Adjunct faculty member, Old
Dominion University.

STRUCTURED INTERVIEW

FOR PARENTS

1. Why did you decide to join the PACT play group?
2. Tell me about your child. What are his/her strengths and weaknesses?
3. What do you remember about your child's early development?
4. What memories do you have of your own early childhood?
5. What did you gain from the program PACT?
6. Do you have suggestions for improving the program PACT?

PACT

FACILITATOR TRAINING INFORMATION

PACT combines aspects of play therapy with family training. It is action rather than talk oriented. PACT is adaptable to educational, home, or clinic settings and can be utilized for children and/or adults in individualized or multi-family delivery.

PACT has been adapted, by the researcher, from Theraplay developed by Ann Jernberg (1969) for Head Start families. Like Theraplay, PACT has a high degree of predictability because the adult, rather than the child, does the leading. the structured activities are designed to follow a sequence which approximates typical parent-child interactions during the developmental period of 0 - 10 months of age. Consistency of routine is stressed.

Participants in multi-family group PACT experience all of the attachment-fostering and autonomy-enhancing activities which Jernberg has labeled: Structuring, Nurturing, Intruding and Challenging. Activities are not individualized but facilitators may modify the duration and intensity of these activities as indicated by the needs and preferences of the participants.

PROCEDURES:

For the initial session, a large space in the room is cleared of furniture and materials. There are no toys, only the participants. In PACT, it is intended that the adult and child become the primary play objects for each other in much the same way an infant and its caregiver interact.

Participants enter the room together and remain a dyad

throughout the session, maintaining touch and eye contact as much as possible. Sessions begin and terminate with participants sitting together in a large circle which has been outlined in chalk or tape on the floor.

Activities are introduced by the facilitator and vary in a pre-determined way, alternating boisterous and calming experiences. No specific rules are established except that participants must remain in the room. Modeling or a few words from the facilitator signal shifts in activities. Participants are encouraged to discover their own patterns and style of interaction within the basic activity.

Each session has a specific beginning, middle, and end routine. Each meeting contains greeting activities, new activities (session 1 - 6) and review activities (session 2 - 6) and closing activities. Following the play activities, children are taken to a separate area for snacks and games. Parents remain for discussion.

Session I Structuring

Participants begin by sitting together in the large circle (nest) which has been outlined on the floor with chalk or tape. Dyads are instructed to adopt the "waiting" position with the child sitting or reclining between the parent's outstretched legs. Names are exchanged. The facilitator begins with a brief introduction about animal babies, citing ways in which babies are cared for, protected, and taught by their parents. Children are asked if they can remember being a baby. Participants are encouraged to share

any early memories of this time. The facilitator describes how a human baby "waits" to be born, curled up and protected inside the mother. Parents are told to wrap their arms around their "babies" holding them gently but tightly in a ball. The facilitator counts 1-2-3-4-5 and the children "unfold" and stretch. The facilitator describes a typical "first time" meeting of parents and new baby. Parents are told to gently lay the baby down on the bed (floor) and examine the baby to see color of eyes and number of fingers and toes. Later, parents are instructed to rock the baby in their arms, humming or quietly singing a lullaby. Early "games" such as peek-a-boo, pull-ups and mild tickling are modeled. Session concludes with children teaching parents a game from their current school repertoire.

Session II Structuring (Review) and Nurturing

Parents and children enter the room together. Parents have been instructed to remove the children's shoes before coming to the circle (nest). Facilitator greets each person by name and they sit in the "waiting" position. A short period of checking-up is encouraged. "Does anyone have anything that they want to share from last week, or from the time since we were last together? What do you remember about last week? How did that feel to you?"

After a brief discussion, the facilitator begins by asking the dyads to assume the prenatal position, which signals the start of the reenactment. Children practice curling up, holding, and unfolding after the count of 5.

The facilitator asks the parent-child dyads to review a few

activities such as peek-a-boo or finger and toe nibbling from the previous week. They return to "waiting" position, which signals a shift in activities.

The facilitator tells a short story about ways in which different animal parents feed their young. Discussion leads into the feeding of human babies. Mention is made of nursing and bottles, but the activity utilizes spoon feeding of soft foods (applesauce). Children are held in parent's arms when fed and burped over the parent's shoulders.

Session concludes with children teaching parents a game from their current Head Start program.

Session III Nurturing (Review) and Intruding

Greeting activities include a review of names and a short check-up discussion of the last session and intervening week.

Signal to begin activities is the prenatal position, holding for the count of 5 and unfolding. The facilitator reviews the nurturing activities from the previous week and expands to finger foods. Parents and children feed each other bananas.

Signal to shift activities (facilitator returns to sit on the circle in the waiting position). The facilitator tells a short story of animal babies being groomed by parents. The facilitator introduces grooming activities using powder and lotion. Children are asked to stretch out on floor and parents to apply lotion or powder to hands and arms and feet and legs. The facilitator models slow massage with lotion or powder.

Session ends in the same manner with children teaching parents

a current school game. Families take home the individual containers of lotion and powder to use during the week.

Session IV Intruding (Review) and Challenging

Greeting activities are the same as previous weeks: circle, check-up, and prenatal position of holding and unfolding.

The facilitator reviews grooming activities and expands to include combing and brushing of hair. Parents and children groom each other.

Signal to shift activities (waiting position). The facilitator tells story of animals growing up, learning to walk and run and to explore their world. Children and parents are asked to reenact the crawling stage, going around the circle and reversing, establishing a pattern of left - right coordination. Movement progresses to skipping and running around the circle.

The facilitator stops activities by dropping to waiting position on the circle. Closing activities involve child taught games.

Session V Challenging (Review)

Greeting activities include circle, check-up and prenatal position (fold, hold and stretch). The facilitator reviews Challenging activities from last week and expands dyadic activities to include wheelbarrow and leg wrestling. Group challenges such as plate balancing races and pillow fights are encouraged.

The facilitator drops to circle to indicate shift in activities. The facilitator verbalizes that animal babies learn

many things and grow quickly. Discussion introduces idea of maturation and leaving the nest (termination). Activities focus on change and growth. Children and parents use tape measure and bathroom scales to compare their sizes. Outline body pictures is optional.

Closing activities are the same.

Parents are asked to bring baby pictures for next time.

Session VI Termination

Opening activities are the same: circle, check-up, fold, hold and stretch. The facilitator reviews idea of growing up. Discussion includes how families remember: by sharing baby pictures, keeping a favorite toy, and telling stories. Participants compare baby pictures and body outline pictures. Can be a match or guessing game.

The facilitator signals shift in activities by returning to circle. Discuss the idea of taking away something from the group which will help to remind them of all that they have learned. Parents and children work on sanding and gluing wooden blocks to plywood bases.

Closing is the same - more school games as time allows.

EVALUATION OF FACILITATORS

1. Greets each participant by name.
2. Establishes consistent program routines.
 - a. Begins with check-up and holding position
 - b. Reviews previous concept
 - c. Introduces new concept
 - d. Conclude on time
3. Maintains eye contact with participants.
4. Provides positive feedback to participants.
5. Monitors talk/activity ratio for self and participants.