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Teaching And Learning to Care:

An Early Years Prevention Program in Emotional Intelligence

by

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A Thesis
Submitted to the Faculty of Graduate Studies
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Abstract

This study involved a program evaluation of the Teaching and Learning to Care program (T.L.C.), an early years prevention program that used classroom-based theraplay to increase empathy and self-control in children. The T.L.C. program was implemented in 4 elementary classrooms (kindergarten to grade 3) in a Winnipeg school, once per week for 8 weeks. The program's rationale was based on previous researchers who found that social-emotional education has been effective at increasing children's awareness of feelings and social skills. The model of program delivery was a collaborative model that included school clinicians (a social worker and a school psychologist) and school personnel (teachers and a guidance counselor). A program evaluation was designed to evaluate the model of program delivery and the effectiveness of program outcomes (increasing empathy and self-control). Overall, teachers valued the collaborative model as well as the structure, design, and content of the theraplay sessions. Following the completion of the program, there were several indicators that classroom-based theraplay was an effective intervention for increasing empathy and caring in young children. All teachers provided specific examples of children using the theraplay language and activities to express empathy. While the teachers did not feel that the T.L.C. program helped children internalize self-control in the classroom setting, teachers reported that the children learned to demonstrate self-control in the strucutred theraplay sessions. Teachers also reported that theraplay increased children's abilities to exhibit self-control in their social interactions with other students.

Teaching And Learning to Care: An Early Years Prevention Program in Emotional Intelligence

The number of violent and disruptive students is reportedly growing in North American schools (Clements & Sova, 2000). In recent years, the media have focused on sensational reports of school violence, youth gangs, and murder involving youth. "Although dramatic acts of school violence are relatively rare, ongoing aggression and victimization are serious problems that arise in schools on a daily basis." (Leff, Power, Manz, Costigan, & Nabors, 2001, p. 344). According to recent statistics, the most common perpetrators of youth violence are young, heterosexual males, although there is a growing number of females who are violent (Statistics Canada, 1995). Youth violence may be perpetrated collectively by groups or gangs, or may be committed by individuals. In Canada, youth violence may be defined as any intentional physical, sexual or psychological assault on another person (or persons) by one or more young people aged 12 to 19 years.

While there is not a clear consensus on the incidence of youth violence in Canada, every year, approximately 1 in 10 youth comes into contact with the police for violations of the Criminal Code (Hung & Lipinski, 1995). Despite a recent decrease, the rate of youths charged with violent crimes in 1998 was still 77% higher than it was a decade ago, with the highest rates being in Manitoba and Saskatchewan (Statistics Canada, 1998). These official crime statistics do not account for crimes which are not reported to police or when youth are not actually charged with an offence.

An increasing number of children in schools today require psychological services and correspondingly, there is an increasing number of referrals from teachers for children

with emotional issues and disruptive classroom behaviour (Drewes, 2001). Experiencing violence early in life can set a pattern that extends throughout an individual's life and victimization has been linked to increased use of drugs and alcohol, eating disorders, tobacco use, and mental health problems (Health Canada, 2003). School clinicians and teachers have attempted to address the increasing number of children who are at risk for emotional and behavioural problems. Over the past few decades, a number of intervention and prevention programs have been implemented to address violence in schools. A wide variety of school programs is available, such as conflict resolution, mediation, anger management, and anti-bullying. Although many programs target single risk factors, there has been a gradual shift to primary prevention programs which begin at an early age and target multiple risk factors. Recently, some schools have implemented prevention programs that are targeted at decreasing disruptive behaviours and enhancing emotional well-being in young children by increasing emotional intelligence. These programs are aimed at increasing children's abilities to understand, manage, and express the social and emotional aspects of their lives. This includes increasing self-awareness, controlling impulsivity, working cooperatively, and caring about oneself and others.

Emotional Intelligence Defined

Many cognitive theorists have expanded traditional definitions of "intelligence" to incorporate interpersonal skills and emotions. Over the past few decades, a variety of terms have been used in the literature to explain the concept of emotional intelligence (i.e., ***intrapersonal intelligence***, ***interpersonal intelligence***, ***emotional intelligence***, ***moral intelligence***). The varied and inconsistent use of terminology in describing related concepts has created some confusion. While the concepts may vary somewhat in their

meaning, there are some similar themes. Most of these concepts appear to be referring to the ability to develop healthy interpersonal relationships, develop awareness (of self and others), exercise self-control, and gain emotional well-being. The following is a review of the terms, as they are presented in the literature.

Interpersonal and Intrapersonal intelligence

In his theory of multiple intelligences, Howard Gardner (1983) included interpersonal and intrapersonal intelligence as two of his primary intelligences. ***Interpersonal intelligence*** refers to the ability to understand other people, to notice and make distinctions about their moods, temperaments, motivations, and intentions. Gardner identified personal connectedness as an important component of interpersonal intelligence. ***Intrapersonal intelligence*** refers to the capacity to turn inwards, to have access to one's own feeling life. An important part of intrapersonal intelligence is being perceptive about one's emotions and using that perception to guide one's behaviour. Gardner's theory of personal intelligences was later expanded upon by other theorists.

Emotional Intelligence

Salovey and Mayer (1990) expanded their definition of intelligence to include the role of emotions. They defined "***emotional intelligence***" as a set of skills hypothesized to contribute to the accurate appraisal and expression of emotion in oneself and others, the effective regulation of emotion in self and others, and the use of feelings to motivate, plan, and achieve in one's life. Salovey and Mayer proposed a model of emotional intelligence that includes five domains: knowing one's emotions (self-awareness), managing one's emotions (handling feelings so that they are appropriate), motivating one self (using emotions to gain a goal, using self-control, delaying gratification), empathy

(recognizing emotions in others) and handling relationships (social competence, leadership, and interpersonal skills).

The concept of emotional intelligence quickly gained wide exposure in 1995 when Daniel Goleman popularized the term "emotional intelligence" in his book, "Emotional Intelligence: Why it can matter more than IQ". Goleman conceptualizes ***emotional intelligence*** as including: self-awareness, impulse control, persistence, zeal and self-motivation, empathy, and social deftness. People who have a high level of emotional intelligence are able to rein in emotional impulse, read another's innermost feelings, and handle relationships smoothly. According to Goleman, these are the qualities that characterize people who excel in life. People who are lower in emotional intelligence suffer many problems including: anger management difficulties, relationship difficulties, depression, and poor health.

Goleman's theory of emotional intelligence is based on a synthesis of current neurological research that examines the role of early life experiences on the formation of emotions and temperament. Goleman has argued that temperament is not destiny and there is a critical period during which emotional intelligence can be shaped. "Critical experiences include how dependable and responsive to the child's needs the parents are, the opportunities and guidance a child has in learning to handle her own distress and control impulse, and practice in empathy."(Goleman, 1995, p. 226).

Moral intelligence

In recent years, several authors have used the term "***moral intelligence***" to describe emotional or social intelligence in young children. Coles (1997) has written about the moral development of children – how they learn empathy and respect for

others. Michele Borba (2001) popularized the term "moral intelligence" in her book entitled, "Building Moral Intelligence: The seven essential virtues that teach kids to do the right thing". According to Borba, moral intelligence "is the capacity to understand right from wrong; it means to have strong ethical convictions and to act on them so that one behaves in the right and honorable way." (Borba, p. 4). This aptitude encompasses several life characteristics such as the ability to recognize someone's pain and to stop oneself from acting on cruel intentions, to control one's impulses and delay gratification, to listen openly, to accept and appreciate differences, to empathize, and to treat others with compassion and respect. Borba believed that the characteristics of moral intelligence are qualities necessary for all human beings. Borba reported that many children are lacking moral intelligence. She indicated that the causes of the moral decline are complex, including social factors (i.e., a lack of adult supervision, poor models of moral behaviour, little spiritual or religious training, a lack of meaningful adult relationships, non-personalized schools, lack of clear national values, and a lack of community support). Children are also affected by the constant bombardment of negative messages from outside sources (i.e., television, movies, video games, popular music, internet, and advertising).

Borba based her theoretical framework of moral intelligence on Gardner's theory of multiple intelligences, (1983), Goleman's theory of emotional intelligence (1995), and Coles' writings on the moral intelligence of children (1997). According to Borba, moral intelligence consists of seven essential virtues – empathy, conscience, self-control, respect, kindness, tolerance, and fairness – which help children navigate through ethical challenges and pressures they will face throughout life. Of these seven virtues, there are

three virtues that comprise the "moral core" of moral intelligence: empathy, conscience, and self-control. Borba reasoned that this hierarchy is based on the different abilities of moral reasoning that children have at different stages of development, as researched by Jean Piaget and Lawrence Kohlberg. Borba also cited Martin Hoffman, "a renowned authority" who has studied moral development for over three decades. Hoffman (2000) believed that empathy is the main component in pro-social moral development in children. Children develop empathy in a series of stages in which they move from an egocentric, self-centered perspective to one in which they care about others and can feel and understand other people's points of view.

While each definition differs, the concepts of both "***empathy***" and "***self-control***" are found in the conceptualizations of moral intelligence, emotional intelligence, and interpersonal and intrapersonal intelligence. In his definition of interpersonal intelligence, Gardner (1983) identified "personal connection" or empathy as an important component of "interpersonal intelligence". An important part of "intrapersonal intelligence" is being perceptive about one's emotions and using that perception to guide one's behaviour. Empathy and self-control are also important components of the concept of emotional intelligence (Goleman, 1995). Goleman referred to the importance of both empathy and "impulse control" in his definition of emotional intelligence. In their definition of emotional intelligence, Salovey and Mayer (1990) also refer to empathy or the ability to recognize emotions in others. Salovey referred to the concept of self-control and "managing emotions" or handling feelings so that they are appropriate, as a domain of emotional intelligence. Therefore, while each conceptualization varies somewhat,

Source	***Empathy***	***Self-control***
Gardner (1983) *Interpersonal/Intrapersonal Intelligence*	Interpersonal Intelligence - personal connection - the ability to understand people	Intrapersonal Intelligence – using perception of emotions to guide one's behaviour
Salovey & Mayer (1990) *Emotional Intelligence*	- knowing one's emotions (self-awareness) - empathy (recognizing emotions in others)	-managing one's emotions (handling feelings so that they are appropriate), - self-control, delaying gratification
Goleman (1995) *Emotional Intelligence*	Empathy	Impulse control
Borba (2001) *Moral Intelligence*	Empathy	Self-control

Figure 1. Defining emotional intelligence – common themes of empathy and self-control.

a consistent component in all definitions is a form of empathy and self-control.

Empathy defined.

Empathy, as defined by Borba (2001) is "the ability to understand how another person feels." Empathy helps a child feel the emotion of others, and be sensitive towards the needs and feelings of others. Children who are empathic show acts of kindness and caring directed towards others. This is evident when children are sensitive and concerned about others' feelings and act concerned when someone is hurt. Children who are empathic show positive emotions towards others (laughter, smiling, excitement). They have positive physical interactions with others (sharing, cooperation, affection, including others) and engage in positive verbal interactions with others (listen, compliment, encourage, praise). Children who are empathic readily pick up on others' non-verbal cues (gestures, body language, facial expression, tone of voice).

In contrast, children who are not empathic show little concern for others' feelings. They are not concerned when others are distressed, hurt, or treated unfairly. They repeatedly express negative emotions towards others (anger, sadness, indifference, ignoring). Children who are not empathic may have negative physical interactions (acting cruelly to others, acting without thinking of consequences for another person, excluding others) and may engage in negative verbal interactions (put-downs, threats). All of the above behaviours may be used as criteria in defining empathic/non-empathic behaviours of children.

Self-control defined.

Self-control is defined as "regulating your thoughts and actions so that you stop any pressures from within or without" (Borba, p.81). Self-control "helps your child

restrain his impulses and think before he acts so that he behaves right and is less likely to make rash choices with potentially dangerous outcomes." (Borba, 2001, p. 7). Self-control is what helps a child modulate or restrain behavioural impulses. Children who have self-control are able to manage and control their emotions. They are able to delay gratification (i.e., sit quietly, take turns, listen while others speak). Children with self-control are able to calm down when excited, frustrated, or angry. They are even-tempered and do not need frequent reminders to behave appropriately.

In contrast, children who lack self-control have difficulty managing and controlling their emotions. They may be impulsive (cannot delay gratification, have difficulty waiting turns, interrupt others, blurt out answers to questions). Children who have little self-control may have physical outbursts of emotions (aggressive, hitting, kicking) or verbal outbursts of emotions (name calling, yelling out inappropriately). All of the behaviours described above may be used as criteria for defining self-control/lack of self-control in children.

The Background for the Development of A Curriculum in Emotional Intelligence

In North America, the industrial revolution and urbanization contributed to changes in family structures and communities. These changes have been partially linked to an increase in truancy, vandalism, drug abuse, suicide, and violent crimes in youth (Bronfenbrenner, 1980). Children today encounter a high number of stressors including the disintegration of community networks, family fragmentation, abuse, parental stress, economic changes, and exposure to violence (Kusche & Greenberg, 2001). These stressors have contributed to increases in behavioural problems for youth. Generally, delinquent behaviour is thought to be the result of complex interactions of individual

traits with social (family, peers, media exposure), situational (school, home) and neighbourhood factors (Sprott & Doob,1998). The more risk factors children experience, and the more realms they experience them in (individual, social, situational, and neighbourhood), the more at-risk they are for behavioural and emotional problems.

In a Canadian-wide study of risk factors, many individual and family factors were found to be strongly related to children's behaviour problems, such as single parent families, punitive parenting styles, lower socioeconomic status, and urbanization (Tremblay et al., 2001). Children at greatest risk were young males, with young single mothers who had a history of depression. In contrast, children who came from families where there was less dysfunction, greater social support, less maternal depression, positive mother-child interactions, and non-punitive, consistent parenting were more likely to exhibit pro-social behaviours (i.e., helpfulness, cooperation). Frequent family relocation has also been identified as a cause of problematic behaviour, owing to the breakdown in the social network including the extended family, friends, and neighbours that may have helped to regulate the child's behaviour (DeWit, Offord , & Braun, 1998).

A rapidly changing society and the concomitant weakening of the integrity of families and communities have prompted educators and child development specialists to develop programs to support and enhance the development of children's emotional intelligence. In the past, there was no formal social or emotional education. "Two hundred years ago, education for the average child (who grew up under agricultural conditions) consisted largely of teaching by parents and the church." (Kusche & Greenberg, 2001, p.141). Today, according to Goleman (1995), many children are coming to school "emotionally illiterate". There is a concern that children are no longer

learning some of the basic morals and life skills that are so important to our society such as fairness, social justice, honesty, and respect. At present, we leave the emotional education of our children to chance, with ever more disastrous results (Goleman, 1995).

Many educators have argued that social-emotional education should be introduced into the school system. It has long been recognized that there is a window of opportunity during childhood in which rapid learning takes place. Early school experiences shape a child's perceptions of the world and the self in the world. Therefore, schools must teach social and emotional skills such as friendship forming and understanding oneself and one's behaviours (Fopiano & Haynes, 2001). Howard Gardner (1991) argued that education should go beyond the "3 Rs". Before children can learn the traditional subjects taught at school, there is a need to learn life skills such as teamwork, cooperation, and social skills. "Learning how to read ourselves – and the reactions of others – is as important as learning how to read words and numbers." (Cohen, 2001, p. 3). In the early stages it is important to create a classroom environment that is caring, open, and positive (Doty, 2001).

Many schools have tried to addresses students' social and emotional needs by creating an overall positive school climate (Sullivan-DeCarlo, DeFalco, & Verdell, 1998). A positive school climate is characterized by an "emphasis on academics, an ambiance of caring, a motivating curriculum, professional collegiality, and closeness to parents and community."(Witcher, 1993, p.1). A negative school climate is characterized by problems such as high absenteeism, discipline problems, crowding, vandalism, poor school spirit, low staff morale, poor image of school by staff, and other negative factors. According to Clements and Sova, (2000), all children need a safe school – a climate in

which the students learn and play, free of physical assaults, verbal aggression, threats, and intimidation.

Best Practices in Implementing Effective Emotional Intelligence Programs

Many schools have implemented programs targeted at emotional and social development and the most successful programs have several features in common. Programs considered to be successful focus on early years prevention, rather than intervention. They target multiple risk factors rather than a single risk factor. Programs that are integrated into the school curriculum as compared to pre-packaged, "canned' programs, are considered to be more successful. Programs that are "one-shot" programs with no follow-up or "booster shots", may be limited in their ability to have long term effects. Successful programs involve all levels of school personnel. A limitation of many school-based programs is the lack of collaboration between all levels of school personnel (i.e., teachers, guidance counselors, administrators, school clinicians, and paraprofessionals). These limitations may have serious implications for the effectiveness and the sustainability of school-based programs.

Primary prevention versus intervention programs.

Over the past few decades, numerous intervention and prevention programs have been developed to address child and adolescent problems such as aggression, mental disorders, stress, and substance abuse. In the field of school psychology, there is an increasing demand for primary prevention (Bartell, 1995). It has been argued that primary and secondary prevention, rather that tertiary prevention (treatment), should be the focus of a successful school psychology program (Franklin, 1995). Primary prevention seeks to prevent the occurrence of problems by intervening before a problem develops. However,

to date, the focus has been on implementing intervention programs rather than prevention programs.

In the case of school violence, the majority of programs are reactive, addressing violence after an act has been committed (Remboldt, 1998). With the increase in school violence, more drastic interventions have been implemented such as armed security guards, metal detectors, and zero-tolerance rules for harassment. Predicting risk factors for school violence has not been very effective to date and it is a poor substitute for preventing school violence in the first place (Mulvey & Cauffman, 2001). While some of these reactive programs have been effective, it is more effective to prevent school violence before it starts (Baldauf, 1999).

Early years prevention programs.

Early childhood prevention is a rapidly growing field. "In little more than a decade it has been transformed from an emerging service with a primitive empirical base, scant funding, and virtually no public mandate to a robust area of theory, research, and practice." (Mackenzie-Keating & Kysela, 1997). It appears from meta-analytics studies that early intervention programs are consistently beneficial (Mackenzie-Keating & Kysela). Based on a review of 1,200 outcome studies, many exemplary studies of early interventions produced statistically significant and meaningful positive social changes (Durlak, 1998). "There is strong theoretical rationale from attachment theory for providing early intervention services to young children and their families." (Mackenzie-Keating, & Kysela, p.23).

While violence prevention programs have been tailored at every stage of development (Hotvedt, Mayden, & Satcher, 2001), the most effective programs begin at

an early age and have a long duration (Mackenzie-Keating, & Kysela, 1997). The most successful intervention programs begin in the first few years of life, running between 2 to 5 years in duration (Yoshikawa, 1994). Some violence prevention programs have been implemented as early as preschool (Ziwica, 1999) and in kindergarten, prevention programs have been successful in reducing aggression and oppositional defiant behaviours over a 4 year period (Walker et al., 1999). It is crucial to address violent behaviour in childhood, as aggression is a predictor of later high-risk behaviours (Frey, Hirschstein, & Guzzo, 2000). The empirical evidence for the effectiveness of early prevention is convincing, compelling, and comes from multiple and varied studies. "Even without the empirical research basis, however, there is strong widespread societal, political, and economic commitment to early intervention, in addition to theoretical and philosophical reasons for providing early intervention services to young children and their families." (Mackenzie-Keating & Kysela, p. 24).

Prevention targeted at multiple risk-factors.

Exemplary programs are directed at preventing multiple problems, rather than one specific problem. Some of the best programs contain components that address risk factors present at multiple levels (Durlak, 1998). These prevention programs are broader and focus on many issues, rather than intervening with one behaviour or disorder. "Categorical approaches to prevention that focus on single domains of functioning should be expanded to more comprehensive programs with multiple goals." (Durlak, p. 518). Effective prevention programs also focus on enhancing and instilling protective factors rather than treating pathology. For example, given the findings that peer rejection leads to loneliness, decreases in classroom participation, school avoidance, and poor performance

on achievement measures, prevention programs should focus on enhancing classroom participation and reducing exclusion and victimization (Buhs & Ladd, 2001).

Collaborative programs.

To create change in schools, teachers, counselors, psychologists, school administrators, parents and students must work together (Hotvedt, Mayden, & Satcher, 2001). In an ecological model, Bronfenbrenner (1977) distinguished between several structures in a child's environment: microsystem, mesosystem, exosystem, and macrosystem. Each of these structures (i.e., parents, teachers, friends, school etc.) has an impact on a child. Bronfenbrenner (1980) recommended using this ecological model for school psychology research and program development to ensure planned interaction among children, schools, teachers, and parents.

Collaboration among school personnel is especially important for the success of school-based programs. Effective multi-disciplinary collaboration should include an integrated, egalitarian, and reflective problem-solving team (Koskie & Freeze, 2000). Collaborative relationships must be based on mutual respect, trust, and coordinated power status among the participants. Administrators must also play an important role, as a critical feature of effective social and emotional learning programs includes administrative support (Brandt, 1999). "Those involved in organizational change must see that all stakeholders in the system participate in every stage of the change process." (Curtis & Stollar, 1995, p. 55). Parents also play an important role in program effectiveness. Effective prevention programs provide family support in the form of education, training, and resources (Yoshikawa, 1994).

Collaboration and the role of the school psychologist.

In recent years, the role of the school psychologist has been changing to meet the new demands of larger caseloads (Reschley & Ysseldyke, 1995). There has been a push for the transformation of the school psychologists' role from that of conducting individual interventions (i.e., assessment, diagnosis, counseling) to that of providing support in the form of classroom interventions. In the past, "psychological assessment and the WISC-III kit have come to symbolize the identity of school psychologists." (Bartell, 1996, p.86). According to Bartell, school psychologists' roles are now expanding to include the development and implementation of innovative and cost-effective psychological assessment approaches such as ecological assessments linked to classroom interventions. School psychologists who collaborate with other individuals in the system serve as a valuable resource for facilitating change at the classroom, grade, building, and district-wide levels (Curtis & Stollar, 1995). Collaboration between social work and education is also being recognized as a valuable partnership in responding to the social conditions of children and families (Lopez & Torres, 1998). Involving the school clinicians in the implementation of early years prevention programs is cost-effective, as it allows more children to receive the services at an early stage. In times when accountability is so important, "School psychologists must work to ensure that their services are cost-effective, have community support, and are demonstrated to be beneficial compared with what occurs without school psychology services." (Franklin, 1995, p. 69). "Administrators are often pleased to have school clinicians deal through creative and innovative ways with the many children with behavioural problems." (Drewes, 2001, p. 51).

Emotional Intelligence Programs

Several pioneering schools have introduced emotional intelligence or "social-emotional learning" programs (SEL) as a part of their curriculum. Some programs that integrate social skills and emotional literacy as part of the daily curriculum have been in effect for almost 20 years (Charney & Kriete, 2001). Social learning occurs throughout the day and teachers incorporate the lessons of the program into their curriculum and use real-life, spontaneous opportunities to help children learn desirable skills. For example, at Greenfield Center School, the assumption underlying The Responsive Classroom program is that "how children learn social skills and develop emotional and ethical literacy is similar to how they learn to read" therefore there is an emphasis on allowing children to practice these skills everyday in a supportive environment (Charney & Kriete, p.77). Today, these programs are growing in popularity and several books provide ready-made activities to use in the classroom (Elias et al, 1997; Cohen, 1999; Doty, 2001; Pasi, 2001). Overall, the research on social and emotional programs has been promising, as the implementation of emotional intelligence into the curriculum has been associated with increased well-being of children and reduced violence (Cohen, 2001). Such programs have been successful in preventing aggression and promoting social competence in both early elementary and middle schools (Frey, Hirschstein, & Guzzo, 2000). The following are some examples of these programs.

The Child Development Project (CDP) is an elementary school program designed to enhance social, emotional, intellectual, and ethical development (Schaps & Lewis, 1999). The CDP focuses on building supportive relationships, teaching humane values, fostering children's intrinsic motivation, and teaching for understanding. The CDP is

based on the theory, research, and practice of several principles. Firstly, it is based on the principle of attachment research - that building a strong sense of community among students, teachers, and parents is important for healthy child development. Therefore, all children are treated as valued members of the school and classroom community. Secondly, it is based on the principle that children learn human values and develop socially and morally by actually experiencing a wide range of natural, real-life interpersonal situations. Lastly, it is based on the principle of developing intrinsic motivation in children (i.e., children are motivated to be fair, kind, and responsible because of the good feelings that it gives them) and less on extrinsic motivation (i.e., relying on external rewards, recognition, and praise). Since the 1980s, the CDP program has been implemented in about 20 elementary schools in the United States. Facilitators have worked to change the attitudes and philosophies of entire schools, including administrators, teachers, paraprofessionals and support staff. The CDP program is not merely "put into place" in classrooms. The program's creators realize the importance of affecting teachers' and administrators' attitudes as well as the entire school culture. The program uses a collaborative model including teachers, administrators, paraprofessionals, support staff. All staff receive training and a k-8 curriculum is developed to help teachers learn to integrate the program's domains into their teaching.

The CDP has been evaluated in three different longitudinal studies (Dasho, Lewis, & Watson, 2001). Collectively, these authors have shown that the program is effective in a number of settings including high-poverty, affluent, and suburban schools. Benefits of the program include: an increase in conflict resolution skills, concern for others, trust in and respect for others, altruistic behaviour, and positive interpersonal behaviour. CDP has

also been associated with a reduction in negative effects such as loneliness in school, social anxiety, and marijuana and alcohol use.

In 1987, the Reach Out to Schools: Social Competency Program was first implemented in several elementary schools in Massachusetts to improve classroom climates and teach social competency skills (i.e., ability to work cooperatively and to solve interpersonal problems) (Seigle, 2001). The Reach Out to Schools: Social Competency Program has since expanded to include over 2,850 teachers who have delivered the curriculum to over 200,000 students in over 200 schools. This program is a multi-year program for children in kindergarten to grade 5. The program is part of the curriculum, focusing on developing communication, self-control, and social problem solving skills. It is a classroom-based program which is taught twice per week in an "open circle", format, similar to a sharing circle. Teachers receive 4 days of training and on-site consultation by a program consultant to assess their progress and address any specific difficulties. The consultation and training help to ensure that the teachers "buy-in" which is essential to the program's continued success.

In a review of the Reach Out to Schools: Social Competency Program, it has been found that students made significant gains in many areas (Seigle). Students who participated in the program showed an increase in interpersonal skill development (empathy and consideration for others), sense of self-worth and empowerment, problem-solving skills, individual responsibility, and a reduction in problem behaviours. Other gains included improved teacher-student relationships and an improved learning environment such as increased time on task, problem solving ability, and support for others' learning.

Another program, the PATHS program (Promoting Alternative Thinking Strategies), was developed as a social and emotional curriculum for regular educational and special needs children from kindergarten to grade 5 (Kusche & Greenberg, 1994). The goals of the PATHS program include: promoting emotional literacy and social competency, preventing emotional distress, preventing behavioural and emotional problems, reducing risk factors related to later maladjustment, and improving classroom atmosphere and teacher-student relationships. The program is designed for implementation on a regular basis throughout the school year (i.e., 20-30 minute lessons 2 to 3 times per week), with more complex instruction as children mature. The PATHS lessons are on topics such as emotional literacy, self-control, social competency, healthy relationships, positive self-esteem, empathy, and interpersonal problem solving. Supplementary materials are also provided for parental education and involvement.

A review of program evaluations on the PATHS program, showed an increase in children's abilities to recognize and understand emotions, understand social problems, and develop alternative solutions to problems (Kusche & Greenberg, 2001). Teachers reported an increase in pro-social behaviour in their students (i.e., emotional understanding, self-control, ability to tolerate frustration, and use of conflict resolution strategies). The PATHS program also resulted in a decrease in maladaptive outcomes, such as decreased internalized symptoms (sadness, anxiety, and withdrawal), and decreased externalizing symptoms (aggressive and disruptive behaviour).

The benefits of programs aimed at fostering emotional intelligence have also been seen in adolescence. Some social-emotional programs which were implemented in late elementary school have been found to have lasting effects into high school (Elias, Gara,

Schuyler, Branden-Muller, & Sayette, 1991). In a 6 year longitudinal study, (Elias et al., 1991) the impact of a 2 year intensive primary prevention program, the Improving Social Awareness-Social Problem Solving Project (ISA-SPS), was evaluated. This program was developed for promoting social competence and it focused on critical social decision making, self-control, group participation, and social awareness skills. The ISA-SPS program was implemented in grades 4 and 5 by the classroom teachers and it became part of the two year curriculum. Teachers received ongoing support, training, and consultation. When followed up 6 years later in high school, the findings suggested that the children who received the intervention showed higher levels of pro-social behaviour in comparison to control groups. These children also had lower levels of anti-social, self-destructive, and socially disordered behaviour compared to children who did not participate in the program. It was suggested that programs implemented in elementary school have some carry over effects into adolescence. However, while there were some carry over effects, it was recommended that in order to maximize long-term benefits, children and adolescents need to be provided with opportunities to build upon their earlier learning (i.e., follow-ups, booster sessions) (Elias et al., 1991). There were several benefits of increasing emotional intelligence in adolescence, as adolescents who have higher levels of emotional intelligence are better able to identify their own and others' emotions in interpersonal situations and are better able to resist peer pressure (Mayer, 2001).

Most of the programs above satisfy the requirements of an effective school-based program in that they are preventative (beginning at an early age), target multiple risk factors, are collaborative, and are integrated into the curriculum. All of the above

programs began in kindergarten, following an early-years prevention model. All programs lasted more than one year, with the Child Development Project lasting the longest (from kindergarten to grade 8) (Dasho, Lewis, & Watson, 2001). All programs were also integrated into the school curriculum and were implemented throughout the year. Some occurred a few times per week and all programs were taught in the regular classroom context. All programs were preventative and targeted multiple areas (emotional, social, behavioural). However, programs differed in the selected domain of their focus (i.e., communication skills, problem solving skills, cooperation etc). Most of the programs appeared to be based on some sort of theoretical model (i.e., attachment theory).

A strength of the above programs was the use of a collaborative model. These programs were curriculum-based programs administered by trained classroom teachers. A strength of The Reach Out to School program was the strong teacher training component (Seigle, 2001). This program provided teachers with 4 days of training in order to help them integrate the program with their curriculum. "We know that the way a teacher presents the curriculum and includes the concepts throughout the school day is critical to the programs' effectiveness." (Seigle, p. 111). Some programs such as the CDP, focused on a school-wide intervention, including all staff members in their training - the administrators, paraprofessionals, and support staff (Dasho, Lewis, & Watson, 2001). The Reach Out to Schools program had expanded training including all adults who may come into contact with the children in school: parents, secretaries, cafeteria staff, custodians, and bus drivers (Seigle, 2001). This allowed all adults to model the same behaviours for children.

It is often difficult to collect exact empirical support for the effectiveness of social-emotional interventions in schools. Although there is evidence of the effectiveness of many programs, it is difficult to compare the relative effectiveness of one program over another. Many of the programs share similar components and it is difficult to know how the program limitations and program strengths impacted specifically the program effectiveness. There is also variation in how prevalent the program is, as some programs have been in existence for a number of years and have been implemented in a number of different schools, while others are relatively small. There were a few noteworthy limitations of the above programs. While many of these programs used a collaborative model, none of the programs mentioned any school clinician involvement (i.e., social workers, school psychologists). An important limitation is the lack of availability of long-term research to determine the impact of these programs on children's behaviour and development.

Theraplay

Theraplay is a therapeutic technique which was first developed by clinical psychologist, Dr. Ann Jernberg, in 1967 (Jernberg, 1979). Theraplay is an intensive, short-term treatment method for enhancing attachment, engagement, self-esteem, and trust in others. It is based on a combination of object relations theory, self-psychology, psychoanalysis, and developmental psychology (Rubin & Tregay, 1989). According to Jernberg (1979), many of the techniques and theoretical positions of child theraplay are based on the work of Austin Des Lauriers who worked in 1962 with autistic and schizophrenic children using body and eye contact to get them to interact with the therapist. Jernberg also based her work on that of Viola Broday who introduced singing

and active physical contact and control into her therapy sessions. In the early 1970s, theraplay evolved as a treatment method that uses structured play activities that are modeled after a healthy parent-infant relationship.

Jernberg categorized her observations of normal parent-infant interactions into four dimensions: nurture, stimulation/engagement, structure, and challenge. For example, a parent nurtures her child (i.e., feeds, bathes, rocks, and comforts), she stimulates her child to attend to her (i.e., plays peek-a-boo, gives piggyback rides), she provides structure and is in charge of her child (i.e., makes rules, keeps from danger, makes decisions) and she constantly challenges her child to grow and experience competency and success. In theraplay sessions, the adult facilitator seeks to replicate the early parent-infant relationship in all aspects - nurture, stimulation/engagement, structure, and challenge. The adult facilitator nurtures and cares for the child using highly nurturing activities (i.e., lotioning, feeding), she keeps the child interested and stimulated by using games with an element of fun and spontaneity, and she constantly challenges the child by engaging him or her in new activities. The facilitator is always in charge and he or she provides structure and rules, just as a healthy parent would.

Theraplay is an intensive, short-term intervention (about 1-2 times per week for 1 hour for up to 3 months). Parents play an active role in the sessions and they learn healthy parent-child interactions by observing the facilitator interacting with their child. The intake procedure is lengthy, as it involves an assessment interview with parents and an observation through a one-way mirror of the parents interacting with their child. During the first few theraplay sessions, parents observe their child with the facilitator through a one-way mirror. The parents then join the therapist and the child in later sessions, taking

on a more active role. Theraplay sessions are then designed to focus on one or more of the areas (nurture, stimulation/engagement, structure, and challenge), depending on the specific needs of the child. For example, children who are very timid and fearful benefit from challenging activities to increase their confidence.

There has been an increasing interest in theraplay in recent years and many therapists are trained every year at the Theraplay Institute in Chicago, Illinois. Theraplay has been used with a wide age range, from infants to the elderly and it has been used to address a number of social, emotional, and behavioural difficulties (i.e., acting out, aggressiveness, hyperactivity, withdrawn/timid behaviours). Because of its focus on relationships and healthy interactions, theraplay has been used with children diagnosed as having autism, Pervasive Developmental Disorders, Attention-Deficit/Hyperactivity Disorders, Attachment Disorders, Anxiety Disorders, and Depression. Theraplay has been used in a variety of settings including, Head Start programs, day care centers, special education classrooms, early intervention programs, parenting programs, residential and out-patient treatment centers, and private practice. Theraplay includes activities appropriate for many different needs of children and it has easily been adapted for use in small groups or classrooms. Group theraplay is especially appropriate for children who are having difficulty relating to peers.

Theraplay and the Role of Play in Child Development

Theraplay is also based on research that has found play to be essential for the healthy development of children. The importance and benefits of play have been studied by many child developmentalists (Beardsley & Harnett, 1998). Children learn a range of skills through play such as communication and language skills, physical development,

and coordination (Kuchner, 1998). They also learn self-confidence and a sense of mastery. Play is essential for the development of social skills and it provides a medium for interaction among children to express their emotions. Children become more aware of their emotions and learn to share the feeling and emotions of others (empathy) (Sayeed & Guerin, 2000). "Through make-believe or pretend, children also work on social and emotional issues that are part of the nurturing of emotional intelligence." (Kuchner, p. 4). This occurs as children gain better understanding of social roles – trying out different roles allows children to "acquire a better understanding of how others feel, think, and act." (Kuchner, p. 4). Children learn what behaviours are socially appropriate by learning both verbal and non-verbal signs. According to Hoffman (1991), as children get older and they understand themselves in relation to others, their ability to empathize with others increases as well.

"Theraplay" is different from traditional "play therapy". While both theraplay and play therapy are therapeutic interventions, theraplay focuses more on adult-directed structure and interpersonal relationships. In theraplay, the facilitator is in charge and each activity is structured with a beginning, middle, and end. To ensure this, four rules are enforced in a gentle way: "the adult is in charge", "no hurts", "stick together", and "have fun". In contrast, during play therapy, a child may be allowed to freely engage in play while the facilitator looks on. Another difference is that theraplay focuses less on toys and symbolic objects and more on the interactions between the therapist/parent and child. In theraplay, the therapist uses inexpensive materials such as cotton balls or balloons, rather than props or toys, such as in play therapy. During play therapy, a child is encouraged to act out different feelings or scenarios and their behaviours may be

interpreted. In contrast, theraplay does not encourage a child to act out issues in order to be interpreted. Thus, while both therapeutic interventions use play as a medium, there are some differences in how they are implemented. Theraplay is a highly structured intervention, with entire sessions being planned out ahead of time by the facilitator. The facilitator completes all activities and does not usually stray from the session plan. In contrast, play therapy may take many different directions, depending on the response of the child to the sessions. While both therapeutic techniques require a facilitator to implement the intervention, play therapy is a more flexible format.

Theraplay and Attachment Theory

While there is very little research specifically on the effectiveness of theraplay as a therapeutic intervention, theraplay is based on the theory and empirical research findings relating healthy attachment to healthy child development. "Theraplay is based on attachment theory, which proposes that the first relationship a child has is the most important one in his/her life, as it forms the prototype for all other relationships." (Munns, 2000, p. 10). Theraplay asserts that the first relationship that a child has is crucial for all future relationships in life. "There is positive support from both theory and empirical findings for the notion that early interactions between care-giver and infant nurture positive infant attachment to adults and other human beings. This attachment process forms a pathway for the development of healthy social competencies in early childhood and later adult relationships." (Mackenzie-Keating & Kysela, 1997, p.23). The most important component of theraplay is the focus on nurturing activities and the building of a healthy parent-child relationship.

Bowlby (1953) introduced the idea that separation from the maternal figure in early childhood could have an enormous impact on child development. Attachment theory asserts that human infants form attachment relationships to those who care for them, affording a sense of "felt security" as the child explores the world encountering new and difficult situations (Stroufe & Waters, 1977). All but the most seriously isolated infants become attached, but the quality of the attachments depends on the quality of care infants receive. Children who are cared for by sensitive, responsive, and predictable adults feel secure in those relationships, whereas children whose care is less attuned to their specific needs develop insecure patterns of attachment. The quality of these early attachment relationships is believed to be important because they mediate the regulation of emotion and the child's sense of the world as a loving place.

Children who experience extreme, chronic trauma prior to age 5 often develop Reactive Attachment Disorder (RAD) (Sheperis, Renfro-Michel, & Doggett, 2003). The Diagnostic and Statistical Manual of Mental Disorders: Fourth Edition (American Psychiatric Association, 1994) criteria for RAD include: (a) "markedly disturbed and developmentally inappropriate social relatedness in most contexts, beginning before age 5 years". This is characterized by a persistent failure to initiate or respond in a developmentally appropriate fashion to most social interactions and a marked inability to exhibit appropriate selective attachments. There must be evidence of pathogenic care, and a presumption that the pathogenic care is responsible for the disturbed behaviour. There are two types of RAD, Inhibited and Disinhibited, that relate to the presentation of behavioural problems. For the Inhibited subtype, the predominant disturbance in social relatedness is the persistent failure to initiate and to respond to most social interactions in

a developmentally appropriate way. For the Disinhibited subtype, the predominant disturbance in social relatedness is indiscriminate sociability or a lack of selectivity in the choice of attachment figures.

Over the past few decades many pediatricians and clinicians have cared for thousands of children adopted from Eastern Europe, Russia, and Asia who received poor nutrition and limited stimulation in an orphanage setting (Kliman, 2003). Medical, developmental, and behavioural conditions occur in these children with a higher frequency and greater severity compared with most children born in the United States. These children often do not receive emotionally attuned interactions with loving caregivers until their adoption. As a result, there is a lack of preferential attention towards parents, indicating the presence of a change in the normal functioning of attachment. Many of these children have attachment disorders due to a lack of stimulation and neglect. These children then continue to have developmental and relational difficulties even after long periods of stabilization within their adoptive families.

Pediatricians, nutritionists, and mental health colleagues have developed special programs to help these children, as they often require intensive services. According to Kliman (2003), the best results in the treatment of children with reactive attachment disorder are in therapeutic preschools providing intensive psychotherapy. Hanson and Spratt (2000) have suggested that beneficial treatments of RAD should include proper diagnosis at an early age and placement in a secure and nurturing environment. They have recommended that treatment should focus on the family including instruction in empirically-based parenting skills, an emphasis on family functioning, coping skills, and

interaction. Mental health professionals should work with the child and family in a more naturalistic environments as opposed to more restrictive and intrusive settings.

Therapeutic Effectiveness of Theraplay

Theraplay has frequently been used for the treatment of children with attachment difficulties because it focuses on building healthy attachment and nurturing of the parent-child relationship. While theraplay has been used for over 30 years, there have been very few formal studies on the effectiveness of theraplay as a therapeutic intervention. Mahan (2001) was the first to evaluate the effectiveness of theraplay on Previously Institutionalized (PI) children. A pair of twin PI children adopted from an Eastern European orphanage at the age of 3 years and 9 months underwent theraplay interventions with pre-and post-testing. The test data showed that after the theraplay treatment, the twins' problem behaviours decreased and their attachment increased. While theraplay requires further study, the findings of this study and other attachment-related studies suggested that theraplay, a short-term attachment-based play therapy, can be an effective intervention with children who need to strengthen their attachment relationships.

Theraplay has also been used successfully as an intervention for infants with attachment difficulties (Bernt, 2000). In a case study, two at-risk mothers with infants who were described as having Failure–To–Thrive (FTT) participated in a theraplay intervention. The therapist worked with the mothers to model and reinforce a healthy infant-child relationship. Theraplay was described as facilitating the connection between mother and child by increasing positive interactions. After the theraplay intervention, there was reportedly an increase in physical closeness (i.e., eye contact), maternal self-

esteem, and positive maternal feelings towards the child. Theraplay has also been used to decrease the stress of poverty, abuse, and loss of homeless mothers and their children who were living in shelters.

Theraplay has been used to decrease aggression in children (Munns, 2000). According to the theraplay institute, there are several studies in progress that are exploring the effectiveness of theraplay on aggression, language-disordered and behaviour-disordered children. One research study examined the effectiveness of a community-based early childhood program, Adults and Children Together (ACT) for decreasing negative behaviours (Zanetti, Matthews, & Hollingsworth, 2000). The ACT program was a 6 week preventative program based on theraplay that used play activities to replicate healthy patterns of interaction between parents and children. The participants included 15 families (parents and children, ages 3-5) who attended the Head Start Program in Virginia. The goal of the program was to decrease incidents of negative behaviour in children and to reduce parental stress. While there were no statistically significant findings on the objective measures (Abidin Parent Stress Index/Conners' Parent Rating Scale-48), there were some noted differences in children's behaviours and parental stress levels. Analysis of video tapes found observable behaviour changes in both adult and child behaviour (i.e., increased eye contact, more positive touch, and greater cooperative interaction). According to the structured interview, all 12 of the families noted improvements in their children's behaviours and all 15 families wanted to continue their participation in the group.

Classroom-based Theraplay

"With the growth of play therapy as a respected modality, many school

counselors, psychologists, teachers, and social workers have been searching for techniques that could be incorporated into their school settings." (Drewes, Carey, & Schaefer, 2001, p. 13). Play is thought to be so important that many have argued for it to become part of the primary curriculum (Beardsley & Harnett, 1998). Fopiano and Haynes (2001) believe that planned, structured activities should be part of the curriculum to develop strong interpersonal skills and a socially and emotionally sensitive school climate. Clinicians also recognize the need for developmentally appropriate programs that can easily be integrated into early years prevention. Given the limited communication skills of many children, they often need alternative methods of expressing their feelings. "Play and, consequently play therapy, is a natural way for children to express their feelings and emotions." (Drewes, 2001, p. 48). The use of toys and play materials allows children to develop expressive and affective skills, as well as play out life situations and traumas. A number of different types of play therapy are being used in schools today (i.e., sand play therapy, child-centered play therapy, theraplay).

Theraplay has been adapted for use in group or classroom settings (Jernberg, 1979; Rubin & Tregay, 1989; Munns, 2000). In the 1980s, theraplay was adapted for a group of special needs children in a school with children with behaviour disorders. The goal of this group was to form a cohesive, supportive atmosphere where the children would feel a sense of acceptance and belonging. Theraplay has since been used in a number of different group formats. The main goals of group theraplay are to enhance self-esteem, increase trust, increase awareness, promote feelings of concern and caring for others, increase self-control, and increase the ability to relate to others. "The group encourages cooperation, spontaneous sharing, affection, trust, and a heightened sense of

self-respect, and it reduces aggression." (Munns, 2000, p. 23). While group theraplay follows the same assumptions as individual theraplay, there are a few differences. Theraplay in a group or classroom uses more than one facilitator in order to observe, manage, and interact with all of the children. Theraplay in a group is less "intrusive" than theraplay sessions with the child's parents, as the bond between students and facilitators is not the same as the bond between a parent and child. However, in classroom-based theraplay, children and facilitators do engage in several nurturing activities together (i.e., rub lotion on each other's hurts, offer hugs or handshakes, play games which involve some touching).

Healthy attachment, respectful touching, and the building of relationships are an important part of child development. Recently, there has been a moral shift in the education system with codes of conduct discouraging school personnel from touching students. In an effort to put an end to child sexual victimization, school staff must now be very careful about how they touch children. Johnson (2000) has criticized the "no touch" policies that are present in schools today. Teachers are nurturing caregivers for children all day yet they are unable to provide touch that is critical for a child's development. Johnson suggested that educators must collectively work against these "no touch" policies, knowing the research and theory on the importance of human touch. Johnson asks educators to ask themselves "what is gained by our continued support of the "no touch" policy in early childhood education?" In a time when touch is usually absent from our schools, theraplay offers a respectful alternative by teaching touching and caring in a supervised, structured manner.

Drewes (2001) outlined several reasons why a school system is an ideal setting for early intervention and preventative services, as well as being a therapeutic milieu. Offering a play therapy approach as an early years prevention program in a school setting has several advantages. Firstly, it allows many children to receive intervention who would not normally be eligible for play therapy services through the usual school referral process because their behavioural and emotional difficulties are not yet severe enough to warrant a referral. There is also the cost-effective benefit of being able to use school staff, such as paraprofessionals, school teachers, guidance counselors, and even parent volunteers to help implement the programs. Because children attend school daily, it is an ideal environment for providing mental health services regularly and to observe children in a natural setting. Many families of school-aged children with emotional and behavioural difficulties do not have the financial or inner emotional resources to access outside counseling services. The school is in the unique position to offer additional primary prevention and developmental enhancement through play therapy (Drewes, 2001). Early childhood professionals have had to take on the role of helping parents understand the nature and value of play. In a busy society where parents juggle work, personal, and family lives, playing with children is often not a priority (Kuchner, 1998).

Rationale for Selecting Theraplay as a Classroom-based Intervention

An Early Behaviour Initiative grant was given to a school division in Winnipeg, Manitoba to support an early years prevention program designed to decrease disruptive behaviour in elementary school children (kindergarten to grade 2). The school board chose two schools for the intervention based on the high risk factors that included: poverty, single parent families, significant health concerns, issues involving drug and

alcohol abuse, lack of positive role models, and lack of adult supervision. This study focused on only one of these chosen schools.

The goal of the Early Behaviour Initiative grant was to reduce the incidence of behavioural difficulties in young children. Many of the school staff felt that children's behavioural difficulties at this school were due to their inability to relate interpersonally. The community had a number of risk factors and many children reportedly entered school with a lack of basic social skills and emotional awareness. Based on these identified needs, the school personnel (administrators, guidance counselor, school psychologist, and school social worker) decided to base the program framework on the concept of emotional intelligence (Salovey & Mayer, 1990; Goleman, 1995). More specifically, because this program was targeted at young elementary school aged children, the program framework was based on developing two of the core virtues of moral intelligence - empathy and self-control (Borba, 2000). According to Borba, empathy and self-control are the basic skills that must be obtained before the higher-level virtues are attained (respect, kindness, tolerance, and fairness). Empathy and self-control are also important components of the concept of emotional intelligence (Salovey & Mayer, 1990; Goleman, 1995). They have also been included in other elementary school programs that promote emotional intelligence such as the PATHS program (Promoting Alternative Thinking Strategies) that was developed as a social and emotional curriculum for children from kindergarten to grade 5 (Kusche & Greenberg, 1994). The third core virtue, "conscience", was not chosen as a goal for the present program because it is a more abstract concept and more difficult to assess.

It was decided that theraplay would be chosen as the method of integrating emotional intelligence (empathy and self-control) into the classroom for several reasons. Theraplay, is an attachment-based play therapy, which engages young children in its highly structured nurturing activities. Because theraplay emphasizes caring and nurturing at a very basic level, it was decided that it would be a useful technique for enhancing empathy. "For children to become caring, they must believe that to care is to be part of a community that is welcoming, nurturing, and concerned about them." (Elias et al, 1997, p. 1).

Theraplay was thought to be a useful technique for increasing self-control because of its highly structured format that entails cooperative, team-oriented activities with rules. Theraplay has been successfully used as a therapeutic intervention with children who have behavioural difficulties. For example, "theraplay with children with Attention-Deficit/Hyperactivity Disorder seeks to promote self-control and the internalization of rules and structure, so that the child learns to modulate her own behavior." (Theraplay Institute, 2003). Thus, it is believed that the structured activities in theraplay would enhance self-control in children.

Theraplay was chosen for several other reasons, in that it met many of the criteria for a successful social-emotional learning program. Firstly, theraplay could easily be implemented as an early years prevention program, as the activities are developmentally appropriate, easy for young children to understand, and easily adapted to classroom use. Theraplay targets multiple risk factors, as it offers many different types of activities that address the diverse, multiple needs of the children (nurture, stimulation/engagement, structure, and challenge). Theraplay could easily be implemented through a collaborative

model, as trained, certified theraplay clinicians work alongside teachers and paraprofessionals, teaching them through the use of modeling and activity booklets.

Model of Program Delivery

The T.L.C. program was implemented using an early years prevention model that addressed multiple risk factors. The implementation of the program involved a different model of service delivery than the one typically provided by school clinicians. The program was implemented using a collaborative model including school clinicians and school personnel. The school clinicians' time (school social worker and school psychologist) was increased and in the case of the school psychologist, the role shifted from primarily of one-individual intervention (i.e., assessment, therapy) to two-individual intervention and classroom-based interventions. The project was supported by the administration and teachers were provided with classroom coverage for any meetings. It was important that teachers did not view participation as a mandatory task or burden.

T.L.C. Program Evaluation

The purpose of the present study was to conduct a program evaluation of the classroom-based theraplay program, T.L.C. "Teaching and Learning to Care". A program evaluation is an information-gathering endeavor that attempts to answer a specified set of questions about a program's performance and effectiveness (Rossi, Freeman, & Lipsey, 1999). A thorough program evaluation involves several steps, some of which occur before the program is implemented, and others that evaluate the program after it is completed. Before a program is implemented, it is necessary to conduct a needs assessment, an assessment of program theory, and statements of the programs goals and objectives with descriptions of how these will be carried out. After the program is up and

running, a program evaluation can be used to determine the effectiveness of program delivery and program outcomes.

After the need for a program has been determined, a program evaluation requires an assessment of program theory (what feasible interventions are likely to ameliorate the problem?) (Rossi et al., 1999). An important aspect of program evaluation involves concrete statements of the program's goals and objectives, how the desired outcomes are expected to result from program action, and the relationships expected among program functions, components, and activities must be described. A final program evaluation consideration before a program begins is whether this particular intervention is reaching its target population.

The pre-program implementation considerations were not the primary focus of the present program evaluation study, as they were already determined at the school level (by school board, administrators, clinicians, teachers, and guidance counselors). This program evaluation focused on an assessment of program process - was the intervention being implemented well?, (Rossi et al) This type of program evaluation determines whether its service delivery and support functions are consistent with the original program design. This is also known as the "fidelity" of program implementation. Assessment of program process or program delivery is the most common type of evaluation used for accountability in the social sciences. When a program is new, it provides valuable feedback to administrators and other stakeholders about the progress that has been made. It is also useful to evaluate the program delivery, particularly, although not necessarily, if the expected outcomes were not obtained.

This program evaluation also considered an impact assessment (was the intervention effective in attaining the desired goals or benefits?) (Rossi, Freeman, & Lipsey, 1999). Impact assessment gauges the extent to which a program produces the intended improvements in the social conditions it addresses. Impact assessments are essential when there is an interest in determining the effectiveness of the program for ameliorating a target problem. The aim is to produce an estimate of the net effects of an intervention.

The Objectives of the Study

The goal of the T.L.C. program evaluation was to (1) assess the efficacy of the delivery of the program and (2) examine the outcome or effectiveness of classroom-based theraplay, that is, increasing empathy and self-control (emotional intelligence) in young children.

Assessment of program process.

The program evaluation of T.L.C. sought to answer a number of questions about the efficacy of program delivery including the program design, structure, management, and functioning. The specific research questions to be answered in this study were as follows: (a) how effective was the model of service delivery? (b) how effective did teachers find the collaborative model? (c) did teachers like/dislike the structure and design of the T.L.C program? (d) what were the program strengths and weaknesses? (e) was the program sustainable - will the teachers continue to use the T.L.C. program?

Impact assessment.

The program evaluation also sought to explore whether theraplay was an effective intervention for increasing empathy and self-control (emotional intelligence). It was

anticipated that because theraplay instills some of the basic needs of children such as nurturing and structure, that there would be an increase in empathic and self-control behaviours and a decrease in non-empathic behaviours or behaviours that lack self-control.

Method

Participants

The participants of this study included 4 teachers (kindergarten to grade 3) and their students (n=89) in a suburban elementary school in Winnipeg, Manitoba. The program was limited to the earliest grades (kindergarten to grade 3), as the Early Behaviour Initiative Grant was intended to target behavioural difficulties in the early years of school. One class from each grade participated in the program (1 kindergarten, 1 grade 1, 1 grade 2, 1 grade 2-3 split). It was hoped that the T.L.C. program would be a building block for the younger grades, which would eventually be followed by more age-appropriate programming as the children grew older (i.e., social skills training).

Participant Recruitment

The school was chosen for the Early Behaviour Initiative grant by the school division. Within the school, the early years teachers were recruited through an orientation for the T.L.C. program. Letters were placed in all seven of the primary elementary school teachers' mailboxes (kindergarten to grade 3) inviting them to an orientation about an early years prevention program (see Appendix A). Coverage was provided for all teachers so they could attend the orientation meeting for 1 hour. During the orientation, the program facilitators presented information on classroom-based theraplay, showed a theraplay video, and involved teachers in several theraplay activities. Teachers were

informed that participation in the T.L.C. program was not mandatory. Teachers were also reassured that if they chose to participate, there would not be any additional tasks or time required. After the orientation, all seven teachers indicated that they were interested in participating. However, only four session spots were available (one for each grade) due to the facilitators' limited time. The teachers decided amongst themselves who would receive the program in their classroom.

Of the 89 students who participated in the T.L.C. program, 6 children were randomly selected from each classroom for further study. Each teacher was asked to assess her students based on three categories – emotional/social and behavioural well-being. Students were either identified as "troubled", "healthy" or "medium". Six students from each class were then randomly chosen from the stratified sample: 3 "troubled" students and 3 "medium". This smaller sample was chosen as a random representation of the students from the four classrooms. Each teacher filled out a questionnaire on these 6 children before and after the program to determine whether there was any increase or decrease in empathy and self-control. "Healthy" students were not chosen for this small sample, as it was expected there would be no meaningful difference in empathy and self-control after the program. It was also not feasible for teachers to fill out the questionnaires for all of the 89 students, due to time limitations.

Instruments

The program evaluation materials consisted of a questionnaire comprised of three different sections which was administered prior to the program, and again, following the completion of the program. The questions were formulated using various different

sources of information. The format of the questions included Lickert-type scales, yes/no questions, choices, and open-ended questions.

The Classroom Characteristics Questionnaire.

The Classroom Characteristics Questionnaire is a brief measure that was designed by the school clinicians (see Appendix B). The purpose of the questionnaire was for teachers to rate several characteristics of their students in order to estimate the incidence of behavioural problems in each of the classrooms. Teachers were asked to give a rough estimate of the incidence of children in their class who experienced social/emotional, academic/cognitive, attention/behavioural and family problems (i.e., 1-2; 3-4; 5-6, more than 7). They were also asked to indicate how much time they spent dealing with these problems each day and what discipline techniques were commonly used. The purpose of this informal measure was to obtain a snapshot of the classroom characteristics and overall classroom climate.

The Individual Student Rating.

The Individual Student Rating was designed by the school clinicians in order to rate the behaviours (empathy and self-control) of the 6 randomly selected students from each class (see Appendix C). Teachers were asked to rate each student on a Lickert scale from 1 (never) to 5 (always) to indicate the student's frequency of empathic/non-empathic behaviours and self-control/lack of self-control. The scale was based on the concepts of self-control and empathic behaviours, as defined by Michelle Borba (2001).

The T.L.C. Program Evaluation.

The T.L.C. Program Evaluation is a post-measure designed for teachers to evaluate the program delivery and program outcomes (see Appendix D). The

questionnaire was designed by the clinicians and was based on a process evaluation and impact assessment model (Rossi, Freeman, & Lipsey, 1999). Process questions were designed to determine the teacher's perceptions of the program implementation (model of service delivery). Questions were also included to assess the impact or outcome of the program, to determine whether the intervention was effective for increasing empathy and self-control. Many of the questions were in open-ended format in order to obtain rich qualitative descriptions from the teachers.

Theraplay materials.

Several materials were used during the T.L.C. sessions. Each class required theraplay supplies for the nurturing and feeding activities (i.e., bottles of hypo-allergenic lotion, potato chips, anti-bacterial hand soap). Various inexpensive materials were also required for the theraplay activities (i.e., bean bag, ball, stuffed animals, balloons, etc). Signs were created on the computer by the clinicians to illustrate the theraplay rules in the classroom – "No Hurts", "Stick Together", and "Have Fun" (see Appendix E). These signs provided the children with a visual prompt and were hung in each classroom. The clinicians also created theraplay activity booklets for the teachers so they could follow along with the activities (see Appendix F).

Procedure

Pre-program Implementation

The program facilitators (clinicians and guidance counselor) trained for the T.L.C. program by attending a 4-day certified theraplay workshop, offered through the Theraplay Institute. The program facilitators then collaborated to develop eight T.L.C program sessions. Clinicians' (school psychologist and social worker) time at the school

was increased by 1 day per school cycle to accommodate the extra demands of planning and running the program. This extra time was covered by the Early Behaviour Initiative grant. One goal of the program was to involve teachers in the activities in the classroom, without making their participation in the program a burden (i.e., extra planning). Therefore, all materials were prepared ahead of time by the clinicians and the guidance counselor. Before the program began, notes were sent to the teachers (see Appendix G) and parents (see Appendix H) to inform them about their participation in the program and to enquire about any concerns or feedback.

Program Implementation

All 4 classes received a 45-minute theraplay session once per week for a total of 8 weeks. The 4 classes began at different intervals to accommodate the facilitators' schedules. Two facilitators were randomly assigned to each classroom. During the first four sessions, there were two facilitators present and the classroom teacher. The teaching assistant was also included if available. For the last four sessions, one of the facilitators was phased out to encourage the teacher to take on a greater role as facilitator. After the 8 weeks were over, each classroom received periodic follow-ups, or booster sessions, to reinforce the program and provide further support and consultation for teachers.

Session Structure

A typical 45-minute T.L.C. session included an opening song, an introduction activity, several theraplay activities, two nurturing activities, and the closing song. Each T.L.C. session began with an opening song in which the children sat in a circle with their arms linked together. This opening song was followed by an introduction activity that was designed to acknowledge each child (i.e., the Name Game). This introduction was

followed by approximately four different activities that were composed of the four components of theraplay (engagement/stimulation, structure, challenge, and nurture). These activities were a mix of low energy and high-energy activities to sustain the children's interest. The activities were adjusted somewhat for each developmental stage. Towards the end of the T.L.C. sessions, two nurturing activities were always included: the "lotioning of the hurts" and the "food share", as these are important components of theraplay. Sessions always ended with the same closing song in which the children sat in a circle with their arms linked. The last theraplay session was devoted to a party, in which the children were asked to pick from some of their favorite theraplay activities. A description of some of the T.L.C. activities can be found in Appendix E .

Data Collection

Each classroom teacher filled out a pre-measure (The Classroom Characteristics Questionnaire and Individual Student Rating) to assess the overall classroom characteristics and to rate the 6 randomly selected students on empathy and self-control. Observations were completed by the program facilitators on 6 randomly selected kindergarten children to identify behaviours that exhibited empathy or self-control. These 6 children included 3 children who were identified as "troubled" and 3 who were identified as "medium". Each child was observed for 12 minutes on three separate occasions. Observations were recorded in a narrative format and were to be analyzed for behaviours that indicated self-control/lack of self-control and empathy/lack of empathy. Children in grades 1 to 3 were not observed due to time constraints and the lack of opportunity to observe these children in a less structured environment (i.e., free play time).

After the program was completed, the 6 kindergarten children were supposed to be observed again to see if there had been an increase/decrease in empathy and self-control behaviours. These final observations were not completed due to a tragic auto accident which resulted in the death of one of the kindergarten students. The children in the kindergarten class were devastated by the sudden death of their classmate and the final weeks of school were devoted to helping the children grieve and cope with their loss. It was evident that observations of representative behaviour could not be expected during these difficult weeks. For this reason, post observations of the individual kindergarten students were not completed and this part of the study was omitted.

After the T.L.C. program was completed, the Classroom Characteristics Questionnaire and the Individual Student Rating were administered again to evaluate any differences in classroom and/or individual levels of empathy and self-control as a result of the theraplay intervention. Teachers also completed the T.L.C. Program Evaluation, designed to obtain information about the program delivery and effectiveness. Teachers were invited to meet with the program facilitators for feedback.

Results

The analysis of results for this study was qualitative and descriptive in nature. Qualitative analysis and descriptive reporting were chosen to capture the detailed descriptions of the teachers' opinions, perceptions, and observations about the T.L.C. program. Qualitative analysis was also chosen due to the difficulties of collecting reliable and valid quantitative data about behavioural change in a school setting. The Classroom Characteristics Questionnaire was analyzed to report overall classroom and student characteristics. The T.L.C. Program Evaluation was analyzed to determine the efficacy of

the program's model of service delivery. Responses were analyzed to determine the effectiveness of program design, structure, management, and functioning. Responses to closed-ended questions were analyzed by looking at the frequency of each teacher's response. Open-ended responses were analyzed to determine common themes.

Both the Individual Student Rating and the T.L.C. Program Evaluation were analyzed to determine whether theraplay was an effective intervention for increasing empathy and self-control (emotional intelligence) in children. For the T.L.C. Program Evaluation, both open-ended and closed-ended responses were analyzed for behaviours that indicated empathy/lack of empathy and self-control/lack of self-control. The Individual Student Ratings were also analyzed to see if there were differences in empathy and self-control after the program completion. The mean responses were calculated for each of the four different response categories – empathy, lack of empathy, self-control, and lack of self-control. Comparisons were made between each teacher's class (A, B,C, D) and between the two groups of children ("medium" versus "troubled"), both before and after the program.

Classroom Characteristics Questionnaire

In order to get an overview of the needs of the students in each class, all teachers were asked to rate their classrooms using the Classroom Characteristics Questionnaire. Teachers were asked to estimate the number of students in their classes that exhibited social/emotional problems, academic/cognitive problems, attention/behavioural problems, and family problems. Teachers may have included students in more than one category (i.e., rated students as having both family problems and academic/cognitive problems). In the Classroom Characteristics Questionnaire, teachers were also asked to

estimate the amount of time needed to deal with these problems on a daily basis, as well as the type and frequency of discipline techniques that were used. The Classroom Characteristics Questionnaire was administered both before and after the T.L.C. program to assess the consistency in which teachers rated the characteristics of their classrooms. A summary of the four classrooms may be seen in Table 1.

Classroom A was a kindergarten class that consisted of 23 students (14 girls and 9 boys). Teacher A rated her class as having more than 7 students in each category (social/emotional problems, academic/cognitive problems, attention/behavioural problems, and family problems). This teacher reported that the students in this class were "somewhat more challenging" than other classes she had taught in the past. In 27 years of teaching, Teacher A indicated that she had never taught at a school with so many concentrated problems in one class. Teacher A reported that she spent an average of 30-40 minutes per day addressing social/emotional problems, and over 1 hour per day addressing attention/behavioural problems. The following discipline techniques were used by Teacher A: verbal reprimands (frequently); time-outs, phone calls to parents, and trips to office (sometimes). Suspension was reportedly never used. Other discipline techniques included: reminders of class rules, coaxing, positive reinforcement, hand gestures, and taking away toys if there was a fight.

When the same classroom questionnaire was administered to Teacher A after the T.L.C. program had ended, Teacher A had similar responses but there were a few noteworthy differences. She now rated her class as being "much more challenging" (instead of "somewhat more challenging"), and she added that three of the children had seen a behavioural specialist before entering kindergarten. The time allotted for dealing

with attention/behavioural problems had decreased from 1 hour per day to approximately 30-40 minutes per day. The only difference in the types of disciplines used was an indication that suspension had been used sometimes.

Classroom B was a grade 1 class with 21 students (10 girls and 11 boys). Teacher B rated her class as having more than 7 students with social/emotional problems and more than 7 students with academic/cognitive problems. Teacher B estimated that she had approximately 5-6 students with attention/behavioural problems and 5-6 students with family problems. Teacher B also had "two Level II funded children in her class who had difficult home situations that challenged their emotional, social, and cognitive well-being". Overall, this teacher indicated that the students in this class were "somewhat more challenging" than other classes she had taught in the past. Teacher B reported that she spent an average of 40-50 minutes per day addressing social/emotional problems and over 1 hour per day addressing attention/behavioural problems. The following discipline techniques were reportedly used by Teacher B: verbal reprimands (sometimes); time-outs (rarely); phone calls to parents (sometimes); and trips to office (sometimes). Suspension was reportedly never used.

The same classroom questionnaire was administered to Teacher B after the T.L.C. program had ended. Overall, Teacher B rated her class as having the same number of difficulties as before. However, Teacher B noted that she spent less time dealing with social/emotional problems per day (decreased from 40-50 minutes to 30-40 minutes) and attention/behavioural problems per day (decreased from 60 + minutes to 40-50 minutes). There were no changes in the types or frequency of discipline techniques.

Classroom C was a grade 2 class with a total of 22 students (9 girls and 13 boys). Teacher C rated her class as having 3-4 students with social/emotional problems, 5-6 students with academic/cognitive problems, 5-6 students with attention/behavioural problems, and 5-6 students with family problems. Teacher C indicated that the students in this class were "somewhat more challenging" than other classes she had taught in the past. Teacher C commented that her overall class was quite low academically and they had difficulty with sustaining attention and making transitions. Teacher C indicated that she spent less than 30 minutes per day dealing with social/emotional problems and less than 30 minutes per day dealing with attention/behavioural problems. The following discipline techniques were reportedly used in dealing with these students: verbal reprimands (frequently); time-outs (sometimes); phone calls to parents, trips to office, and suspensions (rarely).

When the same classroom questionnaire was administered after the T. L. C. program had ended, Teacher C had similar responses but there were a few noteworthy differences. Teacher C now rated the class as having more students with social/emotional problems (5-6 students) than at the beginning (3-4 students). Teacher C also indicated that she had to spend an average of 10 minutes more per day dealing with attention/behavioural problems (30-40 minutes per day). There were a few differences in the types of discipline techniques used, as she reported an increase in trips to the office and use of suspension (from "rarely" to "sometimes".)

Classroom D was a grade 2-3 split class that consisted of 23 students (11 girls and 12 boys). Teacher D indicated that while the students in her class had high needs, it was the "same as previous classes". However, this was the teacher's second year with the

same group of students and only her second year teaching. Teacher D rated her class as having more than 7 students with social/emotional problems, more than 7 students with academic/cognitive problems, 3-4 students with attention/behavioural problems, and 3-4 students with family problems. Teacher D indicated that she spent an average of less than 30 minutes per day dealing with social/emotional problems and 30-40 minutes per day dealing with attention/behavioural problems. The following discipline techniques were used by Teacher D: verbal reprimands (always); time-outs (sometimes); and phone calls to parents (sometimes). Trips to the office and suspensions were rarely used. This teacher indicated that her most effective discipline strategy was positive reinforcement (i.e., stopping to praise a child who is making a good choice).

When the classroom questionnaire was administered at the end of the school year, Teacher D rated her class as being "somewhat easier" in comparison to other classrooms she had in the past. There was reportedly a decrease in the number of students who had social/emotional problems and academic/cognitive problems from more than 7 to 5-6. The number of students who had attention/behavioural problems remained the same (3-4) and there was an increase in the number of students who had family problems (5-6). Teacher D did not report a change in the amount of time needed to deal with social/emotional and attention/behavioural problems. With respect to discipline techniques used, the number of verbal reprimands had reduced from "always" to "frequently".

The T.L.C. Program Evaluation

The T.L.C. Program Evaluation was administered to teachers to evaluate the program model. Results were reported to address the main research questions posed in

this study: (a) how effective was the model of service delivery? (b) how effective did teachers find the collaborative model? (c) did teachers like/dislike the structure and design of the T.L.C program? (d) what were the program strengths and weaknesses? (e) was the T.L.C. program sustainable - will the teachers continue to use the program? (f) program effectiveness – did the T.L.C. program increase empathy and self-control?

How effective was the model of service delivery?.

All teachers reported that they would like to see early years prevention become part of the curriculum, addressing the areas of emotional, physical, social, and behavioural development of children. Teachers felt that these developmental skills could be taught in a number of formats including: lessons addressing specific topics, units/themes integrated into the curriculum, special guest speakers, small group work, and the use of pre-existing lesson materials such as books, videos, plays, and music. Three of the teachers, Teachers A, B, and D, indicated that they would be interested in receiving classroom-based interventions on numerous topics including: anger management, teasing/bullying, social skills training, morals/conscience, feelings, problem solving, and conflict resolution. Teacher C emphasized an interest in teasing/bullying morals/conscience, and conflict resolution. Thus, all teachers recognized the need for addressing topics and issues that do not fall under a traditional academic curriculum.

Teachers reported that their students had been exposed to a few of the above topics through school support staff (school guidance counselors and resource teachers) or by the classroom teachers themselves. Teacher B participated in classroom-based programs on anger management, teasing/bullying, social skills training, and conflict resolution. Teacher D had received classroom instruction in social skills training (respect,

kindness, tolerance) and feelings identification. Some classroom teachers implemented programs on their own and Teacher A indicated that she had never received any help from other school personnel. Teachers A and C had addressed the following topics in their classrooms: anger management, teasing/bullying, social skills training, morals/conscience, feelings, problem solving, and conflict resolution.

How effective did teachers find the collaborative model?.

None of the teachers in this study had collaborated with a school psychologist or social worker in a classroom intervention, with the exception of one. Teacher B reported that she had participated in early years academic prevention programs for resource and ESL. She also indicated that she had worked with the school social worker and school psychologist in the early 1990s on a social skills training/problem solving program. The other teachers had reportedly never received early years prevention programs or classroom-based interventions by school clinicians. However, three teachers (Teachers A, B, D) indicated that they had recently begun working with the Speech and Language Pathologist in a classroom-based phonological awareness program (a program which was also funded by the Early Behaviour Initiative Grant). All of the teachers indicated that participation in the phonological awareness program required "extra effort" on their part.

All teachers reportedly valued having school clinicians' involvement in classroom-based programs. When asked the question, "Do you think there is a role for clinicians in the classroom?" all teachers answered, "yes", "absolutely", "definitely!". All teachers felt that early years prevention programs should be implemented by a combination of people including the classroom teacher, school guidance counselor, school psychologist, and school social worker. While all teachers were interested in

classroom-based interventions, they did not want sole responsibility for the planning and implementation of programs. They also did not want clinicians to provide them with ready-made program materials so that the teachers could implement the programs themselves. Similarly, none of the teachers were interested in a model in which the school clinicians were solely responsible for program planning and implementation, without teacher input. However, teachers felt that it would be fine if clinicians were responsible for the program planning but both the clinicians and teachers implemented the program. Overall, all teachers indicated a preference for a collaborative model in which both the clinicians and teachers are responsible for program planning and implementation. A summary of teachers' opinions of the model of service delivery can be found in Table 2.

Did teachers like/dislike the structure and design of the T.L.C program?.

Teachers were asked several open and closed-ended questions about the structure of the T.L.C. program (see Table 3). All teachers liked the format and structure of each T.L.C. session ("Excellent!", "Very organized!") and found the sessions easy to follow. All teachers felt that the program length of 45 minutes was "just right" however, Teacher A commented that if social-emotional programming was to become a part of the daily curriculum, the length of the sessions could be decreased. Teachers unanimously agreed that early years prevention should begin in kindergarten. Two teachers (A and C) felt that the intervention should be daily, while two teachers (B and D) preferred weekly interventions. Three teachers, A, B, and D, would have liked the T.L.C. program to run longer than 8 weeks. Teacher C felt that the program could end after 8 weeks, but should include ongoing follow-up afterwards. Teachers A, C, and D would have preferred the

program to begin right in September, however, Teacher B commented that it might be best to begin after the first report card, as the grade 1 students were still adjusting to their new classroom situation.

All teachers felt there was "adequate staff" to implement the program and they all felt that their involvement in the program planning and program implementation was "just right" (none wanted more or less input). Teachers A and D reported that it took "no extra effort" to participate in the T.L.C program, while Teacher C reported that it took "very little extra effort" and Teacher B felt that it took "extra effort" to participate. Two teachers, A and C, felt that the homeroom location for the program was fine but Teachers B and D felt that their classrooms were too small for some of the activities.

Theraplay activities.

Teachers were asked to express their opinions about the specific theraplay activities from the T.L.C. sessions. All four teachers reported that the activities were developmentally appropriate for their classes. Of the different activity types (structure, challenge, nurture, engagement), all teachers indicated that they liked the nurturing activities best ("lotioning of the hurts" and "food share"). Teacher D commented that she liked the "lotioning of the hurts" activity because "children see and experience what good touches and nurturing looks like". She also liked "food share" because "children reacted very positively to this." Three teachers, A, B, and D, indicated that they liked the opening and closing songs used at the beginning and end of each session. Teacher D commented that the consistent routine at the beginning and the end of each session was a great routine and the familiar songs made everyone feel comfortable. Teacher A commented that her favourite theraplay activities included "cotton ball tickle", "duck-duck-goose-hug", and

"I see somebody special", (activities which are nurturing, engaging, challenging, and structured). Teacher D also liked "cotton ball blow", as it was a gentle way to have fun and do something that all children enjoy (throwing things at each other). She also liked "peanut butter-jelly", a game with structure and silliness. Teacher C indicated that her favourite activity was "tunnel", an activity that challenges children.

Teachers were also asked to rate which theraplay activities they disliked. Teacher A indicated that she disliked several of the activities ("cotton ball throw", "tunnel", "funny faces or noises", "motorboat motorboat", "peanut butter-jelly", "cotton ball blow", "silly bones", and "talking through a balloon"). However, she did not give any reason as to why she did not like these activities. Teachers B and C did not dislike any of the activities. Teacher C added that the children loved the activities and, therefore, she was pleased with the choices. Teacher D did not dislike any of the activities with the exception of "duck-duck-goose-hug", indicating that it would work better with more space in the classroom.

What were the program strengths and weaknesses?.

Teachers were asked to answer a number of open-ended questions to evaluate the weaknesses of the T.L.C. program. Teachers were asked to report any specific challenges in participating in the T.L.C. program and to indicate what they would have done differently (See Table 4). Teacher C indicated that discipline problems were a challenge for her. She reported that in the beginning she was unaware what her position or role in discipline should be but found that it worked out quite quickly. Teacher A indicated two challenges: discipline problems and difficulties with children making transitions between routines and T.L.C. She indicated that she would have placed T.L.C. at the end of their

school day because it had a "party atmosphere so they did not want to settle down for their regular schoolwork after it". Teacher B indicated that her biggest challenge in participating in the T.L.C. program was conflicts in scheduling times. She also felt that the program would be better if there were a permanent place set up for T.L.C. so that she did not have to move around the desks before and after the program. Teacher D did not find any specific challenges in participating in the program, however, she indicated that if she could do anything differently, she would have used a larger space.

Teacher benefits.

Teachers were asked to report any strengths or benefits of participating in the T.L.C. program (see Table 5). All teachers felt that participation in the program benefited them as a teacher. All teachers commented that a strength of the T.L.C. program was the theraplay language. Both Teachers A and C reported that teachers and children "developed a common language". When problems arose, Teacher A felt that her kindergarten children were able to ask for what they needed to make themselves feel better (e.g., "Do you need a hug or a handshake?"). Teacher C added that for her grade 2 students, "it made it much clearer to them that they were giving hurts and that they could do something about that hurt". Teacher C also began asking hurt students in a conflict situation how they felt and if they were okay with the mediation.

A few other benefits and strengths were noted. Teacher B felt that a benefit of the T.L.C. program for her grade 1 students was parental interest in classroom activities. Teacher B heard from parents that some of her students began to transfer this knowledge to the home environment, as the students were "lotioning hurts" at home. Teacher D noted that the T.L.C. program was a great way to start off the day. She commented that

"the program makes you set time aside for very important topics that may not get accomplished as successfully in other parts of the day when there is so much curriculum to cover!" Teacher D liked that fact that the program was very inclusive, as "all children can excel in this program whether they are the brightest or weakest student". She liked that the program "builds a sense of community". Teacher D added that "it was interesting to watch all the students in such a unique setting. Some children behaved in ways that surprised me (e.g., girls hugging boys, students feeding each other with no complaints about who they had to feed)." When asked what teachers found to be the most useful, Teacher A liked the common language and Teacher B liked the "lotioning of the hurts" activity.

Discipline techniques.

Teachers were asked whether the T.L.C. program influenced the use of any of their respective discipline techniques. Teacher A said "No – the program probably didn't run long enough for this particular class. They were a tough group with lots of emotional problems." Teacher C felt that the T.L. C. concepts influenced her use of verbal reprimands and her method of resolving problems between the children. "I am more aware of the feelings involved and if the victim is feeling secure at the end of the dispute. I also now bring it to the attention of the child that is giving hurts in a more clear and concise manner." Teacher D also felt that T.L.C. influenced the use of verbal reprimands. She indicated that verbally she could use the language from T.L.C. to remind the children about appropriate actions. Teacher B felt that the use of the program influenced her use of verbal reprimands and time-outs but did not provide any explanation as to why this was

the case. None of the teachers felt that T.L.C. affected their use of the following discipline techniques: phone calls to parents/guardians, trips to office, or suspension.

Overall teacher ratings.

All four teachers indicated that their overall experience in the T.L.C. program was "very positive". Teacher B added that is was an "enriching experience, as well as rewarding". Teacher D added that "it was a great experience to work side by side with school clinicians in the classroom". When asked to indicate the reason for choosing to participate in the T.L.C. program, Teacher A explained that many children have social-emotional problems. Teacher B indicated that she thought it was a good program to offer all students for developing social skills. She also felt that her two Level II funded special needs children would benefit from the program. Teacher C felt that the program was targeting skills in which her class was weak. Teacher D reported that during the orientation meeting, there were a handful of kids that immediately popped into her mind, who would really benefit from the T.L.C. program.

When asked if the T.L.C. program met their original expectations, Teachers B, C, and D said yes ("Absolutely and more…", "the people involved were great", "the children looked forward to T.L.C. every week"). However, Teacher A indicated that the program would have to run a lot longer to meet her expectations. All four teachers rated their overall experience of participating in the T.L.C. program as being positive ("very positive", "excellent", "very good", "A ++"). Teacher D added that "the children reacted and responded very well to the program and that she referred back to the program in other parts of the day (e.g., taking care of each other)."

Did the T.L.C. program achieve sustainability?.

All four teachers indicated that they planned to continue to incorporate theraplay activities into their class routine in the future. More specifically, Teacher C wanted to begin the T.L.C. program with her new class in the fall. Teacher B said she would be incorporating the "lotioning of the hurts" into her regular classroom routine. Teacher D said she planned to use some of the activities on a regular basis, such as "cotton ball throw", "lotioning", "feeding", "tunnel", "peanut butter-jelly", and "funny faces or noises". Teacher A indicated that she would continue to use the "theraplay language" (i.e., "What do you need to make it better?"; "no hurts allowed") more than any specific "theraplay activities", with the exception of lotioning. Some teachers reported that they already modeled the theraplay language in the classroom, outside of the program time thus further reinforcement opportunities for their students.

All four teachers said they would participate in the T.L.C. program in the future and Teacher A added that she believed "children need positive role models from other adults, not just the teacher". All teachers also added that they would be interested in participating in any kind of early years prevention program in the future. Teacher A added "the more input from other professionals with certain areas of expertise, the better."

Program Impact or Effectiveness - Did the T.L.C. Program Increase Empathy and Self-control?

The Classroom Characteristics Questionnaires, the T.L.C. Program Evaluations, and the Individual Student Ratings were analyzed to determine the effectiveness of the T.L.C. program for increasing empathy and self-control in children.

Classroom Characteristics Questionnaire

Teachers were asked to indicate which, if any, students benefited from the T.L.C. program (i.e., those with social/emotional problems, academic/cognitive problems, attention/behavioural problems, or family problems). Teachers B and C felt that those students with social/emotional problems or attention/behavioural problems benefited the most, although teacher B also felt that students with family problems benefited from the program. Teacher D felt that students experiencing any sort of difficulties benefited from T.L.C. None of the teachers stated that the program specifically benefited children with academic/cognitive problems. Teacher A commented that "it was too short to really tell". whether the program benefited any of the students.

T.L.C. Program Evaluation

Success indicators.

In the T.L.C. Program Evaluation, teachers were asked to rate the impact or outcomes of the program on their students (see Table 6). First, teachers were asked whether they thought the program was beneficial to their students and why. Teacher A felt that the program was beneficial for many of her kindergarten students. At the end of the school year, when a classmate died in a tragic car accident, she indicated that her students were using the theraplay language (i.e., they were very good at giving each other hugs in order to help the distraught children feel better). Teacher B felt that the program benefited her grade 1 students. She said that "the children were actively monitoring each others' attitudes and were freely expressing their assessment of the situation." (i.e., "That hurts", "That's not very caring"). Teacher C felt that the program benefited her students because not only did they learn a common language, they were able to express their

feelings, and then focus on problem solving (i.e., what do you need to do to make it better?). She also liked that it made children accept ownership when they had done something wrong. Teacher D commented that she thought the T.L.C. program benefited her students because there was a set time to let each and every student know that he or she was special. She also felt that her children learned different ways to nurture and care.

Teachers were asked to comment on any specific observable behaviours which may have indicated that their students benefited from the T.L.C. program. All of the teachers reported that they observed several indicators that their children had learned and integrated the theraplay language. All of the teachers overheard their students using the theraplay language in the classroom and also witnessed their children offering expressions of caring and affection. For example, Teacher A witnessed her children asking each other for a "hug or a handshake" (theraplay language) following a confrontation with a friend. She observed a kindergarten boy remark, "saying sorry isn't good enough, I need a hug." Teacher A commented that her students came to her for "lotioning of the hurts" throughout the day as a way to receive nurturing from an adult. Students also came to her to tell her about a "caring story." Teacher C reported that during the parent-teacher interview, a parent informed her that her child had been using the theraplay language and the "lotioning of the hurts" with her younger sibling at home. Teacher D believed that her children used the theraplay language and expressions of caring and affection because of her continued modeling in the classroom - "as a teacher, I am able to model some of the language in everyday situations". She felt that she would have witnessed even more of the T.L.C. behaviours if the program had started earlier in the year.

Teachers were asked to note any indicators that their students liked or disliked the T.L.C. program. All teachers indicated that their students were excited on days when the T.L.C. program occurred. Three teachers, B, C, and D, reported that their students asked for the program and talked about the program in class. Teacher C said that her students were disappointed that T.L.C. did not run all year long. Teacher D said that her children liked the program and looked forward to it every week. None of the students expressed dislike or made negative comments about the program. Teachers were also asked to comment on any additional spontaneous statements made by the children about the T.L.C. program. Comments included: "I love T.L.C.", "I like the games and the feeding and lotioning", "I like the feeding", "T.L.C. is fun". Teacher C said that many of her children wrote about T.L.C. in their journals. Two teachers, C and D, reported that when students were asked to give their best memory of the school year at the end of June, many stated that T.L.C. was their favourite memory. Teacher A also commented on parent feedback about the T.L.C. program. A parent volunteer who participated in a T.L.C. session indicated that she thought the program was a great idea.

Theraplay activities - empathy.

Teachers were asked which, if any, of the specific theraplay activities increased empathy and caring in their students (See Table 7). All teachers thought the "food sharing" and "lotioning of hurts" (nurturing activities) elicited caring in their students. Teachers A, B and D also believed that the opening and closing songs, "duck-duck-goose-hug", (activities that involved hugging or touching), "I see somebody special" (an activity in which compliments are given to children by their classmates), and "tunnel" (a trusting activity in which children form a tunnel for another child to pass through) elicited

caring in students. Teacher D also included "cotton ball throw" and "talking through a balloon" as activities which increased caring. Both of these activities require cooperation, gentleness, and trust. Teacher C liked the fact that there were activities that focused on demonstrating empathy rather than just "talking" about empathy.

Theraplay activities - self-control.

Teachers were also asked if, in their opinion, any of the theraplay activities increased self-control in their students (See Table 8). Teachers C and D believed that some of the theraplay activities increased self-control in their students: "food share", "cotton ball blow", and "talking through a balloon". Teacher B, C, and D all felt that "tunnel", an activity that requires cooperation, increased self-control in their students. Teacher A did not feel that any of the theraplay activities increased self-control, as she commented that "these did not help with self-control as I see it".

Individual Student Ratings

In addition to rating the overall effects of the T.L.C. program on the entire classroom, each teacher rated the behaviours of 6 randomly selected students in her class. Each teacher rated 3 students who were described as the most "troubled" students and 3 students who were described as "medium" students. Teachers filled out the Individual Student Rating both before and after the program. The rating scale was designed to guide teachers' observations to see if there was an increase in empathy and self-control after the completion of the program.

Teachers were asked to rate each student to indicate the frequency of behaviours that indicated empathy/lack of empathy and self-control/lack of self-control. Students were rated on a Lickert scale from: 1 (never), 2 (rarely), 3 (sometimes), 4 (frequently),

and 5 (always). Results were analyzed by calculating the average score between 1 to 5 for each of the four domains – empathy, lack of empathy, self-control, lack of self-control. For example, an average score of 4 on the empathy domain would indicated that the child was "frequently" observed doing empathic behaviours (i.e., expressing caring). The scores were then sorted by teacher (A, B, C, D) and by student category (medium, troubled) in order to make comparisons between groups. The average scores (ranging from 1 – 5) for 21 students are presented in Table 9. One teacher did not return the rating scales for her 3 "medium" students, therefore, those scores were omitted.

When the scores for each teacher were compared, a few trends were evident. The first trend indicted that there was no difference among teachers in the way that the students were rated. Before the T.L.C. program, all teachers rated their "medium" students as having more empathy and self-control than their "troubled" students. Overall, all teachers rated their "medium" students as having empathy, "sometimes", a lack of empathy "rarely", self-control "sometimes", and a lack of self-control "rarely". In contrast, teachers rated their "troubled" students as having empathy "rarely", a lack of empathy "sometimes", self-control "rarely", and a lack of self-control "sometimes-frequently".

A second overall trend was that all teachers rated their students as having made very few changes in empathy and self-control after the T.L.C. program. All teachers rated their "troubled" students as having the same levels of empathy and self-control both before and after the program. Overall, teachers also rated their "medium" students as having made very little changes after the program, however, there was a slight tendency for teachers to rate their "medium" students as having less empathy and less self-control

after the T.L.C. program. While these differences were minimal, all teachers reported that the "troubled" students stayed the same, but the "medium" students were worse.

Discussion

The primary purpose of this study was to evaluate the model of service delivery of the T.L.C. program, an early years classroom-based theraplay program. The secondary purpose of this study was to examine the effectiveness of classroom-based theraplay for increasing empathy and self-control in school-aged children. Four teachers provided detailed information about their opinions on the program model of service delivery (structure, design, content, strengths and weaknesses). Like social-emotional programs cited earlier, the T.L.C. program satisfied the requirements of an effective school-based program in that it was preventative (began at an early age), targeted multiple risk factors (emotional, social, behavioural), used a collaborative model (between school clinicians and classroom teachers), and became integrated into the classroom setting. Results from the T.L.C. Program Evaluation revealed that teachers valued the model of service delivery. Overall, teachers liked the design and structure of the program and they especially valued the collaborative model. Several indications suggesting some increases in empathy and self-control were found in the anecdotal reports in the Program Evaluation and in the pre and post-program teacher ratings of randomly selected students in the Individual Student Ratings. There were also a few reported indications that the T.L.C. program effects may be sustainable and generalizable to other classroom situations and to the children's home environments.

Effectiveness of Model of Service Delivery

The first part of this study examined teachers' perceptions and opinions about the model of service delivery of the T.L.C. program.

Early years prevention.

All teachers in the study recognized the need and importance for early years prevention programming, given the high numbers of children in their classrooms who were experiencing difficulties. The four participating teachers reported at least 5-7 children with social/emotional problems, academic/cognitive problems, attention/behavioural problems, and family problems. In this particular school, the children were exposed to multiple risk factors (individual, social, situational, and neighbourhood), that may be placing them at risk for behavioural and emotional problems (Sprott & Doob,1998). This is consistent with Michelle Borba's claim that many children are coming to school without the seven essential virtues of moral intelligence – empathy, conscience, self-control, respect, kindness, tolerance, and fairness (Borba, 2001). It is also consistent with reports that increasing numbers of children in schools today require psychological services (Drewes, 2001).

An interesting finding in this study was the teachers' perceptions about the supports available for dealing with these difficulties. All of the teachers estimated that they spent a minimum of 30 minutes – 1 hour of their teaching time per day dealing with these problems. Teachers also reported that their classes were "more challenging" than classes they had taught in the past. This observation of the teachers is consistent with other reports that the number of disruptive students is growing in North American schools (Clements & Sova, 2000). Despite their experiences of increasing numbers of

children with difficulties, all teachers felt that they had to deal with these problems on their own within the classroom setting. Teachers usually relied on verbal reprimands and time-outs and rarely used outside discipline options such as trips to the office or suspensions. Today, teachers are presented with the challenge of trying to cover the academic curriculum requirements in addition to providing children with the appropriate social/emotional and attention/behavioural supports. Given these demands, all teachers supported the need for primary prevention that targeted multiple risk factors.

Collaboration.

Based on research that shows the collaborative models to be effective, it was expected that teachers would rate collaboration with school clinicians and the guidance counselor as being favourable. This study found that teachers supported a collaborative model for implementing a classroom-based early years prevention program. All four teachers felt strongly that programs should be collaborative across several levels including: the school psychologist, school social worker, guidance counselor, and classroom teacher. While teachers believed that social-emotional learning was an important part of the curriculum, they did not want to be solely responsible for the planning and implementation of these programs. Teachers clearly stated that they did not want "extra effort" on their part. This is consistent with other findings that "the amount of time a teacher must spend outside the normal framework of her lessons should be minimal." (Pasi, 2001, p. 59). Teachers are increasingly asked to take on additional roles and responsibilities, sometimes with little support from school personnel (i.e., guidance counselors, paraprofessionals, and clinicians). There was a common theme in this

program evaluation, that teachers felt overwhelmed and stressed and wanted to receive support and acknowledgement from other professionals.

While teachers valued the input of clinicians in their classrooms, none of the teachers were interested in pre-packaged programs implemented by clinicians without the teachers' input or assistance. Many efforts in the past have violated this rule in which the discussions, planning, and implementation involved everyone but the classroom teacher (Curtis & Stollar, 1995). Teachers felt that if clinicians were to become part of the classroom interventions in the future, a collaborative model would be essential with both clinicians and teachers sharing responsibility for program planning and implementations.

Interestingly, given all of the behavioural, social, and emotional problems that exist in today's classrooms, three of the four participating teachers had never worked with a school psychologist or school social worker in the classroom environment. Most teachers had implemented programs (i.e., anger management) on their own or with the assistance of the school guidance counselor. The teachers had not received assistance from a school clinician in the areas of social/emotional, attention/behavioural, and family functioning, however, they had received academic classroom interventions from the speech and language pathologists for phonological awareness. Therefore, despite reports of high numbers of children with social/emotional or attention/behavioural difficulties, interventions from school clinicians tend to focus on academics.

Several additional strengths of the collaborative model were identified in this study. The collaborative classroom-based model was perceived to be both preventative and cost-effective in that it allowed more children to receive services. When clinicians were in the classroom, they observed children in their natural setting and identified

children at risk who might have gone unnoticed otherwise (i.e., the shy, withdrawn child who does not attract a great deal of attention). This was consistent with other reports that indicated that the changing role of the school psychologist might be necessary to meet the new demands of larger caseloads (Reschley & Ysseldyke, 1995). Involving the school clinicians in the implementation of early years prevention programs is cost-effective, as it allows more children to receive services at an early stage. Having clinicians participate in classroom-based programs also allowed them to form strong relationships with many children over a short period of time. These relationships differed from the relationships that are normally formed during the traditional clinical pull-out model. Other successful elementary programs designed to enhance social, emotional, intellectual, and ethical development, focus on building supportive relationships (Schaps & Lewis, 1999).

Another advantage of the collaborative model that was identified in this study, was the strengthening of relationships among the members of the school support team. During the program implementation, the school clinicians worked closely with the school support team and the classroom teachers, forming close relationships and bonds. Teachers reported that they felt supported and they appreciated working together with clinicians to manage children's behaviour in a natural setting. It must be noted that the collaborative model of this program was successful due to the support from the administration. The administrative support is crucial, as it sets the tone for the school climate. "Leaders convinced of the importance of SEL must act upon their commitment by giving teachers the necessary tools and time as well as giving moral support through public encouragement and recognition." (Brandt, 1999. p. 178). The T.L.C. program

received assistance from the administration in the form of funding for supplies, extra clinical time (from the grant money), extra time for teachers, and moral support.

Another purpose of the T.L.C. program was to implement an effective intervention that could be sustained or carried out by teachers after their program had ended. The collaborative model appeared to be effective for increasing teacher ownership and program sustainability. By phasing out the role of the clinician, encouraging active teacher participation, and providing teachers with training and materials, it was hoped that teachers would increase ownership and continue the program after the 8 week period. Clinicians also modeled theraplay language and positive discipline techniques in a classroom setting. All teachers indicated that they planned to continue using some of the theraplay language and activities in the future. Other programs such as the Child Development Project have realized the importance of collaboration, in that a program should not merely be "put into place" in classrooms but that teacher's attitudes must be affected (Schapps & Lewis, 1999). Thus, using a program model of collaboration has the additional benefit of encouraging teachers to be actively involved from idea generation to program delivery.

Theraplay.

As part of the evaluation of the model of service delivery, teachers responded to questions about the strengths, benefits, weaknesses, and challenges of the T.L.C program. All four teachers rated their overall experience of participating in the T.L.C. program as being extremely positive and all said that they would participate in the T.L.C. program or any other early years prevention program in the future. All teachers liked the format and structure of each T.L.C. session and found the sessions developmentally appropriate for

their class and easy to follow. While each teacher seemed to have different favourite activities, the preferred activities seemed to be the most highly nurturing activities – lotioning of the hurts and food share. A commonly reported benefit was the use of theraplay language to identify feelings and solve problems. Teachers believed that this language was also transferred into different situations (i.e., when conflicts occurred on the playground) and in different environments (the children's homes, as reported by parents). Teachers found the program to be inclusive, allowing all children to experience success and building a sense of community. In general, three out of four teachers reported that the T.L.C. program benefited students who experienced social/emotional or attention/behavioural problems. However, they were less likely to see the benefits of the program for children with academic difficulties, despite research that has found these children to be at risk for developing other difficulties.

While there were a few suggestions for changes in the program design and structure, most of these suggestions were minor (i.e., location, timing etc.). Two teachers found discipline problems to be a challenge, as there was sometimes confusion as to whether the facilitator or the teacher was in charge. It would be helpful if future programs address this issue in the beginning stages of the program implementation to assure teachers that they always remain in charge of their classrooms. Other challenges included scheduling conflicts and preferences for a larger space. Scheduling difficulties present a considerable obstacle when trying to coordinate clinicians' and teachers' schedules, however, it is hoped that the benefits of collaboration outweigh the obstacles of trying to find common times to work together. While a larger space such as a gym would provide more room for children to move around for the very "active" theraplay activities, there is

an advantage to using the classroom for interventions. The classroom becomes strongly associated with the program goals (empathy and self-control) and helps to create a positive classroom climate within the context that children learn. Many of the most successful social-emotional learning programs occur in the classroom context.

Program Impact or Effectiveness

Another goal of this program study was to determine whether classroom-based theraplay was an effective intervention for increasing empathy and self control in young children. It was expected that because theraplay addressed some of the basic needs of children, such as nurturing and structure, there would be an increase in empathy and self-control. While there were some anecdotal findings to suggest that theraplay is effective, these results are qualitative and should therefore be interpreted with caution. While most teachers reported that the T.L.C. program met their original expectations, the findings on program effectiveness were mixed. Most reports seemed to support the effectiveness of the T.L.C. program for increasing empathy, however, there was not as much support for increasing self-control.

Empathy.

Teachers rated several of the theraplay activities as being effective for increasing empathy in their students. All teachers thought the nurturing activities of theraplay, "food share" and "lotioning of the hurts", elicited caring in their students. Teachers believed that theraplay taught caring and empathy experientially by actually doing activities rather than trying to teach children through lessons. One teacher commented that the theraplay activities focused on "experiencing" empathy rather than just "talking" about empathy. This is consistent with other reports that play helps children become more aware of their

emotions and learn to share the feelings and emotions of others (empathy) (Sayeed & Guerin, 2000). Each teacher chose different activities which they felt elicited caring and empathy in students, such as activities in which children must touch (i.e., hugs), give compliments, or trust the other students (i.e., "tunnel"). Teachers also commented that the T.L.C. program built a sense of community and increased feelings of belongingness for all children in the class. All children were included and "stuck together" as a group. A sense of belonging or community has been linked to increased concern for others, pro-social conflict resolution skills, altruistic behaviour, intrinsic pro-social motivation, enjoyment of helping others to learn, and positive interpersonal behaviour in class (Schaps, 1998).

All of the teachers were able to give specific examples of observations of children using the T.L.C. language, activities, and expressions of caring and affection in different settings and contexts, suggesting an increase in empathy. One of the benefits of the T.L.C. program that teachers cited was that the children "developed a common language". This common language was especially useful to help children express their feelings and understand the feelings of their classmates. Teachers noted that the children seemed more perceptive of others' feelings and that they learned new ways to nurture and care for classmates (i.e., hugs or handshakes). For example, one teacher reported that the children used the theraplay language to help other students cope with the tragic loss of one of their classmates. Teachers reported that children used the theraplay language outside the program, as there were several reports that students were beginning to transfer their T.L.C. language into the home environment.

The results from the 21 randomly selected students ("medium", "troubled") did not reveal any increases in empathy after the completion of the T.L.C. program. Teachers rated the "troubled" students as being the same (lacking empathy) both before and after the program. This is likely due to the fact that the program was short in duration and the teachers were not likely to rate these students as having made drastic improvements in empathy. While the teachers rated the "medium" students as having similar levels of empathy, in most instances, the teachers rated these students as having slightly less empathy after the T.L.C. program. This may be in part due to the teachers' heightened awareness about empathic behaviours in the "medium" children. It is likely that the teachers did not focus on the "medium" children before the study as much as the "troubled" children. Completing the rating scales may have increased their observations and awareness of the "medium" children's behaviours, causing them to look at the children from a different perspective. It is also possible that the tendency for the "medium" children to be rated as less empathic may be due to measurement errors, as the Individual Student Rating scale was not a statistically reliable or valid scale.

Self-control.

The relationship between theraplay activities and self-control was less clear. While three of the teachers believed that theraplay activities increased self-control in their students, one teacher did not feel that any of the activities increased her students' abilities to practice self-control. The activities that reportedly increased self-control had high elements of structure and group cooperation (i.e., forming a tunnel so students could crawl through). While the teachers reported that the children appeared to benefit from the

theraplay activities, it is difficult to say whether theraplay had a direct impact on increasing self-control.

Overall, teachers were less likely to report specific examples of behaviours which indicated increased self-control (i.e., the ability to restrain impulses). While teachers reported that children demonstrated some self-control within the structure of the theraplay sessions, they did not feel that the children internalized self-control, demonstrating it in other contexts (i.e., managing their impulses in a classroom setting). However, teachers did report some examples in which students demonstrated self-control in their social interactions with other students (i.e., taking turns, delaying gratification, engaging in positive social interactions). For example, teachers reported that several students were observed using the theraplay language for problem solving, mediating, and solving conflicts (e.g., "Do you need a hug or a handshake?"). Teachers reported that the theraplay language helped the children develop social skills and problem solving skills around relationships and real-life social situations. Therefore, while theraplay may not have directly increased self-control (i.e., calming self down, behaving appropriately), it is felt that it provided children with some beginning skills (i.e., teamwork, cooperation, turn taking, problem solving) which are important for developing both self-control and social skills. Thus, the children demonstrated the development of a foundation of social skills or emotional intelligence, as defined by Salovey & Mayer (1990), Goleman (1995), and Borba (2001).

There are several extraneous factors which may have affected the teachers' reports of self-control such as individual student differences (i.e., attention/behavioural difficulties) and different teaching styles/perceptions. Some children may have individual

personal factors (i.e., Attention-Deficit/Hyperactivity Disorder) which may make it difficult for then to make noticeable gains in self-control. Different teaching styles and perceptions may also affect observations and reports about children's self-control. Given the high number of reported attention/behaviour and social/emotional difficulties and the large amount of time that teachers spent dealing with these difficulties, it is likely that teachers were more focused on "lack of self-control". While play has been documented as important for child development, teachers may have more difficulty believing that play can "improve" children's behaviour or increase self-control. In contrast, teachers were easily able to see how the nurturing theraplay activities increased empathy.

The results from the 21 randomly selected students ("medium", "troubled") did not reveal any increases in self-control after the completion of the T.L.C. program for either the "troubled" or the "medium" students. Teachers rated the "troubled" students as being the same (lacking self-control) both before and after the program. This is likely due to the fact that the program was short in duration and the teachers were not likely to rate these students as having made drastic improvements in their abilities to restrain their impulses. While the teachers rated the "medium" students as having similar levels of self-control before and after the program, contrary to what would be expected, the teachers rated many of the "medium" students as having less self-control after the T.L.C. program. Like the empathic behaviours, this may also be due to the teachers' heightened awareness and perceptions about self-control behaviours. Teachers may not have focused on the "medium" children's lack of self-control in the past, as much as the "troubled" children's lack of self-control. Completing the rating scales may have increased their awareness of

the "medium" children's behaviours and therefore, changed the teachers' perceptions of these children.

Program Successes: What We Learned from the T.L.C. Program

Perhaps one of the best "success indicators" for measuring the T.L.C. program, was the children's reaction to the program. All teachers reported that there were several indicators that their students liked the T.L.C. program and the students were excited on days when the program occurred. The children requested the program, talked about how they loved the program, and were disappointed when the program ended. Some children wrote about the program in their journals and mentioned it as a favourite memory of the school year. It is apparent that the children related to the developmentally appropriate play activities. They learned to nurture through hands-on concrete tasks (i.e., lotioning of the hurts), simple rules (i.e., "stick together") and a common language. This is consistent with other findings which have found play to be an effective intervention in schools (Beardsley & Harnett, 1998; Drewes, Carey, & Schaefer, 2001; Fopiano and Haynes, 2001). Therefore, it seems that the T.L.C. program was successful in increasing the interest of children in the area of social-emotional development. In order for children to benefit from a program, they must like a program. It is likely that if the program had been implemented in a traditional approach with lessons or talking, it would not have been as effective, given the young age of the children.

Limitations of the Present Study

While there were many indications that the T.L.C. program was successful, both the program and program evaluation study had several limitations. The following variables should be considered when interpreting the results of this study.

Program Limitations

As with the development of any new program, there are several recommendations for improvement. One limitation of the T.L.C. program was the time constraints. It is likely that, if the program had run longer than 8 weeks, students would have experienced more gains in empathy and self-control. As it was not feasible to increase the program length due to time constraints, several efforts were made to increase the likelihood of program sustainability (use of a collaborative model, training of teachers, activity booklets, follow-up sessions). Time constraints also may have affected the collaborative relationship between teachers and clinicians. While debriefing sessions occurred throughout the program, there was not always a consistent time after each session to debrief and discuss progress. It would be beneficial in the future to ensure that teachers remain an active part of the collaborative process throughout the program. It would also be beneficial for all teachers to get together to share ideas and increase communication.

While the T.L.C. program encouraged teacher participation, a limitation of this program was the lack of parental participation. Although the parents in this study were informed about the T.L.C. program and were invited to an orientation session, only three parents attended. For this particular school, encouraging parental involvement in school programs has been an ongoing challenge, due to the high needs of the community. In addition, there was limited time for clinicians and school personnel to actively recruit parents. However, parental involvement is important to increase the likelihood of program success and sustainability. Research has found that the most effective programs focus on increasing communication between home and schools (Clements & Sova, 2000). Family supports and resources are crucial for successful programs and programs that

achieve long-term results provide education, training and resources to families (Yoshikawa, 1994).

While theraplay was generally well accepted, there are a few potential challenges for using a therapeutic technique in a classroom setting. Some teachers may not understand the importance of "play", and therefore, may not find it a good use of academic teaching time. Some parents do not want "therapy" or "therapeutic interventions" for their children and they may object to having clinicians in the classroom due to the stigma of having the "psychologist" watching their child. Some parents and teachers may have objections or questions about the use of nurturing activities. Many people fear touching activities in times of "no touch" school policies, germs, and diseases. Therefore, implementing a therapeutic intervention in a classroom setting requires a certain comfort level and trust by parents and teachers.

These challenges have been found in other play therapy techniques that have been used in schools (Drewes, Carey, and Schaefer, 2001). Drewes et al., suggested that clinicians must advocate for play therapy programs and may need to change the program name to reduce the stigma associated with "therapy" (i.e., play development). They suggested explaining the program in concrete terms to help school personnel and parents better understand what the program offers and what play therapy can realistically accomplish. (i.e., what the program is, how it can help children, and how it fits into the school's educational objectives). Play is so important to use with children because it is their language – they are engaged and interested in the program.

Methodological Limitations

There are several variables that may have affected the implementation, evaluation, and interpretation of this study's results. Chambless and Hollon (1998) produced a set of methodological standards which they believe to be essential for effective treatment programs including: an experimental design that uses random assignment procedures, a well-documented treatment procedure, uniform therapist training, multi-method outcome measures demonstrating adequate reliability and validity, an assessment of effects at follow-up, and replication conducted by different investigators. However, in a recent review of aggression prevention programs, most programs failed to satisfy all of these criteria (Leff, Power, Manz, Costigan, & Nabors, 2001). While this study satisfied some of these criteria (random assignment, a well-documented treatment procedure, uniform therapist training), there were several limitations that may have affected the results of this study. This study is limited in its generalizability beyond the present sample due to several factors such as sample selection, the nature of the data collection, and facilitator effects.

Sample selection.

There were several limitations with respect to the sample used in this study. Although random selection was used to choose the 21 selected students, the school was not randomly selected, as it was chosen to be the recipient of the Early Behaviour Initiative grant by the school division. Because the sample (four teachers and their classes) was a convenience sample from a school division in Winnipeg, it cannot be assumed that this sample is a representative sample. Therefore, results from this study may have limited generalizability. Another limitation was the small sample size (4

teachers and 21 randomly selected students). There also was no control group to determine whether the changes in empathy and self-control were due to the program or due to other extraneous factors. While a larger sample with a control group would have provided more validity to the study, it was not feasible given the demands of running a classroom-based program. It must be noted that expectancy effects were not controlled for, as all teachers were active participants in the program and were aware of the desired program outcomes (increased empathy and self-control).

Data collection.

In this study, there were several extraneous variables (individual, home, and school) that could not have been controlled, and therefore, may have impacted the data. Changes in children's behaviour may have been influenced by personal or individual factors or home factors (i.e., chaotic home environments). While implementing classroom programs in a school setting has several advantages, it also has several disadvantages, as it is difficult to control for extraneous classroom variables such as differences in teachers' perceptions, and teaching and discipline styles. Given these extraneous variables, it is very difficult to establish cause-effect relationships in a school environment.

Another difficulty with data collection in this study was the conceptual and measurement problems that are inherent to the emotional intelligence construct (Pfeiffer, 2001). The concept of emotional intelligence grew out of broader conceptualizations of intelligence. While it is clear that we are in a changing society that places emphasis on social and emotional skills to succeed, there are some difficulties with the new concepts of emotional intelligence. There is some confusion in that different studies use different terminology (i.e., emotional intelligence, moral intelligence). This makes it difficult to

compare literature, replicate studies, and further knowledge in this area. Thus, there is a need for a clear, widely accepted definition of emotional intelligence in order to advance research in the area of social emotional educational programs. "It is suggested that emotional intelligence be tentatively viewed as a possible kind of intelligence, awaiting further theory, development, and validation." (Pfeiffer, 2001, p. 138)

Another difficulty in collecting data about emotional intelligence is the lack of valid and reliable measures of emotional intelligence (EI). "A major weakness with the existing EI research literature is the lack of scientifically sound, objective measures of the EI construct." (Pfeiffer, p. 6). Because the construct is still developing, the development of an emotional intelligence measure is still very new. "At this time, there is no brief, objective, theoretically grounded measure of EI that enjoys acceptable reliability or validity." (Pfeiffer, p. 141). "Unlike the many carefully developed cognitive ability measures, measures of EI are almost all based on self-report instruments, lack norms or a standardization group, and if measures exist at all, have unacceptable levels of internal consistency or stability." (Pfeiffer, p. 6).

In the present study, it was difficult to find appropriate measures for emotional intelligence (i.e., the constructs of empathy and self-control) in young children. As noted above, measures of emotional intelligence often consist of self-report which is not suitable for very young children. While other measures are available to provide quantitative data about children's behaviours (i.e., Conners' Teacher Rating scales, Achenbach's Child Behaviour Checklist), these measures are cumbersome, time consuming and do not offer relevant information specific to measuring the construct of emotional intelligence (i.e., empathy and self-control). Therefore, in this study, Michelle

Borba's conceptualization of empathy and self-control was used. While Borba's conceptualizations provided rich descriptions of these constructs, they were not operationally defined nor were they empirically tested. Thus, in this study, the measurement of empathy and self-control was mainly dependent on observations and checklists with limited reliability and validity. "Does early intervention work? The response would most likely be unanimously positive based upon experience and perception". (Mackenzie-Keating & Kysela, 1997, p. 22). While perceptions and observations provide detailed data about children's behaviours, they must be interpreted with caution. Future research is needed to determine reliable and valid instruments for measuring emotional intelligence in young children.

Another limitation of the data of this study was the inability to complete the kindergarten student observations due to the unfortunate tragic death of one of the students and the late time of year (June). Given the qualitative nature of this study, these pre and post-observational data would have been a valuable "snapshot" of the children's behaviours in the classroom.

Facilitator effects.

Another limitation is that the program facilitators may have unintentionally affected the findings of the study. All facilitators had a dual role in that they were active participants in the T.L.C program and they were also responsible for the data collection. Therefore, the program facilitators had a personal role or investment in the T.L.C. program that increased the risk of a "self-fulfilling" effect or a personal bias in which the facilitators influence the observation and/or the reporting of the results consistently with their expectations. Teachers may have had a tendency to report the program in a more

positive light because of their relationship with the facilitators, a phenomenon known as the "halo effect". Although efforts were made to encourage teachers to respond honestly, these factors should be considered when interpreting the findings.

Future Plans for Practice and Research

Several interesting findings and suggestions should be considered for future implementation of classroom-based emotional intelligence programs. Overall, teachers supported the need for early years prevention programming in emotional intelligence, given the high numbers of difficulties found in their classrooms. Since the collaborative model was viewed as successful, future programs should ensure that teachers are active participants in the entire process from start to finish. In future efforts, the inclusion of other school personnel (i.e., paraprofessionals) would also be desirable whenever possible. Future programs should try to increase parent involvement using creative methods such as: offering a personal invitation to participate in a T.L.C. session, going to parents' homes to explain the program, using parent-teacher interviews to promote the program, sending out newsletters, or providing more enticing orientations (i.e., BBQ's). Program facilitators may also have success with adding a few T.L.C. sessions to pre-existing school programs that have experienced success with families in the community (i.e., the F.A.S.T. program – Families and Schools Together).

Future classroom-based programs may have more impact and program sustainability if the entire school adopts a common theme around emotional intelligence. For example, next year, this particular school has decided to integrate emotional intelligence into the k-8 curriculum by implementing a school-wide "empathy" theme. All staff will receive professional development training in the theories of moral and

emotional intelligence. Extra time will be allotted during each school day and there will be special school-wide events such as assemblies to celebrate the theme. Adopting a school-wide theme increases the likelihood that social emotional training becomes part of the daily school curriculum. Having the them for all grades will also increase the likelihood of sustainability, as the children grow older.

There is an advantage to running emotional intelligence programs within the classroom setting, therefore future programs should take place in the classroom whenever possible. The classroom environment becomes strongly associated with the program goals (i.e., empathy and self-control) and helps to create a positive classroom climate within the context that children learn. While classroom and school-wide programs have the benefit of impacting large numbers of children, there will usually be some children with challenging behaviours or social/emotional difficulties that require more intense therapeutic services above and beyond the classroom intervention. Future programs may want to have clinicians running small groups for the children with the highest-level needs. Thus, children receive small group or individual interventions from clinicians but would also have the benefit of experiencing the program in the context of their classroom.

There are several considerations for future research in the area of classroom-based programs in emotional intelligence. While theraplay has long been used as an individual intervention, there is a need for quantitative data on the effectiveness of theraplay as a classroom-based intervention. There is also a need for longitudinal research on the lasting effects of social-emotional programming that begins in elementary school. Future studies

involving comparisons of the relative effectiveness of several different programs on social and emotional education are warranted.

Conclusion

Given the increasing numbers of students who have behavioural, emotional, and social difficulties, many education systems have expanded their mandate to include social-emotional programming. The T.L.C. program was successfully implemented as a classroom-based theraplay intervention for increasing empathy and self-control in early elementary school age children. The T.L.C. program, like other successful models of effective programs was preventative (began at an early age) and targeted multiple risk factors. The T.L.C. program has been found to be effective for (a) successfully implementing a collaborative model between school clinicians and classroom teachers for classroom-based interventions (b) providing children of diverse backgrounds with a developmentally appropriate intervention to teach the basic concepts of emotional intelligence (i.e., empathy and self-control) (c) providing school personnel and children with a common language to express their feelings and solve interpersonal conflicts (d) providing appropriate supports to teachers (i.e., training, materials) to ensure program sustainability. Therefore, the program appeared to benefit school teachers, support staff, school clinicians, and children with different needs (i.e., academic, behavioural, social/emotional).

The results of this study suggested that there are several factors that can increase the effectiveness of school-based programs. An effective model of service delivery should be preventative and collaborative. The present study found that teachers have had limited opportunities to work with clinicians in a classroom setting. Given the increase in

childhood difficulties, there is an increased recognition of the usefulness of including school clinicians in classroom-based programs, as there is a need for programs to be carried out by well-trained mental health professionals (Fopiano & Haynes, 2001). It is hoped that the present study will support the argument for shifting the school psychologist's primary role from that of individual interventions (i.e., assessment) to include classroom-based interventions. There are several advantages to having school clinicians use classroom-based vs. traditional models of service: teachers value their input, clinicians can reach more children, and classroom-based interventions are preventative rather than reactive.

In conclusion, this study increased the awareness of school personnel of the need for social–emotional education in a school setting. It is hoped that all schools will one day focus on making social-emotional teaching an integral part of the curriculum. Our changing society requires a change in the way that we offer supports for children. It can no longer be assumed that children will learn emotional or social intelligence from families and communities, as they may have in the past. All school personnel should play an important role in advocating for emotional intelligence to become part of the school culture and curriculum. To create change in schools, teachers, counselors, psychologists, school administrators, parents and students must work together.

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Appendix A

Attention Teachers
K-2

Do you have children in your classroom with these difficulties?

- No understanding of personal space
- No understanding of personal feelings
- Use of inappropriate language
- Lack of caring for others
- No respect for others
- No self-control

You may need the T.L.C. program.....

Teaching and Learning to Care
(T.L.C.)

The T.L.C. program involves the use of Theraplay techniques. These techniques are fun, game-like activities, facilitated and controlled by adults. The activities promote increased self-awareness, empathy, self-control, and self-confidence in children.

To help you learn more about the T.L.C. program, a special presentation has been arranged for January 9th, 2002 at 11:00 a.m. (coverage provided). See you there!

Appendix B

Classroom Characteristics Questionnaire
T.L.C. (Teaching and Learning to Care)

The following questions are designed to get an overview of all of the students in your classroom.

Estimate of the number of students in your classroom that have:

Social/Emotional problems	1-2	3-4	5-6	more than 7
Academic/Cognitive problems	1-2	3-4	5-6	more than 7
Attention /Behavioural problems	1-2	3-4	5-6	more than 7
Family Problems	1-2	3-4	5-6	more than 7

How does your current class compare to other classes you have taught in the past?

____ Much more challenging
____ Somewhat more challenging
____ The same
____ Somewhat easier
____ Much easier

Explain:

Give a rough estimate of the amount of your teaching time required to deal with these problems each day.

Note: not including the time the students spend with a para

Social/Emotional problems

Less than 30 minutes
30-40 minutes
40-50 minutes
60 + minutes
Other_____

Attention/Behavioural problems

Less than 30 minutes
30-40 minutes
40-50 minutes
60 + minutes
Other_____

Indicate how often the following discipline techniques are used with your students.

Verbal reprimands

5=Always *4= Frequently* *3= Sometimes* *2=Rarely* *1=Never*

Time outs

5=Always *4= Frequently* *3= Sometimes* *2=Rarely* *1=Never*

Phone calls to parent/guardian

5=Always *4= Frequently* *3= Sometimes* *2=Rarely* *1=Never*

Trips to office

5=Always *4= Frequently* *3= Sometimes* *2=Rarely* *1=Never*

Suspension

5=Always *4= Frequently* *3= Sometimes* *2=Rarely* *1=Never*

Other:

Appendix C

Individual Student Rating
T.L.C. (Teaching and Learning to Care)

Student_____

Grade _____

The following questions are designed to get a description of a specific student in your classroom. Try to answer the questions to the best of your knowledge.

My student listens to others when they are talking.

5=Always 4= Frequently 3= Sometimes 2=Rarely 1=Never

My student has difficulty waiting for something or taking turns.

5=Always 4= Frequently 3= Sometimes 2=Rarely 1=Never

My student expresses caring towards others (i.e. affection, smiling, concern, kindness).

5=Always 4= Frequently 3= Sometimes 2=Rarely 1=Never

My student is in control of his or her emotions (i.e. even-tempered).

5=Always 4= Frequently 3= Sometimes 2=Rarely 1=Never

My student excludes other students.

5=Always 4= Frequently 3= Sometimes 2=Rarely 1=Never

My student can be cruel to others.

5=Always 4= Frequently 3= Sometimes 2=Rarely 1=Never

My student waits for others to finish speaking before he or she speaks.

5=Always 4= Frequently 3= Sometimes 2=Rarely 1=Never

My student behaves appropriately with little adult help.

5=Always 4= Frequently 3= Sometimes 2=Rarely 1=Never

My student uses verbal put downs/criticizes others.

5=Always 4= Frequently 3= Sometimes 2=Rarely 1=Never

My student has a difficult time calming down when excited, frustrated, or angry.

5=Always 4= Frequently 3= Sometimes 2=Rarely 1=Never

My student praises and compliments others.

5=Always 4= Frequently 3= Sometimes 2=Rarely 1=Never

My student ignores others when they are talking.

5=Always 4= Frequently 3= Sometimes 2=Rarely 1=Never

My student encourages others to participate or belong.

5=Always 4= Frequently 3= Sometimes 2=Rarely 1=Never

My student seems oblivious to others' non-verbal cues (gestures, body language, facial expressions, tone of voice).

5=Always 4= Frequently 3= Sometimes 2=Rarely 1=Never

My student shows she/he understands another person's feelings.

5=Always 4= Frequently 3= Sometimes 2=Rarely 1=Never

My student loses control of his or her emotions quickly (i.e. physical aggression, outbursts, tantrums).

5=Always 4= Frequently 3= Sometimes 2=Rarely 1=Never

My student has positive interactions with others (i.e. shares, cooperates, gets along).

5=Always 4= Frequently 3= Sometimes 2=Rarely 1=Never

My student acts concerned when someone is hurt or treated unfairly.

5=Always 4= Frequently 3= Sometimes 2=Rarely 1=Never

My student speaks out of turn (i.e. interrupts others, blurts out in class).

5=Always 4= Frequently 3= Sometimes 2=Rarely 1=Never

My student needs reminders, coaxing, or reprimands to behave appropriately.

5=Always 4= Frequently 3= Sometimes 2=Rarely 1=Never

My student readily picks up others' non-verbal cues (gestures, body language, facial expressions, tone of voice).

5=Always 4= Frequently 3= Sometimes 2=Rarely 1=Never

My student can be indifferent towards others.

5=Always *4= Frequently* *3= Sometimes* *2=Rarely* *1=Never*

My student has the ability to wait for something and takes turns.

5=Always *4= Frequently* *3= Sometimes* *2=Rarely* *1=Never*

My student seems unaware of others' feelings.

5=Always *4= Frequently* *3= Sometimes* *2=Rarely* *1=Never*

My student has negative interactions with others (doesn't share, is uncooperative, has conflicts).

5=Always *4= Frequently* *3= Sometimes* *2=Rarely* *1=Never*

My student calms down easily when excited, frustrated, or angry.

5=Always *4= Frequently* *3= Sometimes* *2=Rarely* *1=Never*

My student seems unconcerned or indifferent when someone is hurt or treated unfairly.

5=Always *4= Frequently* *3= Sometimes* *2=Rarely* *1=Never*

Please indicate if this student has any of the following:

_____Social/Emotional problems
_____Academic/Cognitive problems
_____Attention /Behavioural problems
_____Family Problems

How does this student compare to other students you have taught in the past?

____ Much more challenging
____Somewhat more challenging
____The same
____Somewhat easier
____Much easier

Scoring:

Empathy = (items # 1, 3, 11, 13, 15, 17, 18, 21)
Lack of Empathy = (items # 5, 6, 9, 12, 14, 22, 24, 25, 27)
Self-control = (items # 4, 7, 8, 23, 26)
Lack of Self-control = (items # 2, 10, 16, 19, 20)

Appendix D

T.L.C. (Teaching and Learning to Care)
Program Evaluation

Teacher_____

Have you ever participated in an early years prevention program in the classroom before?

____ Yes
____ No

If yes, what program(s):

Program_____
Date_____

Have you ever worked with school clinicians in the classroom in the past?

____ Yes
____ No

If yes, which clinician(s) have you worked with?

_____ Social worker
_____ Psychologist
_____ Speech and language pathologist

If yes, what kinds of activities/programs were implemented in the classroom?

_____ Anger management
_____ Teasing/Bullying
_____ Social Skills Training (respect, kindness, tolerance)
_____ Morals/Conscience
_____ Feelings (empathy, caring)
_____ Problem Solving
_____ Conflict Resolution
_____ Health (physical/emotional)
_____ Social skills
_____ Other_____

Did your participation in these program(s) require:

_____ Extra effort
_____ Some extra effort
_____ No extra effort

How would you describe your overall experience?

Why did you choose to participate in the T.L.C. program?

Did you find participation in the T.L.C. program required:

_____ Extra effort
_____ Some extra effort
_____ No extra effort

How would you rate the amount of staff available for the program implementation:

_____ Adequate staff
_____ Not enough staff

How would you rate your involvement in the program *planning*:

_____ Wanted more input
_____ Just right
_____ Wanted less input

How would you rate your involvement in the program *implementation*:

_____ Wanted more input
_____ Just right
_____ Wanted less input

Do you think there is a role for clinicians in the classroom?

Yes _____
No _____

If no, why not?

If yes, what would this look like:

_____ Clinicians should be responsible for both program planning and implementation
_____ Clinicians should be responsible for program planning but both clinicians and teachers should implement the program
_____ Clinicians and teachers should be responsible for both program planning and implementation
_____ Clinicians should plan the program materials but teachers should implement the programs

Do you feel there is a need for early years prevention programs on social/emotional skills?

____ Yes
____ No

If no, why not?

If yes, who do you feel should be responsible for this kind of programming?

____ School Psychologist
____ School Social Worker
____ Guidance Counselor
____ Classroom Teacher
____ Combination of_____
Other _____

What format(s) do you feel would be the most effective?

____ Lessons addressing specific topics (i.e. anger management)
____ Lessons addressing general topics (i.e., physical, social, emotional well-being)
____ Units/ themes integrated into the curriculum
____ Special guest speakers
____ Small group work
____ Use of pre-existing lesson materials such as books, videos, plays, music
Other_____

Which, if any, topics would be of interest to you as a teacher for your classroom:

_____ Anger management
_____ Teasing/Bullying
_____ Social Skills Training (respect, kindness, tolerance)
_____ Morals/Conscience
_____ Feelings (empathy, caring)
_____ Problem Solving
_____ Conflict Resolution
Other_____

In your experience, what topics have your students been exposed to through the school (i.e. Guidance counselors, teachers, resource teachers, classroom resources)?

_____ Anger management
_____ Teasing/Bullying
_____ Social Skills Training (respect, kindness, tolerance)
_____ Morals/Conscience
_____ Feelings (empathy, caring)
_____ Problem Solving
_____ Conflict Resolution
Other_____

Is there currently a section of your curriculum devoted to health and well-being?

____ Emotional
____ Physical
____ Social
____ Behavioural

If no, why not?

Would you liked to see early years prevention become part of the curriculum?

____ Yes
____ No

If yes, in what areas:

____ Emotional
____ Physical
____ Social
____ Behavioural

What grade should this begin?

How often should the programming be implemented?

_____ Daily
_____ Weekly
_____ Monthly

Did you find the length of each 45-minute program session to be:

_____ Too long
_____ Just right
_____ Not long enough

How long should the program last:

_____ 8 weeks
_____ More than 8 weeks
_____ Less than 8 weeks

When is the best time of year to begin the program (i.e. what month)?

How would you rate the classroom facilities used for the program?

How would you rate the overall structure of each T.L.C. session?

Were the activities easy to for you to facilitate or follow along?

Which activities(s) did you like best and why?

_____ Lotioning of the Hurts
_____ Food Share
_____ Cotton ball throw
_____ Closing Song
_____ Tunnel
_____ Cotton ball tickles
_____ Funny face or noise
_____ Opening Song
_____ Motorboat Motorboat
_____ Peanut butter-Jelly
_____ Cotton ball blow
_____ Silly Bones
_____ Duck-Duck-Goose Hug
_____ Talking through a balloon
_____ I see somebody special

Which activities(s) did you dislike and why?

_____ Lotioning of the Hurts
_____ Food Share
_____ Cotton ball throw
_____ Closing Song
_____ Tunnel
_____ Cotton ball tickles
_____ Funny face or noise
_____ Opening Song
_____ Motorboat Motorboat
_____ Peanut butter-Jelly
_____ Cotton ball blow
_____ Silly Bones
_____ Duck-Duck-Goose Hug
_____ Talking through a balloon
_____ I see somebody special

Were the activities developmentally appropriate for your class?

_____ Yes
_____ No

If no, which activities were not appropriate?

What were some of the challenges in participating in the program?

_____ Extra time required
_____ Scheduling conflicts
_____ Discipline problems
_____ Difficulty for children making transitions between routines and T.LC.
Other _____

What, if anything, would you have done differently?

What were some of the benefits of participating in the T.L.C. program?

Did the T.L.C. program meet your original expectations?

How would you rate your overall experience in participating in the T.L.C. program?

Would you participate in the T.L.C. program in the future?

_____ Yes
_____ No

Why or why not?

Would you participate in another early years prevention program in the future?

Why or why not?

Do you plan to continue to incorporate theraplay activities into your class routine in the future?

_____ Yes
_____ No

If yes, which activities?

If no, why not?

_____ Don't have the time
_____ Don't feel they are beneficial
_____ Don't know how to carry them out without a facilitator
Other _____

Did you find participation in the program to be beneficial to your students? Please Explain.

Have you seen any of the following behaviours in your students that indicate they have incorporated some of the theraplay lessons:

_____ Using theraplay language in the classroom (i.e. "no hurts")
_____ Expressions of caring and affection (i.e. offering hugs, handshakes)
_____ Copying some of the theraplay activities (i.e. games, lotioning)

Comment on any other behaviours you have witnessed that you feel are related to the T.L.C. program.

Have you seen any indicators that your students liked/disliked the T.L.C. program?

____ Students asked for the program
____ Students talked about the program in class
____ Students asked to do some of the activities in class
____ Students seemed excited on days when T.L.C. program occurred
____ Students seemed disappointed that the program occurred
____ Students made negative comments about the program
____ Students seemed indifferent to the program
Other_____

Please comment on any statements made by children about the T.L.C. program:

Please comment on any feedback from parents about the T.L.C. program.

In your opinion, which, if any of the theraplay activities increased empathy and caring in your students?

_____ Food Share
_____ Cotton ball throw
_____ Closing Song
_____ Tunnel
_____ Cotton ball tickles
_____ Funny face or noise
_____ Opening Song
_____ Peanut butter-Jelly
_____ Cotton ball blow
_____ Silly Bones
_____ Duck-Duck-Goose Hug
_____ Talking through a balloon
_____ I see somebody special

In your opinion, which, if any of the theraplay activities increased self-control in your students?

_____ Food Share
_____ Cotton ball throw
_____ Closing Song
_____ Tunnel
_____ Cotton ball tickles
_____ Funny face or noise
_____ Opening Song
_____ Peanut butter-Jelly
_____ Cotton ball blow
_____ Silly Bones
_____ Duck-Duck-Goose Hug
_____ Talking through a balloon
_____ I see somebody special

Which students, if any, do you feel benefited the most? Those with:

_____ Social/Emotional problems
_____ Academic Cognitive problems
_____ Attention/Behavioural problems
_____ Family Problems
_____ No students benefited

Did you find participation in the program to be beneficial to you as a teacher?

If yes, what did you find the most useful?

Have the T.L.C. concepts influenced the use of the following discipline techniques?

_____ Verbal reprimands

_____ Time outs

_____ Phone calls to parent/guardian

_____ Trips to office

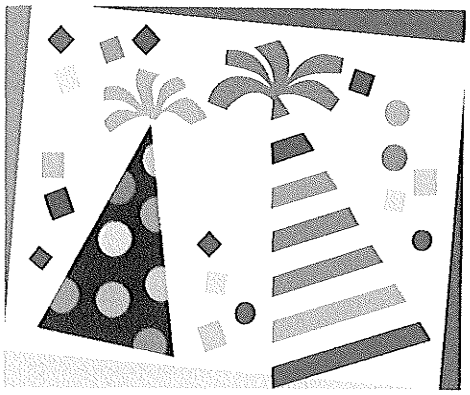
_____ Suspension

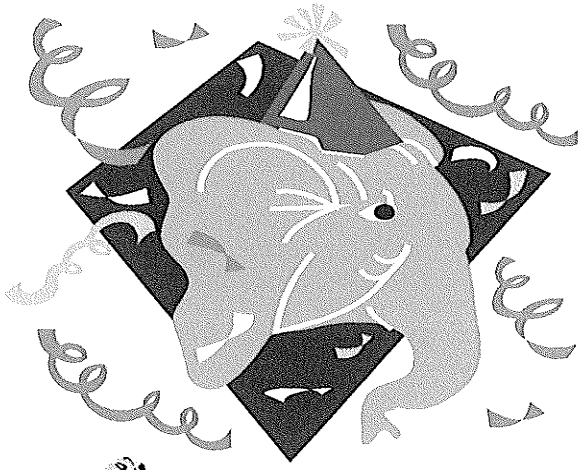
Explain.

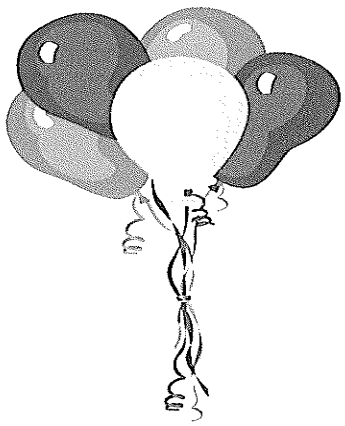
Appendix E

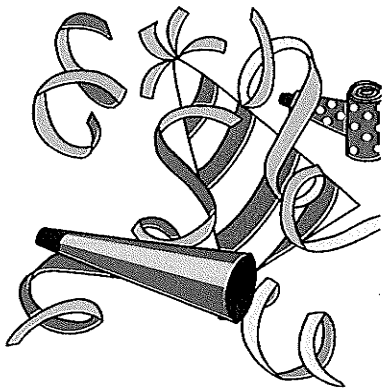
NO HURTS

STICK TOGETHER









HAVE FUN

T.L.C. Rules

"No hurts" - This rule reminds children that no one is to inflict injury on another, whether physical or verbal. If there is an incident in the classroom, it is immediately attended to by the facilitator. This rule helps to create a safe environment where everyone works together to prevent "hurts".

"Stick Together" – Stick together is a rule to remind children of the importance of the interdependence of group members. We "stick together", we include everyone, we help each other, and we listen when the facilitator is talking.

"Have Fun" - This rule sanctions the importance of adults and children having fun together. In theraplay, the adult is actively engaged in the fun activities (i.e., crawling on the floor etc.).

"The adult is in charge" – This is an unspoken rule which indicates that the facilitator is in always in charge.

The first three rules are shared with the children at the beginning of each session. Children also receive copies of the rules for their classroom. The last rule is shared with the teacher but is not stated explicitly to the children.

Appendix F

TEACHING AND LEARNING TO CARE (T. L. C.)

Theraplay Program Activities

Teaching and Learning to Care – T.L.C.

Theraplay Program Activities

PLANNING A THERAPLAY SESSION

Each Theraplay session is made up of activities, which have different combinations of the four Theraplay elements. The elements are:

- Nurturing
- Engagement
- Structure
- Challenge

Every Theraplay session includes:

- The "Welcome Song"
- An Introductory Activity (e.g., "Name game")
- Several Activities (appropriate to the developmental stages of your students which may become increasingly challenging over time)
- Feeding & Lotioning of the Hurts (the nurturing activities)
- The "Closing Song"

T.L.C. RULES

T.L.C. has three simple rules. They are:

1. **NO HURTS**
2. **STICK TOGETHER**
3. **HAVE FUN**

The rules are explained to the children at the beginning of the first T.L.C. session. They are reviewed each session to encourage good behaviour and so the children become familiar with the "Theraplay" language. Teachers will be provided with their own set of posters, which have the "TLC rules", to be placed on the classroom walls. Teachers are encouraged to use the three rules throughout the week to help the children internalize them.

The following is a compilation of Theraplay activities.

INTRODUCTORY ACTIVITIES

- **The Welcome Song**

"The More We Get Together"

The more we get together, together, together
The more we get together, the happier we'll be.
Cause your friends are my friends,
And my friends are your friends.
The more we get together, the happier we'll be.

- **Name Games**

While seated in a circle, each child is given a turn to introduce him or herself, allowing the child to be acknowledged. This can be done in a number of ways, depending on the age of the group. During introductions, each child must have a turn. Some of the withdrawn or shy children may need help with this activity. As children improve at this activity, more sophisticated introductions may be used to develop social interaction and communication skills. Some eye contact should be encouraged.

For younger children or in early sessions, a very simple introduction is used:

1. Each child in turn says: *"My name is* _____*."* Everyone in the group responds back: "*Hello*_____!"

2. Each child passes an object (i.e., ball or stuffed animal) around the circle and says his or her name along with something he or she likes: *"My name is* _____ *and I like* _____*."*

3. As children become more familiar with this activity, they may interact with their neighbour. "*Hello, my name is* _____*, (and passes object to next person).* The child who receives the object responds back: "*Thank you* _____".

Other possible introductions include:

1. Each child uses a "hand-shake" to say hello to his or her neighbours.
2. Each child rolls a ball across the circle to anyone else in the group and says: "*Hello*_____." The child receiving the ball says: "*Thank You* _____."

NURTURING ACTIVITIES

Nurturing activities are an important component of Theraplay. These activities are included in every session, as they give children the opportunity to be cared for and to care for one another and help develop empathy.

- **Lotioning of Hurts**

When first beginning this activity, the adults nurture the children. Later on, each child can check his or her neighbour for hurts and do the lotioning with adult supervision. For classroom purposes, we recommend lotioning hurts that are on hands. Children must be reminded not to rub lotion directly into an open cut or sore.

If there is more than one adult supervisor and the children are familiar with the activity, it may be easier to divide the group into two smaller groups. The activity will be quicker and children may not lose interest as easily.

To begin this activity, have all children sit in a circle. The facilitator goes around the circle to see if each child has any hurts to be "cared for".

The facilitator asks: "_____, *do you have any hurts today?"* If the child says *"yes"*, take a dab of lotion and rub a bit around the hurt.

Once this process has been completed, ask the child: "*Does that feel better?"*

Then, turn to the group and say: *"Hey everybody, _____feels better, let's give him a cheer.* The class joins in and cheers: *"Hip Hip Hooray!"*

If a child does not have a hurt, the group can give him a congratulatory cheer: *"Everybody, _____ does not have any hurts today, let's give him a cheer. "Hip Hip Hooray"!*

The child is given a choice, *"Do you want a hug or a handshake?"*

- **Food Share**

Preparation for Feeding Activity: Before starting the feeding activity, the children's hands are washed using a disinfectant hand cleanser.

To begin the feeding activity, the facilitator may want to feed each child first (a safe treat that children will not be allergic to, i.e., pretzels, raisins, chips, smarties).

Afterwards, each child feeds his or her neighbor a treat. A bowl is passed around and each child takes the treat in his or her fingers and feeds the child beside her. Each child

gets one treat per turn but if time permits, children may pass around the treat bowl one more time.

Very young children may need assistance or modeling to feed the treat into their neighbors mouth without eating it first! Eye contact and sharing should be promoted. During this activity, all children give and receive nurturing.

THERAPLAY GAMES

The following activities are suitable to use with the entire classroom. These activities promote a combination of engagement, structure, challenge, and nurturing for the children. It is important to encourage turn taking and to include each child every activity, whenever possible.

- **Mirroring Funny Faces and Noises**

The facilitator begins by making up a funny face or noise which she "passes" to her neighbor. Each child turns to his neighbor and "passes" the face around the circle until it has reached the end. Children should be encouraged to attend to the other person.

- **Peanut Butter-Jelly**

The facilitator always says "*Peanut Butter*" and the children always respond "*Jelly*" in the *same* voice used by the facilitator.

The facilitator should use a different voice each time (i.e. funny voices, high/low pitch, whisper etc.).

- **Cotton Ball Throw**

Children are divided into two groups and face each other in a line about 3 feet apart. All children get on their knees. Cotton balls are sprinkled in between the two groups.

When the facilitator says, *"GO"*, each line throws cotton balls to the other side as quickly as they can, so as not to be left with any on their side, when the facilitator yells, *"STOP."*

For a cooperative game, try getting children to play catch with a cotton ball.

- **Cotton Ball Tickles**

Children pair up. Each child is given a cotton ball. The children take turns touching each other gently on the face with a cotton ball.

- **Cotton Ball Blow**

Each child tries to blow a small cotton ball to another child. Children can lie on their stomachs, hold hands, or touch shoulders. This can be done as a cooperative game in which the children blow the cotton balls back and forth, or as a "letting off steam" approach where they try to keep the cotton balls away from themselves by blowing as hard as they can.

The children can also tell whom they are going to blow the cotton ball to: "*I'm going to send the cotton ball to* _____".

- **Duck, Duck,Goose-Hug**

(fashioned after Duck Duck Goose)

All children are seated in a circle. With smaller children, adults may need to stay outside the circle to direct the game.

A child walks around the outside of the circle until she selects someone by gently tapping her on the head or shoulders and saying, *"Goose!"* The child who is tapped, gets up and races the other child back to the empty spot.

While they race around the circle, the children must *hug* at the point they meet. The child who gets back to the spot first is seated and the child left standing repeats the process (chooses the next child.)

- **Tunnel Game**

Children form a long tunnel by getting up on their knees and hands (arching up) or standing with hands to hands with a partner. Begin at the end, giving each child a turn to pass underneath. When each child gets to the end of the tunnel, he or she rejoins with her partner so the tunnel is not broken. Keep going until every child has had a turn to pass through.

- **Mirroring**

The facilitator guides the group by doing different actions (no words) (i.e., hands on head, hands on shoulders, etc.), or Simon Says (for older children that can follow the pattern).

- **Silly Bones**

This game can be done with partners or as a circle game with the entire class. Children can pass around touches with an elbow, ear, etc., one at a time, to each neighbour until it gets back to the starter. As a group, everyone can try to touch each other at the same time. This is a more challenging activity for the older child.

- **Talking through a Balloon**

The facilitator begins this game by passing a phrase to the person seated beside her, through a balloon. This game is like telephone, except the phrase is said through a balloon. Each person in the circle is given a turn until all children have heard the phrase.

- **I See Somebody Special**

The children pass around a small box with a mirror inside. The facilitator tells each child to look inside the box and they will "*see someone very special.*" As the child is looking inside the box, the facilitator may say something special about each child:

For example: *"I see two beautiful eyes and a big wonderful smile".*

The other children will not know what is inside the box until it is their turn. The child is instructed to not tell the other children what is inside the box.

SONGS

Some activities may involve the use of songs.

- **Motor Boat, Motor Boat**

Children join hands in a circle and their movement mirrors the chanting:

Motor Boat, Motor Boat, goes so slow (walk slowly)
Motor boat, Motor boat step on the gas (start getting faster)
Motor boat, Motor boat goes so fast, (move fast)
Motor boat, Motor boat goes so slow (start to slow down)
Motor boat, Motor boat runs out of gas (fall to the floor)

- **Row, Row, Row, Your Boat**

Partners sit facing each other with legs straddling the other's legs and holding hands. One lies down and they take turns pulling each other up into a sitting position as they sing, *"Row-row-row your boat".*

- **"If you're Happy and You Know It"**

If you're happy and you know it clap your hands
If you're sad and you know it say "boo hoo".

If you're mad and you know it say "I'm mad"

If you're happy and you know it say "hooray".

- **Goodbye Song**

Each theraplay sessions usually ends with the same goodbye song. One commonly used song is "You are my Sunshine" but other short songs may be used.

Appendix G

Teaching and Learning to Care (T.L.C.)

Dear Teachers,

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

As part of an evaluation of the effectiveness of the Teaching and Learning to Care (T.L.C.) program, a questionnaire has been designed for thesis research. The first part of the questionnaire asks you to indicate whether you have noticed any changes in your students' behaviour. The second part of the questionnaire asks your opinions about the program delivery model. This information will be valuable in determining the success of the program and can be used to improve the design of future programs.

It is important to note that the names of the school division, school, teachers, and students, will ***not*** be used in the study. All of your responses will remain anonymous and your identity will only be known to the researcher. The children's identity will remain strictly confidential with the teachers and school clinicians.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal responsibilities.

Your participation in this research is voluntary, not mandatory. You are free to withdraw from the study at any time, and/or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

If you have any questions or concerns or wish to withdraw from the study, please do not hesitate to call myself, Cheryl Thorlakson at the school (633-5641), or my academic advisor, Dr. Riva Bartell (474-9048). After the study has been completed, all teachers will be provided with feedback.

This research has been approved by the Education/Nursing Research Ethics Board. If you have any concerns or complaints about this project you may contact any of the above-

named persons or the Human Ethics Secretariat at 474-7122. A copy of this consent form has been given to you to keep for your records and reference.

Teacher's Signature_____ Date_____

Researcher and/or Delegate's Signature_____

Date_____

Please provide the information below if you would like to receive feedback on this study:

Name:_____

Address:_____

_____

e-mail address:_____

Appendix H

Teaching and Learning to Care (T.L.C.)

Dear Parent (s):

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

As our earlier letter indicated, the school has recently put together a new program called Teaching and Learning to Care (T.L.C.), which is part of thesis research. The program includes fun activities designed to increase empathy, caring, and self-control in young children. The T.L.C. program has been developed for children in Kindergarten through grade 2 and is currently in your child's class during school hours once a week. It is being led by the classroom teacher along with the guidance counselor and/or Child Guidance Clinic Clinicians.

To evaluate the success of this program, we would like to include some observations of children's behaviour both before and after the program. These observations will only be used for the purposes of evaluation of the program. As the legal guardian of your child, we are asking permission to include your child in a program evaluation. Your child would be observed in his or her natural classroom setting while involved in play and daily classroom activities. Evaluators would be looking for behaviours that indicate empathy and self-control to see if the program has been effective. This information will be valuable in determining the success of the program and will be used to design future programs.

It is important to note that these observations will only be used to determine the success of the program. The children's identity will remain strictly confidential with the teachers and clinicians. No names will be used in the study.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to allow your child to participate as a subject. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal responsibilities. You are free to withdraw your child from the study at any time, without prejudice or consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation. Participation on this program evaluation is voluntary; it is not required by the school

If you have any questions or concerns or wish to withdraw your child from the study at any time, please do not hesitate to call myself, Cheryl Thorlakson at the school (633-5641), or my academic advisor, Dr. Riva Bartell (474-9048). After the study has been completed in June, all parents will be welcome to receive any feedback.

This research has been approved by the Education/Nursing Research Ethics Board. If you have any concerns or complaints about this project you may contact any of the above-named persons or the Human Ethics Secretariat at 474-7122. A copy of this consent form has been given to you to keep for your records and reference.

Parent's Signature_____ Date_____

Researcher and/or Delegate's Signature_____

Date_____

Please provide the information below if you would like to receive feedback on this study:

Name:_____

Address:_____

e-mail address:_____

Table 1

Classroom Characteristics: Estimated number of students that exhibited difficulties.

Teacher	Grade	Total	Gender		Area of Difficulty			
			Female	Male	Social/ emotional	Academic/ cognitive	Attentional/ behavioural	Family
A	K	23	14	9	7 +	7+	7+	7+
B	1	21	10	11	7+	7+	5-6	5-6
C	2	22	9	13	3-4	5-6	5-6	5-6
D	2/3	23	11	12	7+	7+	3-4	3-4

Note: the same students may be included in more than one category

Table 2

Model of service delivery: Teacher opinions

Theme	Sample of responses
Valued early years prevention	"There is a need for early years prevention programs on social skills." "Many children have social-emotional problems." "T.L.C is a good program to teach social skills." "It was targeting skills I felt my class was weak in." "Early years prevention should be part of the curriculum." "Programming should begin in kindergarten."
Limited experience working with clinicians in a classroom setting	None of the teachers, except one, had worked with clinicians in the classroom setting.
Valued collaboration with school clinicians in the classroom	"It was a great experience to work side by side with school clinicians in the classroom." "There is a role for clinicians in the classroom." "Both clinicians and teachers should be responsible for primary prevention."
Valued level of involvement	"My involvement in program planning and implementation was just right." "Adequate staff."

Table 3

Program Structure: Teacher opinions and preferences of program structure

Teacher	Program length	Program duration	Program frequency	Program start	Overall rating
A	45 min.	8+ sessions	Daily	September	"Good"
B	45 min.	8 sessions	Weekly	November	"Excellent"
C	45 min.	8 + sessions	Daily	September	"Very good"
D	45 min.	8 + sessions	Weekly	September	"Organized"

Table 4

Program challenges/weaknesses: Teacher ratings

Theme	Sample of responses
Space/facilities	Limited space for activities
Scheduling conflicts	"I would have preferred T.L.C. at the end of the day."
Discipline problems	"At first I was unaware of my position or role but it worked out quite quickly."
Difficulty with transitions	"T.L.C. had a party-like atmosphere so they did not want to settle down for their regular school work after it."
Timing	"Too short to meet expectations."

Table 5

Program strengths: Teacher ratings

Theme	Comments
Valued overall experience	"Very positive", "A++!" "Enriching experience, as well as rewarding"
Collaboration with clinicians	Provided positive role models Adequate staff for program implementation "Required no/little extra effort"
Modeling for teachers & and children	"Children see and experience what good touches and nurturing looks like." "Children need positive role models from other adults, not just the teacher."
Appreciated the activities	Developmentally appropriate
Builds routine	"A great way to start the day." "Makes you set time aside for important topics that may not get accomplished when there is so much curriculum to cover!"
Inclusive	"Builds a sense of community." "All children can excel in this program whether they are the brightest or the weakest student." "Gave all students "special" attention."
Provided a common language	"As a teacher I am able to model some of the language in everyday situations." "My children and I learned a common language to use when problems arose."
Children liked the program	"The children looked forward to T.L.C."
Parent interest	Parents reported students "lotioning" in the home environment "Parent volunteers who saw the program in action thought it was a good idea."
Future program sustainability	All four teachers indicated that they planned to continue to incorporate theraplay activities into their class routine in the future.

Table 6

Program success indicators: Teacher observations of children's behaviours which indicate increases of empathy and self-control

Theme	Comments/Examples
Children used the common language to express their feelings	"The children were actively monitoring each others' attitudes and were freely expressing their assessment of the situation." (i.e., "That hurts", "That's not very caring").
Children used the common language to express caring and affection towards others	When a classmate died in a tragic car accident, kindergarten students used the language to make the distraught children feel better.
Children used the common language to problem solve during conflicts	Children took ownership after wrongdoings "Kindergarten children were able to ask for what they needed to make themselves feel better." Children were observed asking each other for a "hug or a handshake" following a confrontation with a friend. Teacher commented that the children were able to focus on problem solving (i.e., what do you need to do to make it better?).
Children used the theraplay activities to express caring and nurturing	Lotioning of other students' hurts Requests for lotioning
Children used the theraplay activities outside of school to express caring and nurturing	Parents reported use of language and "lotioning of the hurts" at home.
Children liked the program	Students asked for the program and were excited on days when it occurred. Students talked about the program. Students said it was the best memory of the year.

Table 7

Program success indicators: Teachers' ratings of theraplay activities which increased empathy and caring in their students.

	Teachers			
	A	*B*	*C*	*D*
Activities				
Food share	x	x	x	x
Lotioning of hurts	x	x	x	x
Opening song	x	x		x
Closing song	x	x		x
Cotton ball throw				
Tunnel	x	x		
Cotton ball tickles				
Funny face/noise				
Peanut butter-jelly				
Cotton ball blow				x
Silly bones				
Duck-duck-goose-hug	x	x		x
Talking through a balloon				x
I see somebody special	x	x	x	x

Table 8

Program success indicators: Teachers' ratings of theraplay activities which increased self-control in their students.

	Teachers			
	A	*B*	*C*	*D*
Activities				
Food share			x	x
Lotioning of hurts				
Opening song				
Closing song				
Cotton ball throw				
Tunnel		x	x	
Cotton ball tickles				
Funny face/noise				
Peanut butter-jelly				
Cotton ball blow			x	x
Silly bones				
Duck-duck-goose-hug				
Talking through a balloon			x	x
I see somebody special				

Table 9

Individual Student Ratings: Teacher observations of empathy, lack of empathy, self-control, lack of self-control.

	Teachers							
	A		B		C		D	
	Med	Tr	Med	Tr	Med	Tr	Med	Tr
Empathy								
Before	3.4	2.9	NA	2.8	3.7	2.8	3.8	2.5
After	3.1	2.8	NA	3.0	3.3	2.8	3.2	2.6
Lack of empathy								
Before	2.4	3.1	NA	3.4	2.3	2.9	2.5	3.0
After	2.5	3.2	NA	3.6	2.7	3.1	2.7	3.0
Self-control								
Before	4.1	2.9	NA	2.7	3.5	2.5	3.5	2.7
After	3.6	3.3	NA	2.8	3.5	2.3	3.3	2.7
Lack of self-control								
Before	2.2	3.5	NA	3.7	2.6	3.8	2.7	3.3
After	2.3	3.0	NA	3.9	2.8	3.5	3.1	3.5