THE EFFECTIVENESS OF PEER MENTORING WITH HIGH SCHOOL STUDENT MENTORS AND CHILD MENTEES

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This randomized, controlled study examined the effectiveness of two mentoring programs, child mentor relationship training (CMRT) and peer assistance and leadership (PAL®), on high school mentor empathic behaviors and child mentee behavior problems. Participants were 60 young, at-risk students (61.7% male; 38.3% Hispanic/Latino/a, 31.7% Caucasian, 21.7% African American, 8.3% biracial) and 30 high school students (53.3% male; 66.7% Caucasian, 26.7% Hispanic/Latino/a, 0.03% African American, 0.03% Asian). Mentors and mentees were randomly assigned to CMRT or PAL®, which was treatment as usual in the participating school district. Results from 2 (group) by 2 (time) repeated measures ANOVAs indicated compared to the PAL® treatment group over time, mentors in the CMRT group demonstrated statistically significant improvement in empathic behaviors with a large treatment effect, as rated by independent observers. Analysis revealed a moderate treatment effect with CMRT group mentee behavior problems, but the difference was not statistically significant between treatment groups over time. Further analysis revealed the CMRT group demonstrated statistically significant reductions in behavior problems from pre- to post-test with a very large treatment effect. Overall, findings support CMRT as a promising school-based intervention for at-risk young children that potentially increases school counselor efficiency.

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THE EFFECTIVENESS OF PEER MENTORING WITH HIGH SCHOOL STUDENT MENTORS AND CHILD MENTEES

Introduction

School counseling program resources are limited and the need for direct student support services substantially outweighs time, personnel, and training resources available (American School Counselor Association [ASCA], 2012). In addition, there are a growing number of children who go untreated for mental health concerns (Center for Disease Control [CDC], 2013; Mental Health America, 2013; National Center for Children in Poverty [NCCP], 2014). This mounting crisis places school counselors in a critical role to ensure their responsive interventions meet the social and emotional needs of young school-aged children through approaches that are both effective and efficient (ASCA, 2012; Campbell & Dahir, 1997; Erford, 2015). The ASCA National Model tasked school counselors with responsibilities including designing and managing the delivery of efficacious responsive services to meet the needs of the school community (ASCA, 2012; Sink, 2011). Through a comprehensive school counseling program model, school counselors identify critically needed direct student services and orchestrate interventions to create a positive impact on student well-being.

Mentoring is one approach employed to address the growing need for student support services and maximize the limited resources available to school counselors (ASCA, 2016). Having used a nationally representative sample from a longitudinal public use database, Dubois and Silverthorn (2005) found late adolescent & young adult subjects who reported having a mentoring relationship as a child demonstrated statistically significant outcomes in domains of education and work, mental health, problem behaviors, and physical health as compared to a control group who did not have mentors as children. Results from experimental design research

in the field of school-based mentoring indicated that peer mentoring was effective in improving mentees' academic achievement and self-regulated learning strategies (Karcher, 2008; Nunez et al., 2013). Comprehensive reviews of existing school counseling outcome research concluded that school-based peer mentoring provided many benefits to mentors and mentees such as mentors' increased attendance, grades, attitude, classroom behaviors, social skills, and coping skills and mentees' improvement in socials skill, coping skills, and behavior problems (McGannon, Carey, & Dimmitt, 2005; Whiston & Sexton, 1998). Despite research showing beneficial outcomes, peer mentoring is underutilized programmatically in schools (DuBois & Karcher, 2005), particularly with young children.

One of the largest school-based peer mentoring programs currently in use in the United States is Peer Assistance and Leadership (PAL®; PAL, 2017). The PAL® program trains high school students to serve as mentors for children and offers credit towards high school graduation, but lacks published outcome research to support its effectiveness of peer mentoring on mentees. Mentor-adapted child parent relationship therapy (CPRT) is another promising peer mentoring program for young children that developed out of the well-researched and manualized CPRT (Landreth & Bratton, 2006) model. Derived from child-centered play therapy (CCPT) theory, CPRT facilitators train high school students to become mentors to young children utilizing CCPT principles, attitudes, and skills to develop a meaningful mentoring relationship. Jones, Rhine, & Bratton (2002) conducted a randomized, controlled outcome study comparing the effects of mentor-adapted CPRT to PAL® on mentees' behavior problems and found promising results for the adapted CPRT model over PAL®. However, further research is needed to substantiate the effectiveness of mentor-adapted CPRT as an evidence-based intervention for use with at-risk young children.

School-Based Mentoring

A central rationale for the use of peer mentoring in school settings is a shortage of student support services (ASCA, 2016). School counselors lack sufficient time to meet the demand for social, emotional, and behavioral interventions to all students through direct responsive services (ASCA, 2012). Additionally, school administrators often delegate extraneous responsibilities to school counselors that do not align with job-specific tasks, further drawing school counselors away from meeting students' social-emotional needs (Lapan & Harrington, 2010; Trolley, 2011; Wines, Nelson, & Eckstein, 2007).

A related rationale in support of mentoring programs is their preventative nature in reducing behavioral and social-emotional concerns amongst at-risk students (Erdem et al., 2016; Johnson & Perkins, 2009). Through the use of active approaches rather than reactive interventions, school counselors are able to efficiently navigate concerns related to at-risk students (Amatea & West-Olatunji, 2007). The structure of comprehensive school counseling programs is dependent on the guidance of the school counselor to create preventive and responsive programming that addresses the specific needs and immediate concerns of the school community rather than inefficient responses that may be reactionary in nature (ASCA, 2012; McGannon, Carey, & Dimmitt, 2005; Sink, 2011). Erford (2015) emphasized the urgent priority for school counselors to shift from a role of direct student services provider to one of supervisor of student services to increase efficiency of the school counselor's time.

The NCCP (2012) conveyed concern regarding growth in the number of at-risk young children whose social-emotional problems negatively impact their behavior and academic success. The CDC (2013), Mental Health America (2013), and the NCCP (2014) reported an

increase in the number of children that do not receive the mental health services they need. Specifically, in 2014, the number of children that were diagnosable with a mental health disorder was as high as 20 percent, and less than a quarter of these children received the appropriate services they needed (NCCP). Summarizing the impact of this critical situation, a CDC report (2011) indicated U.S. childhood mental health disorders are "an important public health issue because of their prevalence, early onset, and impact on the child, family, and community" (para. 2). Within the framework of a comprehensive school counseling program, school counselors may meet the growing need for responsive services by referring out to community-based services or by utilizing other persons within the school system (Christenson, 2004; Clark & Breman, 2009). This approach allows for a larger number of students to receive needed support through programming that involves teachers, other students, and parents in the delivery of responsive services (Dahir & Stone, 2013; Gysbers & Henderson, 2012; Myrick, 2011). Peer mentoring is one of the responsive services recommended to meet the growing demand for students in need of support.

Since 1978 and as recent as 2016, ASCA (1978; 2016) released position statements on peer mentoring programs, indicating that they are "implemented to enhance the effectiveness of school counseling programs by increasing outreach and the expansion of available services (p. 1)". ASCA encouraged professional school counselors to implement peer mentoring programs in their school when appropriate and beneficial to students. In their meta-analytic review, DuBois, Holloway, Valentine, and Cooper (2002) demonstrated that empirically supported mentoring programs enhanced the targeted outcomes for participants, including several domains prominently promoted by ASCA: emotional, social, academic, and career competence.

Mentoring literature relevant to school settings has increasingly focused on the relational context between mentor and mentee (Chan et al., 2013; Frels & Onwuegbuzie, 2012; Pryce, 2012; Rhodes & DuBois, 2008; Schwartz et al., 2011). Karcher & Nakkula (2010) summarized the body of literature related to the effects of youth mentoring in both school and non-school settings as fundamentally based in the quality of the mentor-mentee relationship and its interactions. Although mentoring literature has focused on empathy in the mentoring relationship as necessary for positive outcomes (Rhodes, 2005), there are deficiencies in research literature related to empathy in school-based mentoring programs.

Peer Assistance and Leadership

PAL® (PAL, 2017) is an evidence-based peer helping program that trains high school students to become effective helpers for at-risk students. It is the largest school-based mentoring program offering high school students' credit towards graduation. The goal of the PAL® program is placing high school students in a mentor role where they have the opportunity to help other students have a socially positive and academically successful school experience. PAL® was first introduced in 1980 to train high school students in basic communication and helping skills and place them in peer mentoring roles with other students. PAL® mentors are typically paired with mentees for a semester with a primary objective of helping mentees make responsible choices that facilitate a positive school experience (Grant, 1987). PAL® has expanded considerably since its inception and now has a national reputation that includes implementation in over 1000 school districts across 15 states (PAL, 2017) in addition to adoption in Australian school districts (Beavis & Bowman, 1995).

In 2006, PAL® was evaluated by the Substance Abuse and Mental Health Services Administration's National Registry of Evidence-based Programs and Practices ([NREPP]; NREPP, 2017) for assessment as an evidence-based program and was included in the registry based on two unpublished program evaluations. The first evaluation cited incomplete data based on a single group of PAL® participants and concluded that after one semester, participants demonstrated statistically significant improvements to their GPA, state-mandated standardized test reading and math scores, and a decrease in number of failed classes. The second program evaluation reported outcomes for PAL® mentors and concluded that compared to a non-randomized control group, PAL® mentors had statistically significant increases in positive communication their mothers and teachers, perception of inclusion in school programming, and appropriate responses with peers.

CPRT Adapted Play-Based Mentoring

Play-based interventions provided by paraprofessionals including teachers and parents have a long history of utilization (Axline, 1947; Guerney, 1964; Guerney, 2000; Guerney & Ryan, 2013; Landreth & Bratton, 2006). CPRT (Landreth & Bratton, 2006) is an empirically supported play-based intervention (Bratton et al., 2017; California Evidence-Based Clearinghouse for Child Welfare [CEBCCW], 2017; NREPP, 2017) in which parents, teachers, and more recently mentors, are trained as therapeutic agents for young children exhibiting a range of emotional, behavioral, and academic difficulties. CPRT is founded on Bernard and Louise Guerney's filial therapy model developed in the 1960s (Guerney & Ryan, 2013). The Guerneys' model grew out of the belief that parents could be successfully taught CCPT principles and skills to use with their children as an alternative to traditional play therapy.

Building on the pioneering work of the Guerneys, Garry Landreth created a 10-session filial therapy format in the 1980s that preserved the underlying principles and theory of the Guerneys' model while increasing session structure and condensing the length of time needed to deliver the intervention. Landreth and Bratton (2006) formalized the training format and named it CPRT to distinguish it from other filial therapy models. Bratton, Landreth, Kellam, and Blackard (2006) manualized the CPRT protocol for increased treatment fidelity, to allow for replication of treatment in research, and to increase the ease of disseminating CPRT materials.

Consistent with the Guerney's filial therapy model, CPRT emphasizes the viability of training and supervising paraprofessionals to become social-emotional change agents for children. A mental health professional trained in CCPT and CPRT provides didactic training and direct supervision of fundamental CCPT principles, attitudes, and skills (Landreth & Bratton, 2006). In CPRT, as in CCPT, emphasis is placed on the creation of a relationship based in consistency, acceptance, empathy, and interpersonal warmth to facilitate the child's full expression and movement toward overall health and wellbeing (Bratton, Opiola, & Dafoe, 2015).

The evidence base for CPRT currently includes more than 40 research studies that evaluated outcomes with paraprofessionals including parents, teachers, and mentors (Landreth & Bratton, in press). Within this body of research, 19 published studies utilized control group designs with 15 of the studies employing randomized group assignment. A majority of these studies resulted in statistically significant findings with moderate to large treatment effects supportive of CPRT as an effective intervention with constructs including, but not limited to, reducing child behavior problems and increasing empathic behaviors of the paraprofessional towards the child. The evidence base for CPRT has been further supported through meta-analytic studies (Bratton, Ray, Rhine, & Jones, 2005; Lin & Bratton, 2015) and comprehensive systemic

reviews (Bratton, Landreth, & Lin, 2010; Lindo, Bratton, & Landreth, 2015; NREPP, 2017). CPRT was recently evaluated by the Substance Abuse and Mental Health Services Administration's National Registry of Evidence-based Programs and Practices (NREPP, 2017) for inclusion in the registry and was listed as evidence-based (highest rating) for child disruptive behaviors and family functioning and listed as promising for child internalizing disorders. These findings provide a robust indication of the effectiveness of CPRT and CPRT adapted models as well as the influence paraprofessionals have on a child's behavioral wellness when they are trained in this approach.

Although the majority of CPRT research has been conducted with parents, adaptations to CPRT has expanded its use and research support to include paraprofessionals in school settings such as teachers (Helker & Ray, 2009; Morrison & Bratton, 2010; Morrison & Bratton, 2011) and mentors (Baggerly & Landreth, 2001; Jones et al., 2002). In the only published study to examine the effects of training high school mentors in the CPRT model, Jones et al. (2002) conducted a randomized, controlled study to compare mentor-adapted CPRT to the PAL® mentoring program. The high school students in both groups mentored the same child mentee over the course of two academic semesters. Jones et al. found that compared to the PAL® group, the mentor-adapted CPRT group demonstrated statistically significant improvement in mentors' empathic interactions with mentees and statistically significant reduction in child behavior problems. Limitations of the Jones et al. study included a small, but sufficient sample size (n = 30 mentor/mentee dyads) and two semester mentoring structure -- a structure inconsistent with established mentoring programs such as PAL® in which high school students typically begin new mentoring relationships each semester. Although results were promising and suggested the viability of mentor-adapted CPRT, additional research is needed to address possible limitations

of the Jones et al. study and to establish this model as an effective school-based mentoring approach for at-risk young children. For clarity, mentor-adapted CPRT will be referred to from here forward as Child Mentor Relationship Training (CMRT) to reflect the expansion of mentor-adapted CPRT and to simplify future references to the model.

Purpose of the Study

The purpose of this study was to examine the effectiveness of two peer mentoring programs: CMRT compared to PAL®. An additional aim was to determine if the findings from the Jones et al. (2002) study could be replicated within a reduced time frame more consistent with the semester structure typically used in high school settings. Specifically, this study addressed the following research questions: (1) Do CMRT mentors improve in their empathic behaviors towards child mentees over time as compared to PAL® group mentors?; and (2) Do child mentees in the CMRT group demonstrate a reduction in global behavior problems over time as compared to PAL® group mentees?

Methods

I used a randomized control group design to examine the effectiveness of CMRT with high school mentors and child mentees over time compared to PAL® examining the following constructs: mentor empathic interactions towards mentees and child mentee global behavior problems. I designed this study with two treatment conditions (experimental/comparison control) and 2 points of measure (pre and post). Using an a priori power analysis with a G*Power software calculation, I entered an alpha level of .05, a moderate treatment effect size (f = .25), and a minimum power of .80 (Cohen, 1988). I calculated that a minimum sample size of 34

participants was necessary to find a statistical difference between two groups with two points of measure.

Participant Selection and Recruitment

Participants were students from one public school district in a suburban city in the southwest United States and consisted of high school 11th and 12th grade students as peer helpers and preschool through 2nd grade child mentees referred for peer mentoring. Mentors were identified through their enrollment in the participating high school's peer helper classes and mentees through a previously established screening and referral process within the school district.

Mentor participants were volunteer junior and senior high school students enrolled in one of two for-credit peer helper classes offered at the high school. At the time of the study, the students had completed the fall semester of the year-long peer helper course. Additional mentor criteria for inclusion in this study were: (a) between the ages of 16 and 18; (b) able to read, write, and speak English fluently; and (c) not currently involved in any additional mentoring/helping skills training programs.

Mentee participants were volunteer preschool through 2nd grade students recruited from four different school sites: two Head Start preschools and two elementary schools. School counselors referred students to the peer mentoring program based on teachers' report of behavior problems believed to interfere with school success. The criteria for child mentee inclusion in the study were: (a) between the ages of 4 and 8; (b) able to speak English; and (c) not currently participating in counseling or mentoring services.

Consistent with the format and procedures of the already established peer mentoring program in the participating high school, the mentor participants enrolled in the peer helper classes were assigned to the participating child mentees from specifically identified schools within the district. Initially, 74 preschool and elementary children were identified for mentoring; however after finalization of mentoring session times, 14 mentees were unavailable to meet during these times or did not meet inclusion criteria due to receiving counseling services at the time. All high school students from the two peer helper classes volunteered to participate. For the purpose of this study, mentor participants were assigned two child mentees for the duration of the study. The high school mentors from two peer mentoring classes (15 experimental, 15 control) and the child mentees (30 experimental and 30 control) met criteria and consented to participate in the study. Of the mentees, 30 were preschool students attending one of two Head Start programs and 30 were Kindergarten to 2nd grade students attending one of two elementary schools in the district. Figures 1 and 2 depict the flow of participant recruitment and detailed participant demographics for high school mentors and child mentees, respectively.

Instrumentation

In order to measure the effectiveness of CMRT compared to PAL® across time, I administered two assessments at pre-test and post-test. I used the Measurement of Empathy in Adult-Child Interactions (MEACI) to measure the empathic behaviors and responses of high school mentors towards their child mentees as rated by independent observers. The Caregiver-Teacher Report Form/Teacher Report Form (CTRF/TRF) was used to measure the global behaviors problems of child mentees as observed by the teacher with which they had the most class time.

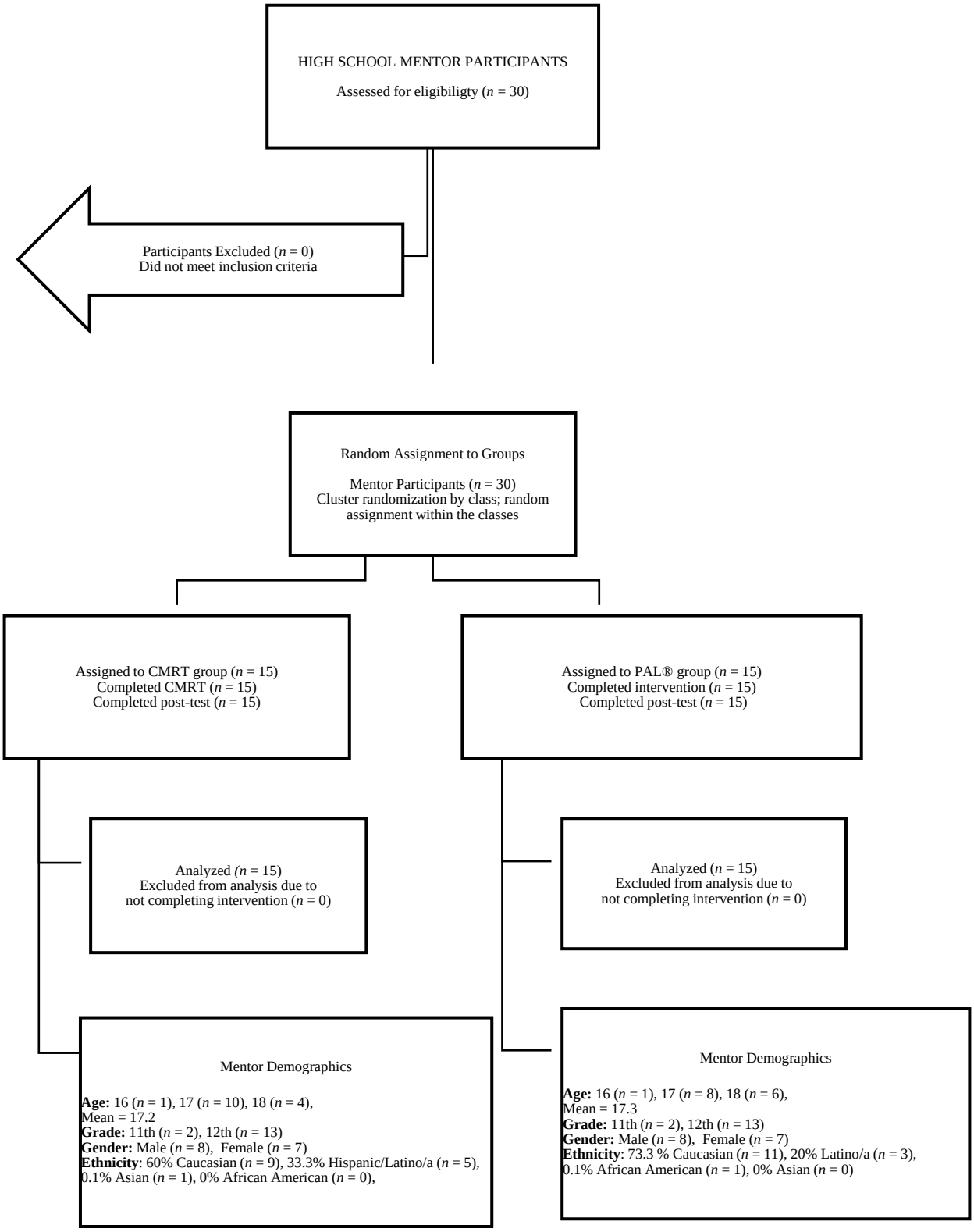

Figure 1. Flowchart of study high school mentor participants.

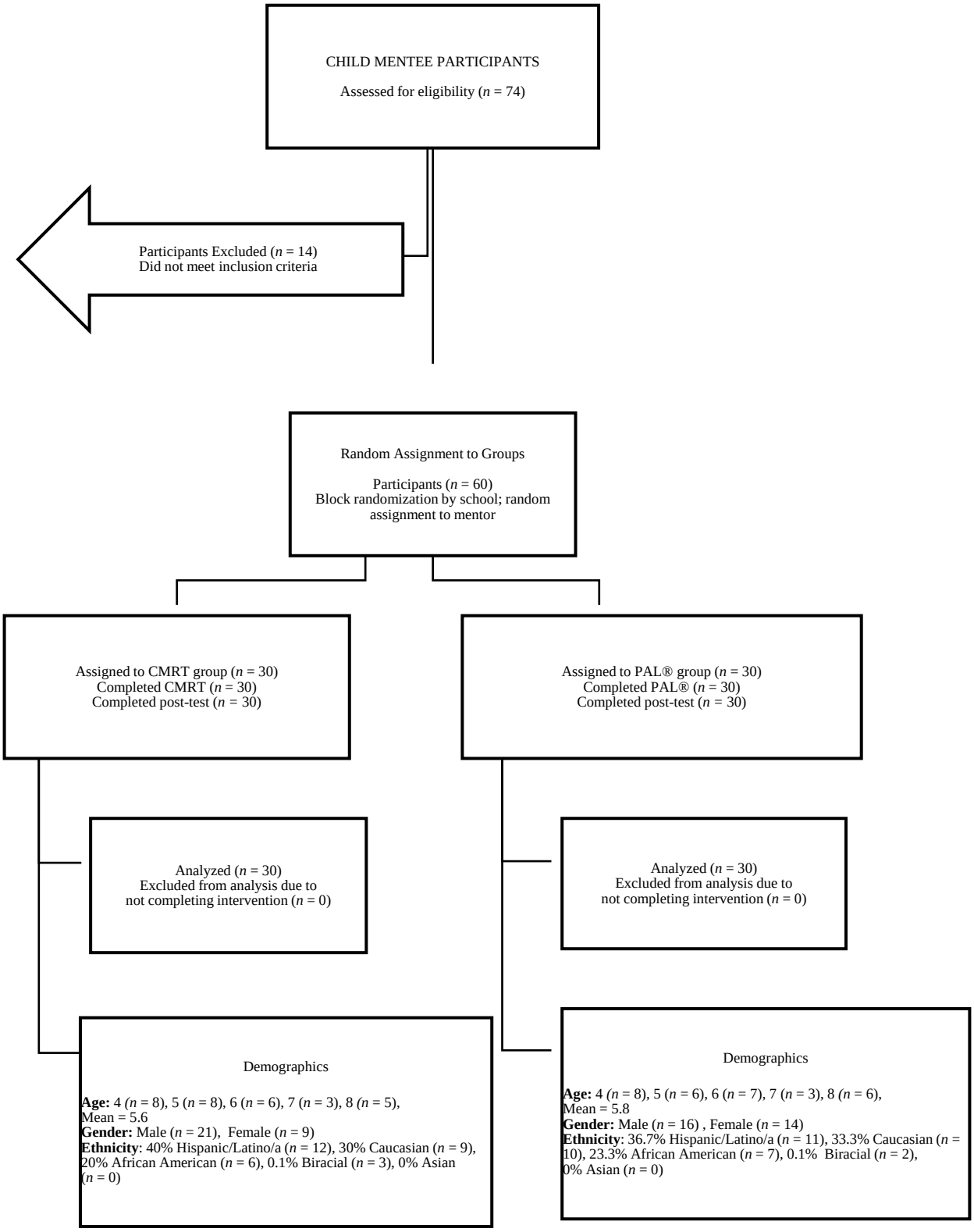

Figure 2. Flowchart of study child mentee participants.

Measurement of Empathy in Adult-Child Interactions

The MEACI (Guerney, Stover, & DeMeritt, 1968; Stover, Guerney, & O'Connell, 1971) is a direct observation instrument that measures an adults' observable empathic interactions during unstructured play sessions with a child. The MEACI consists of a Total Empathy score, comprised of three subscales representing key components of observable empathic behaviors in adult-child interactions: Communication of Acceptance, Allowing the Child Self-Direction, and Involvement (Stover et al., 1971). Blinded to group assignment and timing of the measurement, trained observers code video recorded play sessions to evaluate empathic behaviors on a five-point scale. Lower scores indicate higher levels of empathic responses and behaviors. Prior to coding mentor-mentee sessions, raters establish a satisfactory inter-rater reliability score. Bratton et al. (2006) refined the MEACI coding process to include a streamlined coding sheet and established a training protocol for ensuring inter-rater reliability. Stover et al. (1971) determined the inter-rater reliability for the three MEACI subscales was high with average reliability correlation coefficients of .88 for Communication of Acceptance, .80 for Allowing the Child Self-Direction, and .88 for Involvement. More recently, Bratton and Landreth (in press) examined inter-rater reliability correlation coefficients across seven contemporary CPRT studies representing over 600 coded play sessions and reported coefficients ranging from .82 to .99, indicating a high level of consistency among raters. Construct validity for the MEACI based on its ability to detect differences in adults' level of empathic interactions with children before and after intervention has been reported in the Stover et al. study and recently by Bratton and Landreth (in press).

Child-Teacher Report Form/Teacher Report Form

The CTRF/TRF (Achenbach & Rescorla, 2001) measures teachers' report of behavioral, emotional, and social problems for children (Achenbach & Rescorla, 2000; Achenbach & Rescorla, 2001). The CTRF/TRF requires approximately 15-20 minutes to complete administration of the assessment (Bogan, 2015). An improvement in behavior or in a subscale is indicated by a decrease in score. Achenbach and Rescorla (2001) constructed the instrument to measure three broadband scales: Internalizing, Neither Internalizing or Externalizing, and Externalizing which comprise a Total Problems scale from the broadband scales. The instruments' scales yield T scores in the normative, borderline, and clinical ranges. For this study, the primary classroom teacher of each child mentee assessed their global behavior problems pre- and post-intervention. Two versions of this assessment exist based on the child's age: the CTRF for children ages 1 ½ to 5 and the TRF for children ages 6 to 18. Both assessments were employed in this study to sufficiently cover the age range of child mentee participants. Achenbach and Rescorla (2001) referred to the CTRF/TRF and other instruments comprising the Achenbach System of Empirically Based Assessment (ASEBA) as integrative and consistent across the system including the CTRF/TRF to allow for valid and reliable measurement of participants behavioral functioning throughout the age range supported by the CTRF/TRF. Rescorla (2005) stated an advantage of using these instruments in research settings is the ease of comparability across the instruments' normalized and empirically based scales.

The CTRF/TRF has robust psychometric properties including content validity, construct validity, inter-rater reliability, and internal consistency with exhaustive normative data available for the sample demographics, including gender, socioeconomic status, ethnicity, and geographic distribution of the sample (Achenbach & Rescorla, 2001). The CTRF/TRF test-retest reliability

for these instruments are sufficiently strong (r = .84; .85) and inter-rater reliability was adequate (r = .66; .51 respectively).

Procedures

Upon obtaining research approval from the school district and the university institutional review board, I identified high school mentor and child mentee participants according to procedures established by the participating school district for the peer mentoring program.

Mentors were students enrolled in two peer mentoring classes at the participating high school. After obtaining informed consent from the high school mentors or consent from their parents and assent from the mentor as appropriate for the specific participant's age, the two peer mentoring classes were randomly drawn as individual units to participate in either the CMRT intervention group or the PAL® intervention group, a curriculum-based program adopted by the participating school district for peer mentoring.

Following informed consent and assent from mentee participants, the researchers collected pre-test data for the CTRF/TRF from teachers of potential child mentees during a two week period prior to the onset of mentor-mentee play sessions. In an effort to ensure integrity of the data collected, research assistants were available to answer questions and teachers were offered to complete the assessments in a setting free from distractions. Next, I used a random table of numbers to assign child mentees to high school mentors by school, so both the CMRT and PAL® group mentored an equal number of children at each of the four schools. Consistent with the already established peer mentoring structure and to provide mentors with mentoring experience across developmental stages, each mentor was assigned two child mentees for the

semester: one preschool mentee attending a participating Head Start school and one Kindergarten through 2nd grade mentee attending one of the participating elementary school.

To collect MEACI data, mentor-mentee pairs participated in a 20-minute video recorded play session in a private area at the child's respective school under the supervision of a research assistant. The area was set with specified toys and materials outlined in Appendix G. All MEACI pre-test data was collected during the week prior to the start of the intervention phase.

To maintain the rigor of study methodology and minimize observer bias, teachers of the mentees were blinded to treatment group assignment of the child participants. Teachers were aware that all children were participating in mentoring, which was the term used for both interventions. The high school mentors from both interventions initially introduced themselves to teachers using identical statements, e.g., "Hi, I'm Jessica and I'll be mentoring Josef each week during this semester." Mentors also used identical statements when retrieving their child mentees from the classroom, e.g., "I'm here for Josef," to keep the teachers unaware of the specific treatment group assignment of student participants.

All phases of intervention were conducted during the high school students' regularly scheduled peer helper class time over the course of the spring semester of the year-long class. The high school followed an A-B block schedule with class rotations in which students attended 3 mentoring class periods on "A" week and two class periods on "B" week. Study procedures were similar for both treatment groups. Prior to beginning mentoring, I conducted on-site orientation at the mentees' schools for the purpose of familiarizing all mentors with the mentoring procedures at the Head Start and elementary schools where they would conduct mentoring sessions with their mentees. Both the CMRT and PAL® group students received 3 weeks of training in their respective curriculum for a total of 7 class periods prior to conducting

mentoring sessions at the Head Start and elementary schools. Each class period was approximately 1 hour and 20 minutes. Once mentoring commenced, the high school students traveled to the mentees' schools 2 days per week: 1 day to Head Start schools and 1 day to elementary schools. Child mentees participated in mentoring with their high school mentor for 20-minute weekly sessions over a 15 week period. During the mentoring phases, both the CMRT and PAL® groups participated in 8 additional training classes on “A” week during the class period that they were not mentoring in the schools. The study phase was a total of 18 weeks in length.

During the week after the completion of the study phase, post-test data (CTRF/TRF and MEACI) was collected following the same procedures as pre-testing. To obtain MEACI data from the pre- and post-video recorded mentor-mentee play sessions, a team of independent raters blinded to participants’ assignment to the experimental or control group and to whether the video recorded play session was a pre-test or post-test session rated participants’ 20-minute play session videos. Six doctoral level counseling students, independent of the present study and with advanced training in play therapy and CPRT, scored the videos. Raters were required to review the MEACI scoring instructions and participate in intensive training following the coding protocol outlined by Bratton (1993) and Bratton et al. (2006) to ensure an acceptable level of inter-rater reliability prior to coding the video data. Inter-rater reliability was initially established using recorded mentor-mentee play sessions independent of the present study. Raters viewed and independently scored nine segments of mentor-mentee play sessions. Following the scoring of each segment, ratings were discussed to facilitate clarity of scoring criteria. To ensure maintenance of acceptable inter-rater reliability, checks were performed again at mid- and end-points of the coding period using video segments that the raters determined difficult to score. I

used Stemler's (2004) 70% benchmark and procedure for computing and interpreting consensus estimates of inter-rater reliability (i.e. percentage agreement estimates). Percentage agreement scores were calculated through dividing the total number of agreements by the total number of observations and multiplying by 100. Agreements were defined as ratings that fell within one point of the mode or most frequently occurring rating. For the pre-rating training session, raters attained 93% agreement. For the mid and end point rating sessions, raters achieved 88% and 94% agreement, respectively. To maintain confidentiality, all assessments, treatment notes, and identifying information were coded and securely stored.

Experimental Treatment: CMRT

Consistent with the traditional CPRT model, high school mentors assigned to the CMRT group utilized were taught essential CCPT attitudes, principles, and skills designed to foster a warm and understanding relationship that is responsive to the needs of children. Similar to the Jones, et al. (2002) study, I adapted the structure and length of the traditional CPRT protocol which outlines 10 weekly 2-hour sessions and 7 weekly home play sessions (Bratton et al., 2006). In modifying the CPRT model for use with mentors and mentees, I acknowledged that it would naturally take longer for high school mentors and child mentees to develop a relationship as compared to parents who have a pre-existing relationship with their child. As a result, I structured the intervention to include 15 weekly play sessions. Additionally, I modified the CMRT model used by Jones et al. by reducing the duration of the model from two semesters to one to accommodate the structure of the participating school's peer helper class.

Following established CPRT procedures, high school mentors learned CCPT attitudes, principles, and skills through didactic training and experiential learning activities including skills

training, role-playing, discussion, video demonstration, and supervised application of skills with a child (Jones et al., 2002) from a trained CPRT counselor. In this study, the lead facilitator was an advanced doctoral level counseling intern and had completed advanced coursework and supervised practice in play therapy, filial therapy/CPRT, and supervision. In addition to 15 class periods of training and 15 weeks of mentoring two mentees over the course of the study, the CMRT mentors participated in 30-minutes of small group supervision immediately following their mentoring session with each mentor receiving 15-minutes of focused feedback through video playback and direct observation. Supervisors were master level counselors who had completed coursework and supervised practice in play therapy and filial therapy/CPRT while half of these supervisors were doctoral students with advanced training in supervision, play therapy, and CPRT. Supervisors were under the supervision of a licensed professional Ph.D. counselor and supervisor who is an expert in CCPT, CPRT, and CMRT.

In the week prior to the start of the study, I met with the high school students mentors during three class periods, I first met with mentors at the high school to get acquainted, discuss study procedures, and provide each mentor with mentees' names. Then, I met with mentors twice at the child mentees' schools, once for orientation to the school procedures and a second time to conduct mentor-mentee play sessions for pre-test MEACI data. In addition, I assigned mentors readings from the book, Dibs in Search of Self (Axline, 1964), to connect the high school mentors to an awareness of their role in supporting their child mentees' emotional expression and facilitating self-direction through play and relationship during mentoring sessions. The CMRT intervention consisted of three phases, each phase is described in greater detail below. I used approximate CPRT protocol equivalency session numbers to aid in better understanding the material covered within each phase (Bratton et al., 2006).

- Foundational training phase (CPRT Equivalency Sessions 1-4). In this phase, I taught foundational CCPT/CPRT skills during the high school students' peer helper class time over three weeks for a total of seven 1 hour and 20 minute meetings (approximately 9 hours of training). Through a combination of experiential and didactic activities including discussion, handouts, video and live demonstration, and role-play of skills, the following attitudes, principles, and skills were taught: being present with the mentee and conveying the be-with attitudes (I am here, I hear you, I understand, and I care), following the mentee's lead, reflective listening, reflective responding, tracking responses, and basic limit setting (Landreth & Bratton, 2006). Mentors were provided with play kits following the general guidelines and categories provided in the CPRT treatment manual (Bratton et al., 2006).

- Mentoring and advanced training phase (CPRT Equivalency Sessions 5-10). In this phase of the treatment, the mentors began their mentoring sessions with their mentees. This phase lasted 7 weeks during which mentors conducted weekly 20-minute play session with their 2 mentees and received 30-minutes of small group supervision immediately following each mentoring session. Additionally, mentors participated in 4 class times of instruction (approximately 5 hours and 30 minutes) on "A" weeks focused on supporting their continued development of attitudes and skills taught in Phase I, as well as learning more complex and difficult skills, choice giving, self-esteem building, and encouragement versus praise.

- Mentoring and maintenance phase. The final phase of CMRT lasted 8 weeks and focused predominately on continuing to support the high school mentors during their weekly mentoring sessions and through ongoing supervision. Supervision sessions shifted focus from providing the optimal response to a greater focus on relationship dynamics, sharing strengths and areas for growth, and working together as a group to identify beneficial responses to difficult

mentoring moments. Additionally, mentors participated in 4 class times of instruction (approximately 5 hours and 30 minutes) on “A” weeks focused on supporting mentors’ understanding of relationship dynamics with their mentee. Mentors had the opportunity to share their experiences and struggles as well as ask questions about their mentoring sessions. Sessions not held due to mentor or mentee non-attendance were rescheduled to another date occurring within that same week. The range of mentoring sessions held was 12 to 15 sessions and the mean number of sessions was 13.3.

Treatment fidelity was ensured through on-site supervisors directly observing live mentoring sessions and through viewing video recordings of the sessions. The CPRT skills checklist was used in supervision to ensure mentors maintained fidelity to the CMRT model and to support continued mentor growth in their relational skillset. Due to school district policy, recordings of mentoring sessions were destroyed after weekly feedback during group supervision, preventing their use to calculate overall adherence to treatment fidelity.

Comparison Treatment: PAL®

High school mentors in the comparison group received the PAL® curriculum taught by a certified PAL® instructor who was also the instructor of record for both peer helper classes at the high school. The PAL® protocol involved skills training which included effective communication, decision-making skills, cultural competency, and problem-solving skills designed to support the social-emotional health of the child mentee (PAL Services, 2003). The high school mentors in the comparison group were instructed to utilize these skills in their mentoring sessions with their child mentees.

Consistent with the CMRT study procedures, PAL® mentoring consisted of 15 weeks of mentoring sessions with each of their 2 mentees. High school mentors in the PAL® group received additional didactic training with role-playing to prepare for mentoring young children. In this study, the PAL® facilitator had completed the necessary requirements for certification as a PAL® instructor with years of experience training PAL® mentors. Each phase of the PAL® intervention is described in the manner it was structured in this study below in detail.

- Training phase. Prior to commencing mentoring sessions, the PAL® training focused on developing relational skills during the high school students' peer helper class time over three weeks for a total of seven 1 hour and 20 minute meetings (approximately 9 hours of training). In addition to learning additional ways to relate, the instructor taught effective communication and decision-making skills to utilize in the mentoring sessions (PAL Services, 2003). During this training phase, the certified PAL® instructor's role focused on training mentors in helping skills specific to young children. The PAL® instructor discussed common issues that emerge while mentoring and shared other considerations for encouraging positive growth and direction in their child mentees. During this phase, PAL® high school mentors received a workbook with worksheets, coloring sheets, and possible activities they could use with their child mentees during mentoring sessions. Puzzle-based items already present at the elementary school sites were also allowed by the instructor for use in mentoring sessions.

- Mentoring and advanced training phase. During the mentoring phase of the PAL® model, the high school mentors initiated their mentoring sessions with their child mentees and received continued support regarding their mentoring sessions from the certified PAL® instructor. The topics addressed in these continued training sessions were left to the expertise, proclivities, and available resources of the PAL® instructor in response to the specific needs of

the mentors and mentees. High school mentors held one 20-minute mentoring sessions per week with each of their two child mentees. A research assistant served as an on-site at the schools mentoring was held should any major concerns arise prior, during, or after the PAL® mentoring sessions, but the research assistant did not offer or provide any feedback or supervision. Consistent with CMRT mentors and over the course of the mentoring phase, the high school mentors received 4 additional advanced training sessions during "A" weeks to support their continued development as mentors.

As the PAL® model was delivered by an experienced certified PAL® instructor (PAL Services, 2003), the training and execution is typical of this intervention. Due to the study researchers not having the required training and certification needed to be a PAL® instructor and deliver the intervention, they were unable to completely control the fidelity of the planning, training, and delivery of the PAL® model received by the PAL® mentors and mentees. Research assistants verified that the PAL® mentors adhered to the frequency of mentoring sessions. PAL® mentors were encouraged by their instructor to reschedule any mentoring sessions missed by either the mentor or mentee. The range of mentoring sessions was 9 to 14 sessions and the mean number of sessions was 12.2.

Data Collection

Teachers of child mentees completed the CTRF/TRF (as appropriate for the specific child) prior to beginning both interventions and shortly after completion of the interventions. I made myself available for questions while the teachers completed the CTRF/TRF. Teachers were offered the opportunity to complete the assessments in a setting free from distractions. Independent raters evaluated the videos for the MEACI after completion of the study. The video

recordings were previously coded and de-identified so that raters were blinded to group assignment of the session and time of measurement (both pre- and post-test video recordings). Prior to rating, all raters attended a training to learn how to code and score the MEACI instrument. During this training, sufficient interrater reliability was achieved at 85% or higher as recommended by Stover et al. (1971) prior to raters assessing the mentor-mentee play session videos. Raters met in multiple meetings to ensure they continued to remaining a high level of interrater reliability in coding the MEACI.

Results

I analyzed a two (treatment groups) by two (repeated measures) analysis of variance (ANOVA) of the scores on the empirically-based MEACI Empathy scale as well as the CTRF/TRF Total Problems scale to test the differences in the means of the experimental (CMRT) group and the comparison/control (PAL®) group over time and possible interaction effects, which were of particular interest in this study. I evaluated the data with the Statistical Package for the Social Sciences (SPSS) to ensure that it met methodological assumptions for normality, sphericity, and homogeneity of variance for conducting a repeated measures ANOVA (Armstrong & Henson, 2005; Pallant, 2013). Additionally, I ensured that skewness and kurtosis for the dependent variables were within normal limits. The independent variable was the treatment group type (CMRT/PAL®). Dependent variables included mentees' global behavior problems as operationalized by scores on the CTRF/TRF Total Problems scale and mentors' empathic behaviors towards mentees as operationalized by the MEACI Total Empathy scale. I utilized an a priori alpha level of .05 for determining statistical significance (Thompson, 2002). I assessed the practical significance of the effects of the CMRT intervention as compared to the

effects of the PAL® intervention through reporting partial eta-squared (?p2) effect sizes for each dependent variable. I interpreted the effect size using recommendations established by Cohen (1988) and confirmed their appropriateness for use in school counseling research with recommendations made by Sink and Stroh (2006): .01 was considered a small effect, .06 was considered a medium effect, and .14 was considered a large effect. Table 1 presents the pre- and post-mean scores and standard deviations for CMRT and PAL® groups for each dependent variable. Improvement is denoted by a reduction in scores on the MEACI and the CTRF/TRF.

Table 1

Mean Scores and Standard Deviations for Treatment Groups

		Experimental CMRT (n = 15 mentors; 30 mentees)		Comparison PAL® (n = 15 mentors; 30 mentees)	
		M	SD	M	SD
MEACI Total Empathy	Pre-Test	40.283	4.552	42.846	4.746
	Post-Test	33.250	5.253	46.539	5.438
CTRF/TRF Total Problems	Pre-Test	61.933	9.184	60.800	7.690
	Post-Test	57.700	9.607	59.733	11.114

Research Question 1: High School Mentors' Demonstration of Empathic Interactions with Child Mentees

Results of analysis for the dependent variable Total Empathy indicate a statistically significant interaction effect between treatment groups (CMRT/PAL®) over time (pre to post), $F(1, 26) = 13.979$, $p < .001$, $?p2 = .350$, and treatment effect is considered very large. These findings indicate that according to raters blinded to mentors' group assignment, the CMRT mentors demonstrated statistically significant increase in empathic interactions with their mentees compared to PAL® mentors. A visual inspection of the graph of the mean scores for the

CMRT and PAL® group supports the greater improvement of the CMRT group compared to the PAL® group over time (see figure 3).

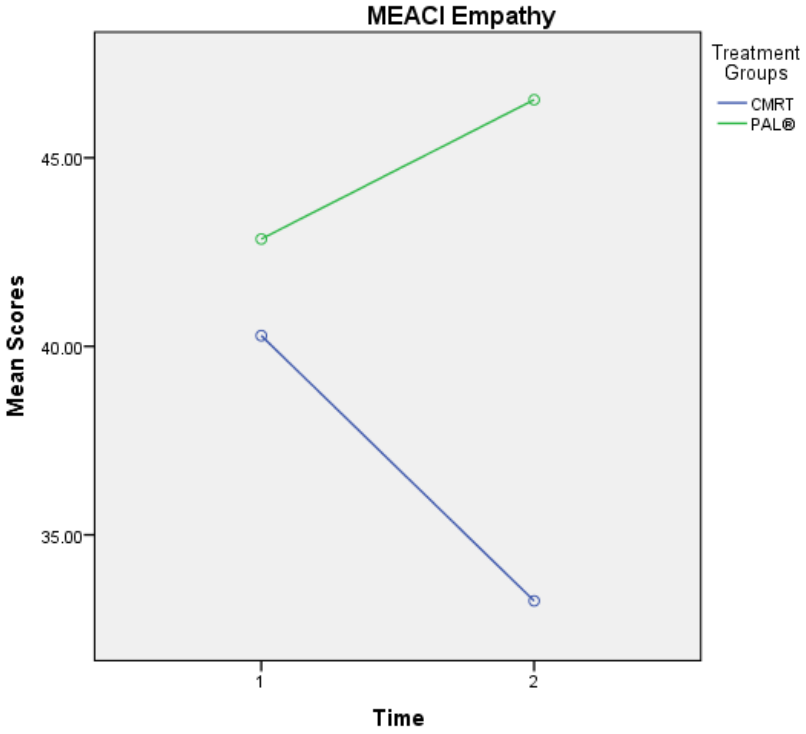

Figure 3. Mean scores on MEACI Total Empathy Scale.

Research Question 2: Child Mentees' Global Behavior Problems

Results of analysis for the dependent variable Total Problems did not indicate a statistically significant interaction effect between treatment groups (CMRT/PAL®) from pre- to post-test, F(1, 58) = 3.251, p < .077, ?p2 = .053. These findings indicate CPRT demonstrated a moderate treatment effect on decreasing children's global problem behaviors when compared to the PAL® intervention, although the difference between groups over time was not statistically significant. Results of the main effect for time showed statistically significant improvement in behavior problems when participants from experimental and control conditions were grouped together, F(1, 58) = 9.108, p < .004, ?p2 = .136), and the treatment effect was large.

Because the main effect for time was statistically significant and CMRT demonstrated a moderate treatment effect over the PAL® intervention, I calculated one-way repeated measures ANOVA for each treatment condition to further explore within group performance. Results of the one-way ANOVAs indicated that the CMRT group demonstrated statistically significant reductions in global behavior problems from pre- to post-test, F(1, 29), p < .006, ?p2 = .234, and the treatment effect size was very large, while the PAL® group did not demonstrate statistically significant improvement F(1, 29), p < .310, ?p2 =.035 and the treatment effect was small. A visual analysis of the graph of the mean scores for CMRT and PAL® treatment groups on the CTRF/TRF Total Problems (see figure 4) supports the greater improvement of global behavior problems in the CMRT treatment group over the PAL® treatment group.

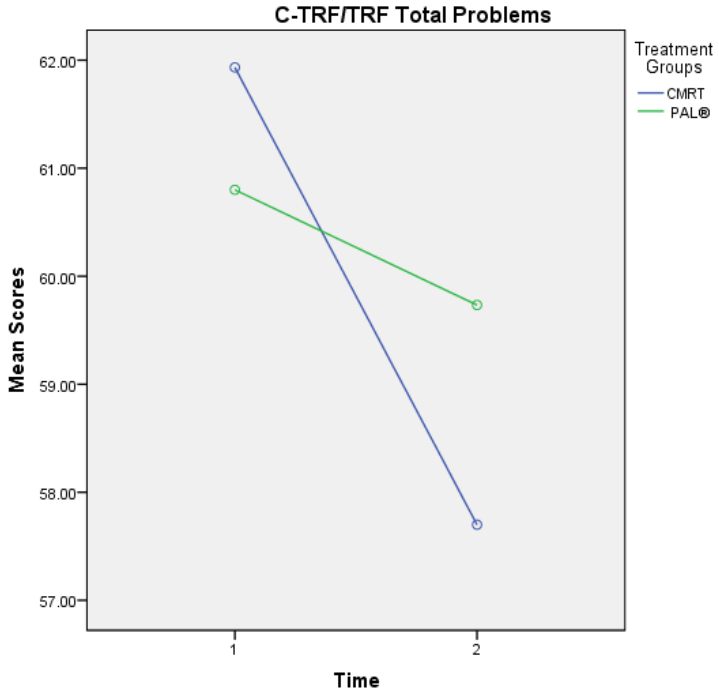

Figure 4. Mean scores on CTRF/TRF Total Problems Scale.

Discussion

The goal of this study was to augment the evidence base for the CMRT model by using similar methods to Jones et al. (2002) and to explore if the beneficial findings from Jones et al. could be replicated in a shorter time frame. The statistical and practical significance of the findings of this study were supportive of the Jones et al. findings and indicated the effectiveness of CMRT as a mentoring approach for use in school settings with young children referred for behavior problems. Particularly noteworthy is similar findings were achieved despite this study's intervention phase lasting one semester instead of two. This substantial reduction in the time needed to effectively deliver CMRT allows more children to be served. Time is often school counselors' most limited resource and a school counselor using a comprehensive school counseling program model is more able to provide proactive services while addressing many students as opposed to consuming a majority of their time with reactive services and crisis situations often restricted to a small number of students (McGannon, Carey, & Dimmitt, 2005).

Effectiveness of CMRT on Mentor Empathic Behaviors

The high school mentors who participated in the CMRT condition demonstrated a statistically significant increase in their empathic behaviors towards their child mentees as compared to high school mentors in the PAL® condition and this treatment effect was very large. This finding is consistent with the Jones et al. (2002) study as well as numerous related CPRT studies (Bratton, Opiola, & Dafoe, 2015; Lin & Bratton, 2015). The PAL® condition reported a decrease in their empathic behaviors between pre- and post-test. Additionally, the mean score change resulted in a 7 point improvement in mentor empathic behaviors with the CMRT group as compared to a -3.7 point decline in the PAL® group. The results of this

instrument was obtained through trained independent coders who were blinded to the participant group assignment of the participants as well as time of measure (pre- or post-test) making this finding noteworthy.

The substantial results of CMRT mentor empathic behaviors demonstrated towards their child mentees is indicative of the importance placed on the development of mentor empathy in CMRT training. CMRT and CPRT literature place an emphasis on the development of empathic interactions (Carnes-Holt & Bratton, 2014; Jones et al., 2002; Morrison & Bratton, 2011). Principles grounded in CCPT highlight the value of allowing children to experience accepting and non-judgmental relationships (Landreth, 2012). Rhodes (2005) offered healthy mentoring relationships serve as corrective relational experiences for children. The increase in mentor empathic behaviors along with a resulting decrease in global behavior problems is also consistent with broader CPRT & CCPT literature (Carnes-Holt & Bratton, 2014; Jones et al., 2002; Kidron & Landreth, 2010; Topham, Wampler, Titus, & Rolling, 2011). Not only is the importance of mentor empathy towards the mentee emphasized in research related to CMRT, it is also noted in broader mentoring research on effecting positive change in at-risk youth (DuBois et al., 2011; Erdem et al., 2016).

The findings indicated a decline in mentor empathy towards child mentees in the PAL® group. Based on the researcher's observation, some high school mentors in this group presented with less enthusiasm and commitment to their mentee over the course of mentoring. The lead researcher tentatively suggests that the PAL® high school mentors exhibited less empathic behaviors towards their mentees than they did at the beginning of the mentoring phase due to a lack of attention in PAL® training that fostered the development of empathy for the child

mentees. Combined with a lack of supervision that may provide continued support and motivation, the PAL® mentors became disconnected from their mentees.

The importance of developing empathy for mentees in CMRT is consistent with literature regarding the effectiveness of youth mentoring. Mentor empathy has been identified as foundational in models of youth mentoring (DuBois et al., 2011; Erdem et al., 2016) and contributes to the effectiveness of mentoring interventions. This aligns with other research in school settings that identifies emotional attunement as essential to create positive change (Pianata, 1999; Poulsen, 2001).

Effectiveness of CMRT on Mentee Global Behavior Problems

Teacher report of child mentees' global behavior problems indicated that teachers perceived a greater reduction in behavior problems in the CMRT group mentees than they did for PAL® group mentees. Although the between group difference was not statistically significant, CMRT demonstrated a medium treatment effect over the PAL® intervention typically employed in the participating school district. Within group differences revealed that the CMRT group demonstrated statistically significant improvement from pre to post, while the PAL® group was not statistically significant over time; the treatment effect for CMRT was over six times greater than the treatment effect for PAL®. These findings are generally consistent with the results of the Jones et al. (2002) study and also consistent with several CPRT & CCPT studies conducted in school settings (Bratton, Landreth, & Lin, 2010; Bratton et al., 2017; Ray & Bratton, 2015).

The decrease in global problem behaviors in the CMRT group is noteworthy in regards to school-based mentoring programs. A primary objective of mentoring programs is to prevent emotional and behavioral problems among at-risk students, especially with preschool and

primary school-aged children (Erdem et al., 2016). The specific needs of at-risk students may be addressed through the well-trained school counselors integrating preventative programming and active approaches (Amatea & West-Olatunji 2007). Johnson and Perkins (2009) reported responding to at-risk students through efficacious early interventions as an element of comprehensive school counseling programs is the primary way to ensure their behavioral and academic success.

Critical components of a school-based effective mentoring approach include strong theoretical grounding and an established body of research that supports its use in addressing the social-emotional needs of mentees (Chan et al., 2013; DuBois et al., 2002). The training provided to high school mentors in CMRT is based in CCPT theory and principles (Landreth & Bratton, 2006); this theoretical approach emphasizes the development of attitudes, knowledge, and skills in facilitating a meaningful relationship. The lead researcher observed successfully prepared mentors: (a) developed attitudes to better empathize with their child mentees; (b) created a safe environment during mentoring sessions; and (c) encouraged the expression of the child's personal and unique way of being. CMRT mentors learned developmentally-responsive play therapy skills to cultivate a relationship with the mentee based on consistency, acceptance, and warmth. According to CCPT theory, when the child mentee experienced this caring relationship with their mentor, they feel accepted, understood, and the environment created under these conditions leads to positive change within the child (Landreth, 2012). Central to CMRT's understanding of the mechanism of change, these principles are corroborated by constructs in mentoring literature including the need for mentor empathy and other mentor relational variables (Chan et al., 2013; Erdem et al., 2016; Raposa, Rhodes, & Herrera, 2016).

Limitations and Recommendations for Future Research

The methods, results, and findings of this study augment the body of research surrounding peer mentoring with young children. Regardless of any benefits this study may afford the mentoring literature, consumers of research need to meaningfully evaluate study limitations when considering these results and the interpretations advanced here. Although the process of identifying and acknowledging limitations in research is inherently subjective, I have earnestly attempted to critically evaluate limitations of greatest consequence in this study.

The generalizability of the study results to the broader population is limited by the sample size as well as geographical restrictions based on the selection of local school sites for inclusion in the study. Despite obtaining a sufficient sample size to detect differences between groups, follow-up or replication studies with a higher sample size across multiple school sites with similar findings would increase confidence in the reliability of these results and enhance the evidence base for CMRT. An additional sample-related limitation was the potential difficulty of controlling for treatment contamination. As both treatment conditions were samples drawn from separate mentoring classes held in the same high school, there is the possibility that a high school mentor from one condition may have been verbally exposed to a portion of the mentoring protocol from a high school mentor in the other condition. While this situation is in the realm of possibilities, it would be difficult for a mentor in the other condition to implement the protocol and/or internalize the specific attitudinal stances without the necessary training.

Although PAL®, the comparison group, is a SAMHSA evidence-based treatment that is manualized and requires the trainer of the comparison group to be certified in the protocol (NREPP, 2017; PAL, 2016), the researchers had limited control over the fidelity of the administration of the PAL® curriculum and the maintenance of treatment fidelity to the PAL®

curriculum in the intervention phase as the certified PAL® instructor provided the training and on-going support. This certified instructor had multiple years of experience in delivering the PAL® curriculum, had access to the PAL® manual, and additional supports surrounding the implementation and execution of the protocol. Related to limitations associated with the delivery of training protocol and maintaining treatment integrity, the lead researcher was extensively involved in participant recruitment and training delivery processes. This had the potential to influence treatment results through experimenter bias. In an effort to minimize the potential of inadvertently effecting findings, the lead researcher met regularly with an expert in CPRT protocol to address the potential of introducing cofounding influences or biases related to the lead researcher's involvement.

Researchers may have missed opportunities to collect data from additional sources of measure that may have provided information not captured in data collection. A parent report of global problem behaviors to substantiate or counter teacher reports would provide a broader perspective on the behavior change process for child mentees. An instrument capable of capturing the direct experience of child mentee participants might also offered unique data with the caveat that children's perspective is often problematic to access for quantitative research due to the difficulty of collecting reliable and measureable data that accurately reflects their experience beyond the present moment.

Implications and Recommendations for Practice

This study corroborated the findings of Jones et al. (2002) and granted additional research support to CMRT as an effective intervention with application in school settings. Built upon the empirical base supporting CPRT (Bratton & Lin, 2015; Landreth & Bratton, 2006) as a mentor-

adapted CPRT model, CMRT holds indications of promise as an approach to expand the impact of a comprehensive school counseling program and meet the social-emotional needs of students. It is important to note that beneficial effects were measured for both mentees as well mentors and that this should be taken into consideration during implementation. CMRT is a proactive model that could potentially avert behavior problems that may require a more acute and resource-intensive response from the school counselor without this preventative intervention. CMRT as an approach is consistent with the ASCA National Model (ASCA, 2012) as well as ASCA's most recent position statement on the substantial value of peer helping as part of a comprehensive school counseling program.

Mentor participants in the CMRT group appeared to have greater amounts of enthusiasm for mentoring and a meaningful connection to the process of mentoring as compared to the comparison group. Based on mentors' verbal feedback, continued skill development and supervision over the course of their mentoring sessions made a difference in mentors remaining connected to the process and receiving needed support for relational success with their child mentees. I emphasize this aspect of the CMRT model as critical to the integration of the attitudes and skills as well as to the outcomes of this intervention. The school counselor implementing CMRT should ensure they are available and accessible to the high school mentors not only during and after their mentoring sessions, but also at specific intervals at least bi-weekly, if not more frequently to supervise developments in their mentoring sessions.

A practical consideration for implementation of CMRT as a school counselor is the requisite for a specific and high level of training to effectively apply CMRT. It is an innovative model that may add considerable value and efficiency to a comprehensive school counseling program and delivering the model with fidelity requires training in CCPT, understanding the

underlying principles guiding CCPT, training in CPRT, and adapting CMRT to the needs of a school within the context of a peer mentoring program. If a CMRT expert protocolized the model, implementation of this intervention by a school counselor may require only CCPT and CPRT training supplemented by the CMRT treatment manual to be sufficiently prepared to successfully implement this mentoring intervention.

Conclusion

A comprehensive school counseling program is most effective when it meets the social-emotional needs of students through appropriate interventions that are preventative in nature (ASCA, 2012; Sink, 2011). It is imperative for school counselors to strategically consider how they may best serve as a leader in their school through implementing interventions that maximize the number of students impacted and through the use of approaches with an established evidence base (Erford, 2015). This conceptual shift within a school counseling programs refocuses intervention from reactivity to proactivity.

Well-trained high school mentors can competently develop the skillset necessary to influentially help child mentees reduce behavior problems in school settings (Johnson & Perkins, 2009). Thoughtful deliberation on the delivery, design, and execution of a mentoring program is critical to positive outcomes (Erdem et al., 2016). Findings from this present study demonstrated the beneficial effects of CMRT on developing high school mentors' empathic behaviors that creates the relational environment necessary for problem behavior change to occur in child mentees. The findings of this study are similar to and support the results of the Jones et al. (2002) study, confirming the positive outcomes of CMRT as a mentoring model for use in schools with research supporting it as a credible and effective intervention. These findings inform school

counselors of a promising intervention as a component of a comprehensive school counseling program that supports students' social-emotional health.

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APPENDIX A

EXTENDED LITERATURE REVIEW

In this appendix, I address the academic and research literature related to this study which includes the following topics of interest: (a) school-based mentoring, (b) child-centered play therapy, (c) school-based child-centered play therapy, (d) filial therapy, (e) filial therapy and play-based mentoring, and (g) Peer Assistance and Leadership.

School-Based Mentoring

A key rationale for the use of peer mentoring in a majority of school settings is due to a shortage of student support services. School counselors lack sufficient time to provide social, emotional, and behavioral support to all of the students that could benefit from counseling-related services (ASCA, 2012). Additionally, school administrators often assign school counselors to responsibilities that do not align with school counselor-related tasks or training, further drawing school counselors away from focusing on students' personal and academic success through meeting their socio-emotional needs (Lapan & Harrington, 2010; Trolley, 2011; Wines, Nelson, & Eckstein, 2007). The structure of comprehensive school counseling programs is dependent on the guidance of the school counselor to create a school counseling program that is able to address the specific needs and immediate concerns of their school community (ASCA, 2012; Sink, 2011). There is agreement in the school counseling literature that a systematic school counseling program with clearly defined services would optimally support school counselors' functioning (ASCA, 2012; Campbell & Dahir, 1997; Erford, 2015). Highlighting this strong consensus is the ASCA National Model's (ASCA, 2003, 2005, 2012) consistent recommendation for school counseling programs to be developed with effective responsive services as a primary component in each of the model's iterations.

The Centers for Disease Control (2013), Mental Health America (2013), and the National Center for Children in Poverty (2014) report there is an increase in the number of children that

do not receive the mental health services they need. The number of children that are diagnosable with a mental health disorder is as high as 20 percent and less than a quarter of these children are receiving the appropriate services they need (NCCP, 2014). In an earlier NCCP (2012) report, the growth of the number of at-risk young children whose socio-emotional concerns are having a negative effect on their behavior and academic success is particularly troubling. Summarizing the impact of this critical situation, a CDC report (2011) indicated U.S. childhood mental health disorders are "an important public health issue because of their prevalence, early onset, and impact on the child, family, and community" (para. 2).

To meet this growing need, school counseling programs continue to move towards responsive services delivered not only by school counselors, but also by other members of the school as well as referring to community services (Christenson, 2004; Clark & Breman, 2009). This approach potentially allows for a larger number of students being reached through programming that involves teachers, students, and parents in the delivery of responsive services (Dahir & Stone, 2013; Gysbers & Henderson, 2012; Myrick, 2011). Peer mentoring is one of the responsive services recommended by the authors noted above to meet the growing demand for students in need of support.

Since 1978 and as recent as 2008, ASCA released position statements on peer mentoring indicating that peer mentoring programs are "implemented to enhance the effectiveness of school counseling programs by increasing outreach and the expansion of available services (p. 1)". ASCA tasked professional school counselors with implementation of peer mentoring program in their school when appropriate and beneficial to student. The successful implementation of a peer mentoring necessitates the school counselor to be involved in the selection of participants, coordination of training, scheduling time for supervision of peer mentors, and continually

evaluating the peer mentoring program to ensure it is addressing the needs of the student mentees. Another aspect of efficacious peer mentoring program is the efficient utilization of mentoring time between the mentors and mentees. DuBois, Holloway, Valentine, and Cooper (2002) demonstrated by employing a meta-analytic review that the effectiveness of mentoring programs for children were enhanced considerably when based in theory and empirical support.

Play-based school mentoring has shown promise as an effective intervention for behavior problems of young children (Jones et al., 2002). This play-based mentoring study was grounded in play therapy principles and procedures to address the social-emotional needs specific to young children. Play therapy is a developmentally-responsive mental health intervention for children with empirically validated support for its use as an effective treatment for a variety of emotional, social, academic, and behavioral issues (Bratton et al., 2005). Play therapy has a long history of clinical application with children since early in the history and development of psychotherapeutic interventions.

Child-Centered Play Therapy

The historical roots of using play-based interventions with children began with Sigmund Freud providing guidance through correspondence to the father of a child referred to in Freud's case studies as "Little Hans" (Freud, 1909). While other early psychoanalysts and directive play therapy approaches were developed early in the history of play therapy (Freud, 1946; Hambidge, 1955; Hug-Hellmuth, 1921; Klein, 1955; Levy, 1939), it was nondirective play therapy, now known as CCPT in the U.S., that became the most widely practiced approach to play therapy (Lambert et al., 2005). Virginia Axline (1947) developed CCPT through extending Carl Roger's person-centered theory to be developmentally responsive with children in a therapeutic setting with play materials and toys. While play therapy approaches continues to develop through a

variety of influences that lead towards innovations in the field today (Crenshaw & Stewart, 2015; O'Connor & Braverman, 2009), CCPT continues to enjoy the wide support.

CCPT emerged from Carl Roger's client-centered approach, later know as person-centered approach, as a distinct modality of play therapy. Rogers (1951) viewed people as being deeply trustworthy and intrinsically forward moving as they grow towards fulfilling their potential as a person. Virginia Axline, one of Carl Rogers' students and later a colleague, applied the person-centered approach to her work with children in play therapy, referring to it as CCPT. Axline (1947) consistently applied Rogers' approach to CCPT by placing an importance on creating a safe environment to facilitate the child's full emotional expression in the playroom. Influenced by Axline, Bernard and Louise Guerney continued to develop CCPT as an approach including identifying stages of the child's expression over the duration of treatment (Guerney, 1983; Guerney, 2001). CCPT was further popularized and developed by Landreth (2012) through his seminal textbook, Play Therapy: The Art of the Relationship, and extensive lecturing on an international scale. CCPT continues today as a relevant and supported play therapy approach. CCPT is the play therapy approach with the most practitioners as well as the having an extensive body of research that supports its usage as an intervention.

Child-centered play therapy (CCPT) places a focus on the therapeutic relationship with a trained play therapist that uses play and play materials as media for allowing the child to express their internal and external experiences as children are unable to use abstract thought which is the primary focus in talk psychotherapy that is utilized with most adults (Landreth, 2012). A primary aim of the CCPT therapist is the creation of a physically and emotionally safe environment that allows the child to express their own direction, make their own choices, and integrate their experiences. The therapist is capable of doing this through meeting some specific attitudinal

conditions identified by Rogers (1951): being congruent, having conditional positive regard, and an empathic understanding of the child. During the play therapy process, the therapist connects interpersonally with the child while creating a psychologically safe environment and cultivates an understanding of how the child experiences the world while gaining insight into the child's perceived view of himself and others.

CCPT has a strong evidence base to support its efficacy for use with children and this is reflected in CCPT research literature (Baggerly, Ray, & Bratton, 2010; Lin & Bratton, 2015). Research on CCPT continued since the 1940s, examining a myriad of variables and problem behaviors. Specifically, 41 CCPT published outcome research studies (17 of these studies used random assignment) have been conducted since 1995 examining the effects of the intervention on children's functioning and well-being (Center for Play Therapy, 2015). The efficacy of CCPT with a variety of social and emotional concerns in addition to the breadth of diversity of children participants that has been investigated through controlled outcome studies indicates CCPT is an effective mental health treatment (Bratton et al., 2005). CCPT and its research support have been summarized by proponents of the approach such as Bratton et al. (2005), Bratton and Lin (2015), Landreth (2012), and Ray (2011). Ray (2011) manualized CCPT protocol to ensure fidelity while maintaining the relational and responsive roots of this play therapy approach. A majority of contemporary CCPT research investigating its effects when delivered by a mental health professional has been conducted in the school setting (Center for Play Therapy, 2015).

School-Based Child-Centered Play Therapy

The use of play therapy with school-age children is grounded in knowledge of the developmental needs of children (Landreth, Ray, & Bratton, 2009). Prominent leaders in the field of development (Berk, 2008; Elkind, 2007; Erikson, 1963; Piaget, 1962; Vygotsky, 1967)

placed a high level of importance in the role of play in the lives of children. Because of children understanding the world around them from a preoperational or concrete operational perspective, children are unable to engage wholly in cognitive and abstract reasoning that is required to express their emotional experiences through verbal means (Landreth, 2012; Piaget, 1962). Leading child mental health experts have expressed that children naturally express their feelings, experiences, and perceptions through play (Allan, 1988; Ginott, 1961; Kottman, 2011; Landreth, 2012; Oaklander 1978; Schaefer, 2011). Erikson (1976) and Piaget (1962) posited the symbolic play of children aids in dealing with conscious and unconscious stressors and serves as a healing and therapeutic role. This developmental foundation provides the rationale for the use of play therapy and play-based intervention with school-age children because of their responsiveness to the distinctive needs of children.

CCPT has been utilized in school-based settings since its inception (Bratton, 2010) and its use in schools is noted early in CCPT literature with Axline recommending teachers to integrate CCPT skills for use with students (1947). The now classic book, Dibs in Search of Self, reached a large popular audience and depicts a play therapist's work with a child using school-based CCPT in a playroom (Axline, 1964). More recently, school-based CCPT has developed increasingly broader empirical support for its use as an efficacious intervention in school settings (Bratton et al., 2005; Ray, Armstrong, Balkin, & Jayne, 2015). Outcome research supports the use of school-based CCPT for decreasing academic issues (Blanco & Ray, 2011; Blanco, Ray, & Holliman, 2012), externalizing problems (Bratton et al., 2013¬; Garza & Bratton, 2005; Ray, Blanco, Sullivan, & Holliman, 2009; Schumann, 2010), internalizing problems (Shen, 2002; Stulmaker & Ray, 2015), and teacher-child relationship stress (Ray, 2007).

School-based CCPT has demonstrated to have a positive impact with non-dominant cultural populations. Garza and Bratton (2005) assessed the effectiveness of using CCPT on behavior problems with Hispanic children. Parents of the children were blinded to the child's group assignment and children were randomly assigned to each group. The experimental CCPT group (n = 15) demonstrated a statistically significant effect (a large treatment effect size) on externalizing behavior problems as compared to the comparison group curriculum-based small group intervention titled Kids Connection (n = 15). Additionally, the CCPT group demonstrated a medium treatment effect size as compared to Kids Connection for the children's internalizing problems, but it was not statistically significant.

The Ray et al. (2015) meta-analysis and systemic review examined and evaluated 23 elementary school-based CCPT studies involving 1106 child participants. Results indicated statistically significant results for several outcome variables: externalizing problems (d =.34), internalizing problems (d = .21), total problems (d = .34), self-efficacy (d = .29), academic, (d = .36), and other behaviors (including social skills, attitude towards school, and child-teacher relationship) (d = .38). The authors concluded that there is strong evidence in support of the use of CCPT in school settings.

Other studies supported similar conclusions regarding the effectiveness of school-based CCPT (Ray & Bratton, 2015). Berkowitz (2005) and Ray et al. (2005) reported school counselors and other school mental health professionals are supportive of the use of play therapy in elementary school settings. Unfortunately, a lack of the specialized training and the scare availability of time to deliver play therapy have hindered its widespread adoption by school counselors and other school mental health professionals.

Filial Therapy and CPRT

The field of play therapy has a long history of including caregivers, especially parents, in training so that they can become an agent of change in the social and emotional health of children. An important development in CCPT approaches and the field of play therapy was the development of filial therapy in the 1960s by Dr. Bernard Guerney. Bernard Guerney's wife, Dr. Louise Guerney, would later play the influential in the continued development and dissemination of filial therapy. The Guerneys created an innovative, formal approach to providing parents with the training and supervision essential to developing CCPT skills and attitudes to become the therapeutic agent with their own child (Guerney, 1964; Guerney, 1969; Guerney & Ryan, 2013). The goals that lead to the creation of filial therapy was to maximize the use of mental health professionals' time and to efficiently help more children than traditional methods had been able to do at that time. Filial therapy consists of weekly group training sessions with parents being taught to hold special weekly playtimes with their child while providing core CCPT principles (Guerney, 2000; Guerney & Ryan, 2013). While this approach's philosophy and foundation is solidly grounded in CCPT attitudes and skills, Bernard Guerney (1964) noted the influences of both Clark Moustakas (1959) and Natalie Fuchs (1957), the daughter of Carl Rogers, as predecessors in suggesting parents are capable of holding play sessions at home would be therapeutic and healing for children.

Early research into filial therapy found mothers trained in filial therapy demonstrated an improvement in their child-parent relationship as compared to before they received the training (Guerney & Stover, 1971; Stover & Guerney, 1967). Stover and Guerney (1967) assessed the effectiveness of training mothers to become the therapeutic agent for their child ($n = 8$) as compared to a waitlist control group ($n = 8$). Through direct observation, the researchers found a

statistically significant increase in the experimental group's use of reflective statements with their child as compared to the waitlist control group over time. Guerney and Stover (1971) later supported these earlier findings after studying 51 child-mother dyads. Results from this study demonstrated positive gains in the psychological adjustment and symptomology of the children over time. However, a limitation of this second study was that it lacked a control group.

Filial therapy was further refined by Landreth (1991) as he examined different lengths of the format to maintain continued parent involvement until completion. Landreth found a 10-session model to be the most optimized in terms of length to reduce parent dropout rate (Bratton, Landreth, & Lin, 2010; Landreth, 2012). This model differed from the Guerneys' due to its condensed duration for training parents. Landreth and Bratton (2006) further refined Landreth's 10-session model filial therapy model that was a concise, structured, and time-limited approach and named it Child Parent Relationship Training (CPRT; Landreth & Bratton, 2006) to distinguish it from other filial therapy approaches. CPRT was protocolized by Bratton, Landreth, Kellum, and Blackard (2006) to ensure treatment fidelity and allow for ease of reproduction of the model. An additional strength of the CPRT model is its strong empirical foundation.

CPRT research has shown very favorable positive outcomes for its use in improving relationships between children and caregivers. Bratton et al. (2005) utilized a meta-analytic review of 93 play therapy treatment outcomes studies and found a large effect size ($d = 1.05$) for paraprofessional provided play therapy (a majority of the studies involved CPRT-trained parents) and an even larger effect size ($d = 1.15$) for filial therapy provided only by parents. Implications identified by the authors includes a greater utilization of CPRT and other filial therapy approaches over play therapy.

Bratton et al. (2010) conducted a systematic review and noted 32 controlled outcome studies involving 916 participants that examined the effects of CPRT on children and caregivers with 13 of those studies being experimental designs. Results of the Bratton et al. (2005) study were further analyzed meta-analytic data gathered by Bratton et al. (2005). The overall treatment effect of CPRT studies had a strong treatment effect size of 1.25 and an even stronger effect size of 1.30 when only CPRT studies with parents are looked it. These findings give a robust indication of the effectiveness of CPRT. The authors offered that full involvement of parents in their child's treatment, parents receiving their training and supervision from mental health professionals who had a strong understanding of the CPRT model, parents receiving direct supervision on their use of the CPRT skills, and the fidelity to the model by the mental health professionals providing CPRT have led to positive outcomes of CPRT studies (Bratton et al., 2010).

More recently, Lin & Bratton (2015) identified 24 controlled outcome studies involving 1848 child participants that had full parent involvement in the treatment process by receiving training and supervision to serve as a therapeutic agent for their child with all of these studies on examining CPRT and found a moderate effect size (d = .59) when compared to the moderate effect size for the utilization of a mental health professional (d = .47). This is an indication of the significant impact both parents and teachers can have on a child's emotional health when the paraprofessional is involved in the child's therapy. The Center for Play Therapy (2015) reported 31 published controlled outcome research studies since 1995 on the effects of CPRT utilizing either parents or teachers with 15 of those same studies using random assignment.

CPRT has been successfully adapted for use with other significant individuals in children's lives, most frequently this has been teachers (Gonzales, 2012; Helker & Ray, 2009;

Morrison & Bratton, 2010; Morrison Bennett & Bratton, 2011; Pronchenko-Jain, 2012; Smith & Landreth, 2004). Andronico and Guerney (1969) offered that there promising potential to applying filial therapy with teachers. Guerney and Flumen (1970) demonstrated the effectiveness of using filial therapy with teachers to increase children's assertiveness while the control group did not show a change in children's assertiveness. A significant development in using CPRT with teachers was the development of a protocolized curriculum for teachers that was coined with term Child Teacher Relationship Training (CTRT; Morrison & Bratton, 2010). An unpublished treatment manual was created by Bratton, Landreth, Morrison, and Helker that specifically reflected this model as it has been adapted for teachers and specific structure as it relates to the child teacher relationship. The model continues effectiveness continues to be augmented by contemporary research (Gonzales, 2012; Pronchenko-Jain, 2012). In addition to CPRT being adapted most frequently for use with teachers, CPRT has also been adapted for use with mentors (Baggerly & Landreth, 2001; Jones et al., 2002).

Filial Therapy and Play-Based Mentoring

An exhaustive review of the filial/CPRT and play-based mentoring literature reveals limited research on filial/CPRT adaptations for peer mentors. A sibling peer helper model following the Guerneys' filial model was studied by Seidenberg (1978). When compared to the waitlist control group sibling dyads (n = 6), the experimental group sibling dyads (n = 6) were found to have an statistically significant increases in interpersonal communication skills, the number of positive comments made about their younger sibling, and in empathic communication towards each other. The experimental group also had a statistically significant decrease in the number of negative comments about their younger sibling.

McHale (1983) investigated the effects of weekly group play sessions delivered by second and third grade mentors (n = 28) following the Guerneys' filial model elementary school mentees who were autistic (n = 28). A group of six mentors would hold the group sessions daily for a week (five consecutive school days) with six elementary school mentees with autism. The mentors were randomly selection from all the second and third graders that returned their consent forms and the There was no use of a control group in this study. Observations were made by the researchers of the interactions between the mentors and the mentees to measure play, verbal communication, social interaction, and solitary behaviors. While not statistically significant, the results indicated an increase in sustained social interactions, verbal communication, and play behaviors between the second and third grade mentors with the autistic elementary school mentees over time as well as a reduction in mentee solitary behaviors over time.

Baggerly & Landreth (2001) examined training 5th grade students as a modification of the CPRT model using peer helpers with kindergarten children in their school. Results from the pre and post test measurements demonstrated kindergarten children in the experimental group were not statistically significantly different from children in the waitlist control group across time on behavior problems from the teachers' perspective (Internalizing Behavior, Somatic Complaints, Externalizing Behavior) and behavior problems from parents' perspective. The results did indicate positive trends in parents rating of the children's global behavior as well as teacher ratings of the children's global behavior across time. Limitations of this study include a small sample size, non-randomization of participants, a waitlist control group, and a relatively small number of peer helping sessions between the 5th grade students and kindergarteners (10 sessions for 20 minutes each).

A randomized, controlled study Jones et al. (2002) conducted to examine the effectiveness of training 29 high school peer mentors using CPRT principles and procedures to apply with 27 young children. This study was the first to investigate an adaptation of CPRT with high school mentors. Jones et al. found that peer mentors successfully learned and applied the required skills to foster emotional growth and behavioral change in children. More specifically, this study found that after children receiving the CPRT training adapted for high school mentors (20 sessions for a 20-minute duration) demonstrated a statistically significant reduction in global behavior problems compared to the PAL® group and the high school mentors demonstrated statistically significant increase in empathic interactions compared to the PAL® group. One strength of the Jones et al. study was the use of CPRT-adapted for high school mentors compared to PAL®, a mentoring program broadly adopted in high schools across the U.S. This allowed for a meaningful comparison of the experimental group (mentor-adapted CPRT model) against an approach that has wide implementation and acceptance. The study also used random assignment ensuring both the experimental and the control groups were statistically equivalent to each other as well as blinding parents, who provided a measure of behavioral change, to the group assignment of the children. While this was the first study in using CPRT adapted to high school mentors, additional research is needed to establish this model as an effective school-based mentoring approach for at-risk young children and continued research is needed. Future studies that use a large sample size, additional points of measure, and replicate the stringent procedures employed by Jones et al. (2002) with similar findings would increase methodological rigor and add to the acceptance of the mentor-adapted CPRT model as a viable intervention. Future studies will add to the evidence base for CMRT and may more accurately capture the effectiveness of CMRT as a peer mentoring program.

Peer Assistance and Leadership

Peer Assistance and Leadership (PAL®) is an evidence-based peer helping program where high school students are trained to become peer helpers for younger students in feeder schools for the high school. The goal of the PAL® program is placing high school students in a mentor role where they have the opportunity to help younger students have a more positive and academically successful school experience. The PAL® program is designed to build resiliency in young children as well as boost academic performance, classroom attendance, classroom behavior, and build friendship with family, peers, and the school (NREPP, 2017).

PAL® began in the Austin Independent School District in Austin, Texas in 1980 as a means of training students in basic communication and helping skills to place them in peer mentoring roles to aid children in having a positive school experience (Grant, 1987). By 1986, the PAL® program had expanded to a majority of Austin Independent School District high schools. PAL® has expanded considerably since its inception and is now has a national reputation that includes implementation in over 1000 school districts throughout Texas as well as school districts in 14 other states (NREPP, 2017) and in Australia (Beavis & Bowman, 1995).

In 2006, PAL® was appraised by the NREPP as an evidence-based program (Peer Resources, 2007). The Arthur, Hawkins, Pollard, Catalano, & Baglioni (2002) study found that students who participate in PAL® had statistically significant within group findings of improvements in GPA, a state-mandated reading exam scores (TAAS), and a state-mandated math exam scores (TAAS) for both high school mentors and the child participants. This same study also found both high school mentors and child mentees who participated in PAL® had a decrease in the number of absences and discipline referrals. Limitations of this study include a lack of a control group and that the results were unclear as to whether the analyses utilized were

between groups or within group results. In another study, Landry (2005) found by a year after beginning to participate as a PAL® peer mentor, the peer mentors had statistically significant increases in their perception of being included in important school programs, increase in praise received from teachers for their hard work, increases in communication with their mothers, increases in appropriate response in dealing with peers, and increases in perception that the school had positive communication with their parents as compared to the control group. Limitations of this study include a non-randomized sample and the appropriateness of data analyses as separate analyses were conducted for between group effects at post test only and within group effects were conducted with the intervention group only.

APPENDIX B

DETAILED METHODOLOGY

In this appendix, I addressed the methodology and procedures used to measure the effectiveness of a play-based peer mentoring program, Child Mentor Relationship Training (CMRT), as compared to a well-established, non-play based peer mentoring program Peer Assistance and Leadership ([PAL®]; PAL®, 2017). PAL® was included in the Substance Abuse and Mental Health Services Administration National Registry of Evidence-Based Programs and Practices. Both programs were designed to train high school students to provide peer mentoring for identified at-risk primary school children. I used a randomized control group design with 2 points of measure (pre and post). The experimental and comparison groups received training in their respective peer mentoring intervention and provided mentoring to child mentees. In this appendix, I included research questions, participant information, instrumentation, methodological procedures, data collection, and data analysis.

Definition of Terms

The terms below have been operationally defined for the purposes of measuring and testing constructs were applied in this study.

- Peer Assistance and Leadership. PAL® (PAL®, 2017) is a program for high school students focused on helping other students with a peer mentoring component. PAL® was defined by the Substance Abuse and Mental Health Service Administration's National Registry of Evidence-based Programs and Practice (2015) as "a peer helping program that seeks to build resiliency in youth by pairing youth with peer helpers who receive training and support from teachers participating in the program" (para. 1). The protocol for PAL® can be accessed here (though a requirement is that one has previously completed the PAL® training): http://palusa.org/.

- Child mentor relationship training. CMRT was defined as a mentoring model adapted from child parent relationship therapy used by Jones et al. (2002) in training high school students to become effective peer mentors with young children.

- Child parent relationship training. CPRT (Landreth & Bratton, 2006) was defined as a filial therapy parent training model (Guerney & Ryan, 2013) that is based in CCPT principles. A trained facilitator teaches parents how to become the therapeutic agent for their child through the use of didactic training, discussion, demonstrations of play sessions, direct supervision under a trained CPRT facilitator, and facilitation of parent-child at-home play sessions. This manualized intervention provides parents with the tools and attitudes necessary to create a therapeutic environment for their child through an accepting and understanding environment to support the parent-child relationship. The following texts contain the protocol and treatment manual for CPRT: *Child Parent Relationship Therapy (CPRT): A 10-Session Filial Therapy Model* (Landreth & Bratton, 2006) and *Child Parent Relationship Therapy (CPRT) Treatment Manual: A 10-Session Filial Therapy Model For Training Parents* (Bratton et al., 2006).

- Child-centered play therapy. CCPT was defined as a play therapy intervention developed by Virginia Axline (1947) using Carl Rogers' person-centered theoretical framework that is based in the "belief in the individual's capacity for self-direction (Landreth & Bratton, 2006, p. 4)". CCPT is grounded in the understanding that the relationship between therapist and child is the primary mechanism for growth and healing in therapy. This therapeutic intervention utilizes play, a developmentally appropriate means of communication and emotional expression for children, as a vehicle to build a safe relationship between the therapist and child so that the child is fully able to explore feelings, thoughts, experiences, and behaviors (Landreth, 2012).Global Behavior Problems. Global behavior problems are defined to include both inward

and outward expressions of behavioral conduct. For the purpose of this study, global behavior problems is operationally defined as child mentees' problems score from the Total Problems aggregate scale which encompasses both the Internalizing Problems and Externalizing Problems broadband scales on the Caregiver-Teacher Report Form and the Teacher Report Form (Achenbach & Rescorla, 2001).

- Empathic behavior. Empathic behavior refers to the verbal and non-verbal behaviors and responses of a high school mentor to express a sensitivity and deep understanding of children's experiences and feelings (Rogers, 1957). Empathic behavior would include the high school mentor responding to their mentee's emotional and behavioral expressions in an interpersonal manner that conveys caring and acceptance. Operationally, empathic behavior is defined as the high school mentors' empathic expression Total Score scale on the Measurement of Empathy in Adult-Child Interaction (MEACI; Stover, Guerney, & O'Connell, 1971).

Research Questions

The purpose of this study was to examine the efficacy of two school-based peer mentoring programs: the NREPP approved PAL® intervention and the CMRT model (Jones et al., 2002) with modifications that reduced the duration of the model from two semester to one to accommodate the specific needs of the schools involved and. Specifically, this study is designed to investigate the effectiveness of the play-based CMRT model as compared to the non-play based PAL® program. Research questions addressed in this study include:

(1) Based on independent observations, do CMRT high school mentors improve in their empathic behaviors towards child mentees as compared to PAL® high school mentors over time?

(2) Based on teacher report, do child mentees in the CMRT experimental group demonstrate a reduction in global behavior problems as compared to PAL® comparison group child mentees over time?

Participant Selection and Recruitment

High school mentors and child mentees were students from a public school district within a suburban city in the southwest United States. A previously established screening and referral process at the school district for mentoring programs identified mentors and mentees for this present study. Human subjects approval was obtained from the researching university's internal review board as well as the participating school district prior to participant recruitment that involved one high school, two elementary schools, and two Head Start preschools. As was consistent with the format and procedures of peer mentoring within this school district, participating high school mentors were assigned to participating child mentees from the schools identified above. Specific participant selection and recruitment information pertaining to each group of participants is noted below.

High school mentors participants were volunteers amongst juniors and seniors that were currently enrolled in the peer helper classes at the high school noted above. These high school students were receiving credit towards graduation for their participation in this course. The students had already completed the fall semester of this year-long peer helper class and in some instances, senior classification participants had also enrolled in the class in the previous academic year. Criteria for the inclusion of high school mentors was: (a) between the ages of 16 and 18; (b) capable of fluently reading, writing, and speaking English; and (c) not currently involved in any other mentoring or peer helper skills training program. All high school students that were attending the two peer helper classes offered at the high school volunteered to

participate in this study and completed the applicable assent and/or consent documentation as appropriate for the age of the high school mentor.

Child mentee participants were volunteer preschool through 2nd grade students recruited from school sites in the same school district as the high school. These four school sites included and two Head Start preschools and two elementary schools. School counselors at each school referred students to the peer mentoring program based on school counselor report and teacher report of behavioral problems that were believed to contribute to diminished school success. The criteria for the inclusion of child mentees was: (a) between the ages of 4 and 8; (b) capable of speaking fluent English; and (c) not currently involved in counseling or mentoring services either at the school or in other settings. Through the established procedures for identifying child mentees, 74 preschool and elementary children were initially identified. However, after finalization of mentoring session times, 14 of these mentors were unavailable to meet during these times or they did not meet full inclusion criteria as they were currently receiving counseling services.

High school mentors were assigned to provide peer mentoring for two child mentees each for the intervention phase of this study. Inclusion criteria and assent/consent documentation was met and obtained by 30 high school mentors (15 in the experimental group, 15 in the control group) and 60 child mentees (30 in the experimental group and 30 in the control group). Within the child mentees sample, 30 were attending one of the two included Head Start preschools and 30 were attending one of the two elementary schools. Illustrated below in flowcharts is the participant recruitment process and detailed participant demographic information that includes age, grade level, gender, and ethnicity in Figures B.1 and B.2.

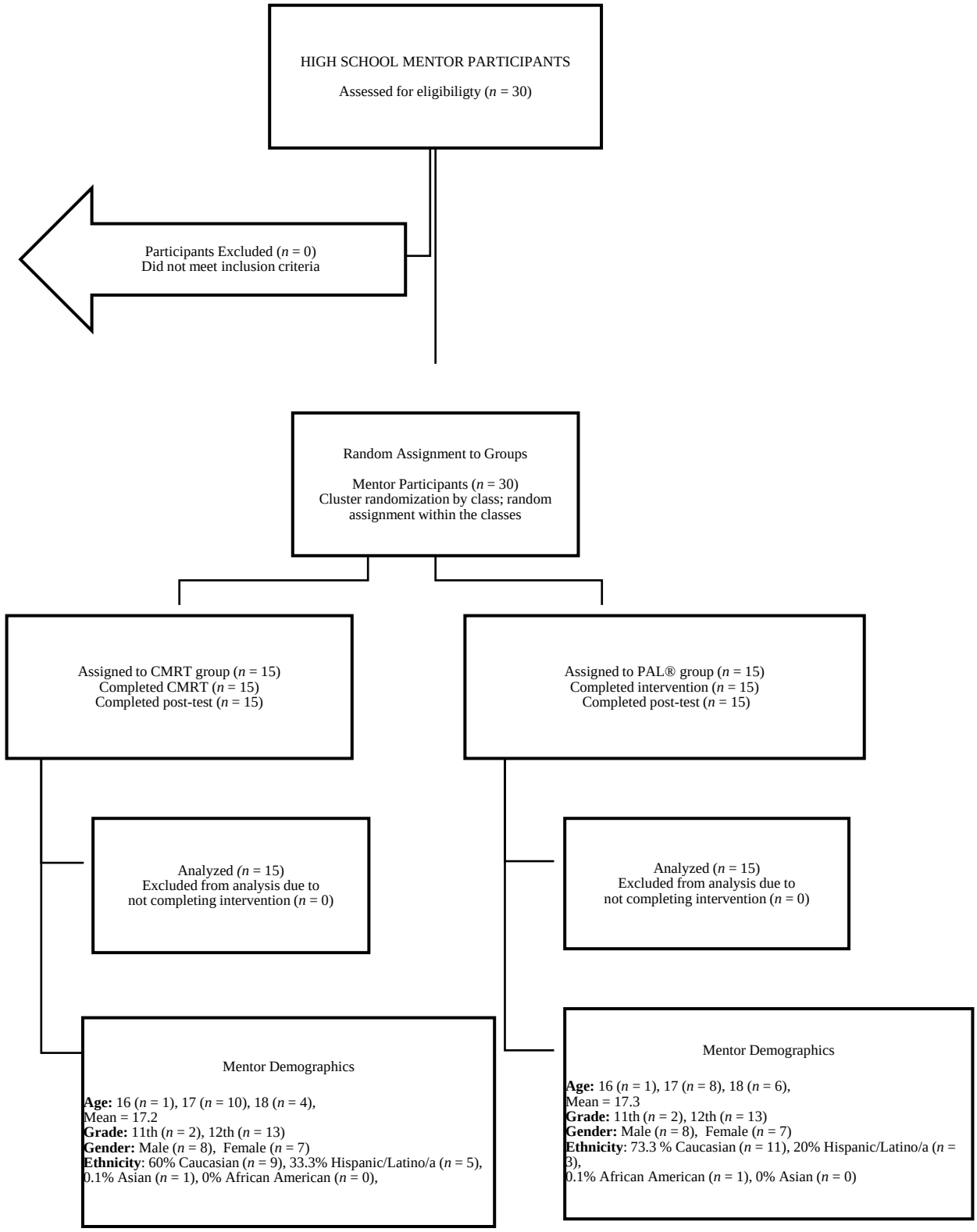

Figure B.1. Flowchart of study high school mentor participants.

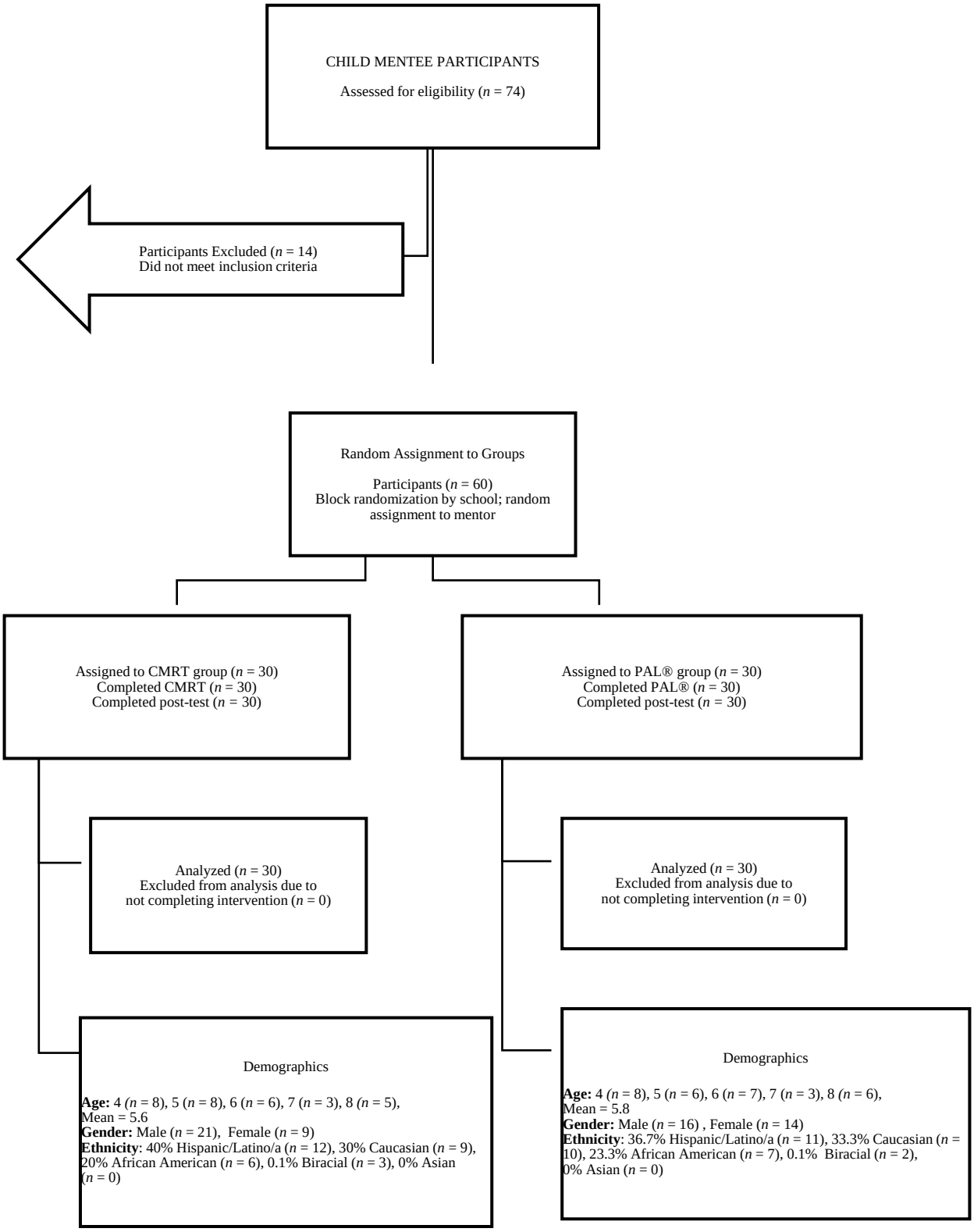

Figure B.2. Flowchart of study child mentee participants.

High School Mentor Participants

All high school mentors in this study were classified as juniors and seniors attending a public high school with a student body of approximately 2000 located in the southwest United States. High school mentor participants were volunteers from the two PAL® classes at the participating high school. Course credit is offered for completion of the class. Each class is composed of 16 students for a total of 32 potential high school participants.

After receiving approval from the school district's research office and the University of North Texas' Internal Review Board, I identified high school volunteer participants through direct contact with the peer helping classes offered at the high school. All high school students in the two PAL® classes requested to volunteer for this study. Prior to obtaining consent from the high school mentors, the study was be thoroughly explained, any additional questions regarding their involvement were addressed, written information regarding the study was provided to the high school participants, and I asked their parents to sign informed consent for the high school student's participation in the study. With the flip of a coin, I randomly selected one class to be the experimental mentoring intervention and the other class to be the comparison mentoring intervention.

Inclusion in the PAL® program required the high school student to be a junior or senior that successfully completes an intensive vetting process by the PAL® program instructor and high school faculty that includes a background check, a mandatory application completed in the semester prior to joining, letters of recommendations from teachers, letters of recommendation from peers, an interview, and a commitment to remain an involved member of the PAL® program for the subsequent academic school year. The PAL® program instructor emphasized the selection process sought to include a diverse cross-section of the high school in terms of

ethnicity, gender, socioeconomic status, high school extracurricular interests, and students who were bilingual. No high school mentors were be excluded from the current study based on gender, race, or ethnicity. Additional criteria for recruiting high school mentors in this proposed study included:

- Mentors are between the ages of 16 and 18 at the time of informed consent;
- Mentors can read, write, and speak English fluently;
- Mentors are not currently involved in any additional peer mentor programs and/or helping skills trainings

Child Mentee Participants

Prekindergarten through 2nd grade child participants were recruited from three different sites: two Head Start preschools and one elementary feeder schools for the high school the mentors attend. All three schools are in the same suburban public school district as the high school. Preschool and elementary school children participating in the study were selected due to their school's preexisting affiliation with the high school PAL® program and their high numbers of at-risk students.

Upon approval from the school district's research office and the internal review board at the University of North Texas, I identified child participants through the aid of the school counselor and teachers as we followed pre-established procedures used by the district for mentoring programs. The researcher requested potential child participants' parents to review and sign informed consent for their child's involvement in this study. Child participants who I believed were able to assent to study were provided a verbal explanation of the research, its purpose, an opportunity ask any clarifying questions, and an assent form to sign. Upon completion of the informed consent/assent, the children's teachers completed the CTRF/TRF. No

child mentees were excluded from this current study based on gender, race, or ethnicity. Criteria for inclusion of child mentees in this current study included:

- Child mentees are between the ages of 4 and 8;
- Child mentees speaks English;
- Child mentees are not currently involved in any additional peer mentor/helper programs;
- Child mentees are not currently receiving counseling or other mental health services during the duration of the proposed study

Instrumentation

I administered two assessments to measure the effectiveness of CMRT compared to PAL®. The MEACI measures empathic behaviors of high school mentors towards their child mentees. The Caregiver-Teacher Report Form/Teacher Report Form (CTRF/TRF) measures global behaviors problems of the child mentees. Both instruments were used to collect data prior to the treatment phase (pre) and after the completion of the treatment phase (post) to quantify the change in treatment outcomes between the two group and over time.

Measurement of Empathy in Adult-Child Interactions

The MEACI is a direct observational rating scale instrument that was used to measure observable empathic interactions with children. This instrument was initially developed by Guerney, Stover, and DeMeritt (1968) and further refined by Stover, Guerney, and O'Connell (1971) to rate the empathic interactions of play therapists or child caregivers that occur between the counselor/caregiver and the child in engaged play therapy. The MEACI was adapted by Bratton (1993) and included the addition of a rating form. In 2006, the MEACI was published with permission from the original author while the scoring protocol was updated with minor revisions to its formatting and clarifying directions for the instrument (Bratton et al., 2006). It is available in print and in digital format on the CD-ROM that is included in the treatment manual

titled Child Parent Relationship Therapy (CPRT) treatment manual: A 10-session filial therapy model for training parents (Bratton et al., 2006).

The MEACI is comprised of a Total Empathy Score and three subscale scores: Communication of Acceptance of Child, Allowing Child Self-Direction, and Adult's Involvement with Child. When utilized in the prescribed manner, the MEACI blinds raters to group assignment and time of data collection when multiple points of measure are involved. The Bratton (2006) adaptation of the MEACI utilizes observational ratings at three minute time intervals with retrospective scoring for each interval using a 5-point scale ranging from a high rating of five to a low rating of one to measure each construct for each of the three subscales. Low scoring signifies the adult displaying higher levels of verbal and non-verbal empathic interactions with the child. Verbally recognizing the child's feeling in an accepting way, showing a willingness to follow the child's lead, and giving the child full attention are indicative adult behaviors of a low total empathy score. Verbally criticizing the child, placing directional demands on the child, and being preoccupied/self-involved are reflective of adult behaviors of a high total empathy score.

The MEACI is utilized frequently in filial therapy and CPRT research and has favorable psychometric properties. Raters of the MEACI must reach a sufficient inter-rater reliability level ($r = .70$) before using the instrument to code recorded play sessions (Stemler, 2004). This is achieved through the raters attending MEACI inter-rater reliability trainings with a focus placed on collectively rating play sessions until the raters reach a full consensus on the rating of each session after rating the session independently of each other. Bratton and Lin (2015) reported a high level of consistency in inter-rater reliability through examining more than 600 coded play sessions and found strong reliability coefficients ranging from $r = .82$ to $r = .99$ across raters.

Stover et al. (1971) found support for construct validity of the MEACI and obtained reliability coefficients for each of the three subscales of the MEACI in a pretest-posttest design study with fifty-one mothers and their children. Mothers in the study displayed a statistically significant increase in their empathic behaviors and responses towards their child between the administration of the pre- and post-play session MEACI. Positive changes in the parents' scores indicated the three scales of the MEACI are "extremely sensitive measures of the behaviors in question" (Stover et al., 1971, p. 267). Construct validity is further supported by the MEACI's consistent outcomes in CPRT research conducted over the past two decades. Construct validity for the MEACI has continued to have favorable support as evidenced by recent CPRT research. Lin and Bratton (2015) concluded that MEACI scores on seven recent CPRT studies were similar to Stover et al. (1971), concluding that the statistically significant increases on all subscale domains indicate the MEACI is a useful instrument in measuring communication of acceptance, allowance of the child's self-direction, and adult involvement with the child of focus.

Caregiver-Teacher Report Form/Teacher Report Form

The CTRF/TRF (Achenbach & Rescorla, 2001) is a self-administered questionnaire designed to measure teachers' reports of behavioral, emotional, and social problems for children. The CTRF/TRF requires approximately 10-20 minutes for the respondent to fully complete the assessment (Bogan, 2015). Achenbach and Rescorla (2001) devised the instrument to measure three major categories that include: Internalizing; Neither Internalizing or Externalizing; and Externalizing scales. Additionally, the CTRF/TRF is comprised of seven syndrome scales (Anxious/Obsessive, Depressed/Withdrawn, Fears, Somatic Complaints, Immature, Attention Problems, and Aggressive Behavior). Additionally, a Total Problems scale is obtained from the measure. Each item of the questionnaire can be rated on a scale of 0 to 2 with a 0 representing

the item is not true, a 1 for sometimes true, and a 2 for often true. A higher score an item on the questionnaire indicates a more acute level of concern for the child. Each subscale is produces a T score assigned to a raw score that can be further identified on the instrument as falling into one of three ranges: normal, borderline, and clinical ranges.

Two versions of this instrument, the CTRF and the TRF, are based on the child's age with the CTRF in use for children from ages 1 ½ to 5 and the TRF in use with children from ages 6 to 18 years old. In this current study, the researchers used both versions of the assessment to address the full range of child mentees who participated. The authors of both instruments (Achenbach & Rescorla, 2001) note that the instruments within the Achenbach System of Empirically Based Assessment (ASEBA) are integrative and consistent with one another, including the CTRF and the TRF which belong to ASEBA; this allows for valid and reliable measurements of participants' behavioral functioning across ages. An advantage of ASEBA is the use of these instruments in research settings allow for ease of comparability across normalized and empirically-based scales (Rescorla, 2005). The CTRF/TRF has strong psychometric properties and exhaustive normative data available regarding the sample demographics including gender, socioeconomic status, ethnicity, and geographic distribution of the sample (Achenbach & Rescorla, 2001).

For the purposes of this current study, some of the participants were an appropriate age to administer the CTRF while other participants fall into the older age range that required the TRF. Achenbach & Rescorla (2001) reported a high reliability of scores across both instruments and that the instruments are analogous to eachother; the scales display scores in relation to the national norms for the child's age and gender. ASEBA, the assessment family that the includes the CTRF/TRF, has been identified as a collection of instruments with extensive support for its

reliability and validity in evaluating and tracking behavioral and emotional problems that it is recommended for use with numerous populations (Bogan, 2015).

Caregiver-Teacher Report Form. The CTRF consists of 99 items and requires 10 minutes to complete. The normative group for the CTRF comprised of 1,076 children (536 boys and 539 girls) with ages from 1 1/2 to 5 years old from across 12 states within the United States and Holland. Test-retest reliability was found to be strong (r = .84) over intervals averaging 8.7 days. Achenbach and Rescorla (2001) reported an adequate in inter-rater reliability (r = .66). Content validity was assessed by professionals in related fields, parent feedback, and through ratings on the CTRF that differed significantly between referred and non-referred children. Evaluation of criterion validity for the CTRF indicated that the items are the questionnaire was sufficiently differentiated between referred samples and the normative sample.

Teacher Report Form. The TRF (Achenbach & Rescorla, 2001) is a self-administered 118-item questionnaire for children from the ages 6 to 18 years old. The TRF requires approximately 15-20 minutes for the respondent to fully complete the assessment. The normative group for the TRF comprised of 4,437 children between the ages of 6 to 18 years old from across 40 states and the District of Columbia within the United States. A moderately high internal consistency was reported by Achenbach and Rescorla (r = .90) on the total problems scale, adequate reliability (r = .72 to .95 on syndrome scales; .73 to .94 on DSM-oriented scales). Test-retest reliability was found to be high (r = .85). Achenbach and Rescorla (2001) reported a sufficient inter-rater reliability (r = .51). Content validity was reported as supported by research and assessed by professionals in related fields, parent feedback, and through ratings on the TRF that differed significantly between referred and non-referred children. Evaluation of criterion

validity for the TRF indicated that the items are the questionnaire was sufficiently differentiated between referred samples and the normative sample (Achenbach & Rescorla, 2001).

Procedures

I described the procedures of the current study below and included detailed information regarding study procedures, the experimental condition, the comparison condition, and data collection. I obtained the appropriate research approval from the participating school district and human subject approval from the University of North Texas Internal Review Board, I identified high school mentor participants from a previously selected high school and child mentee participants from 2 Head Start preschools and 2 elementary schools for the peer mentoring treatment conditions. All high school mentors were currently enrolled in one of two peer helping classes offered at the high school noted above. After obtaining assent and/or consent from the high school mentors (as appropriate to the age of the specific mentor), the two peer mentoring classes were randomly selected for block assignment to participate in either the CMRT experimental group or the PAL® comparison group. High school mentors began providing mentoring sessions for both the CPRT intervention group and the PAL® intervention group held at the preschools and elementary schools every week after the beginning of the treatment phase barring school district holidays and testing days. These procedures were consistent with the frequency of mentoring sessions in a previous CMRT study (Jones et al., 2002).

Per established mentoring protocol in this school district, I requested the school counselor and teachers at the preschools and elementary schools identify children that may benefit from the support of a high school mentor. After receiving assent and informed consent from the child mentee participants and their parents respectively, I collected pre-test data for the CTRF/TRF from each of the child mentees' primary teacher during the two weeks that preceded the

beginning of the mentoring sessions during the treatment phase. The lead researcher and/or research assistants were available to answer questions and offer the teachers the opportunity to complete the assessments in a setting free from the distractions of an active classroom. This process for collecting CTRF/TRF data from teachers of child participants was repeated a second time following the completion of the intervention phase.

Following this, I de-identified child participant data through coding and each child was randomly assigned to participate in the CMRT intervention group or the PAL® intervention group through an online table of numbers. I assigned child mentees to the high school mentors with both interventions groups (CMRT and PAL®) receiving an equal number of mentees in each of the child participants' schools (2 Head Start preschools and 2 elementary schools). Due to the number of children required for the study and the unyielding logistics of holding a potential 16 mentoring sessions simultaneously while providing supervision, I randomized child mentee assignment based on school site. I assigned each high school mentors two child mentees: 1 preschool mentee from one of the Head Start preschools and 1 preschool through 2nd grade mentee from one of the elementary schools.

The collection of pre-test MEACI data occurred during the week prior to the start of the intervention phase. Under the supervision of research assistants, mentors and one of their mentees (same mentee was again used for the post-test) participated in a 20-minute play mentoring session that was recorded in a secluded area at the child mentee's school. The mentoring session areas were previously identified and set with the toys and materials used in a typical CMRT kit detailed in Landreth & Bratton (2006).

In an effort to minimize observer bias and strengthen the methodology of this study, teachers of the child mentees were blinded to treatment group assignment of their participating

students. Additionally, identical statements were used by high school mentors when they introducing themselves to teachers and to their mentees when taking the child out of the classroom for the mentoring intervention, regardless of which assigned treatment group the child mentee belonged in an effort to reduce bias. For example, the high school mentor would state, "Good afternoon, I'm Barbara and I'll be mentoring your student Yolanda each week during this semester…Hi there Yolanda! It's time for us to have our special mentoring time together." Specifics related to the intervention and the child's progress was not discussed with the teachers until after the completion of the study.

The intervention phase for both mentoring interventions were held during the high school mentors' scheduled peer helping class time over the course of the spring semester. This particular high school maintained an A-B block schedule with class rotations. For instance, "A-Day" mentors would attend their peer helping class (during which all treatment phases occurred) for 3 class periods in one week and then attend the same class for 2 class periods in the second week. Conversely, "B-Day" mentors would attend their peer helping class for 2 class periods in first week and then 3 class periods in the following week. Over a two week period, both "A-Day" and "B-Day" mentors would attend 5 peer helping classes. Despite differing days of attendance, the study procedures were similar for both treatment groups. Mentors in both the CMRT and the PAL® intervention groups received 3 weeks (7 class periods with the duration of each class period being 1 hour and 20 minutes for a total of 9 hours and 20 minutes of training) of training in their respective mentoring protocol before beginning to hold their mentoring sessions. After the beginning of the mentoring phase for each intervention, the high school mentors traveled to the child mentees' schools 2 days each week (1 day to a Head Start preschool and 1 day to an elementary school) so that each of their two mentees received 1 mentoring

session per week. Each mentor-mentee sessions lasted for 20-minutes each week over a period of 15 weeks. While the mentoring phase was in-progress, 8 additional trainings were held with CMRT and PAL® mentors during the week that they would have an extra peer helping classes on the schedule. The mentoring phase, that included both mentor-mentee sessions and the additional training, was total of 18 weeks in duration.

Experimental Treatment CMRT: High School Mentors

High school mentors in the CMRT experimental group utilized CCPT principles, attitudes, and skills. Although similar to the Jones et al. (2002) study, I adapted the structure and length of the CPRT protocol to better address the learning and integrative needs of the high school mentors. Traditional CPRT protocol entails 10 weekly 2-hour sessions and weekly home play sessions held between parent and child as described in the CPRT treatment manual (Bratton et al., 2006). I addressed the need for a longer length of time to develop the interpersonal relationship between mentor and mentee as compared to a parent with an already established relationship with their child. Other modifications to the CPRT format include additional adaptations to fit the structure of the school setting and tailoring the examples used in the training to peer mentoring situations. I made these other decisions to best accommodate the high school mentors' learning process and to acknowledge that it may take longer to learn the attitudes and skills than it would for parents. This extended training framework allows the mentors additional time to assimilate and internalize CCPT principles, attitudes, and skills. Extending the number of CPRT sessions beyond the traditional 10 sessions had previously been used successfully (Ceballos & Bratton, 2010) including with high school mentors (Jones et al., 2002). Finally, I modified the CMRT model used by Jones et al. by reducing the duration of CMRT from two semesters to one while surpassing the traditional 10 sessions noted above.

High school mentors learned the essential CCPT principles, attitudes, and skills through training that included didactic instruction, experiential learning activities, skills training, role-playing mentoring situations, video demonstrating peer mentoring relationships, live demonstrations of peer mentoring, and supervised skill application with immediate feedback provided afterwards. These training methods are consistent with established CPRT procedures. High school mentors in the experimental group were instructed to utilize these skills and attitudes in their mentor sessions with their child mentees. Instruction of high school mentors on the CMRT protocol occurred during the peer helping class period. The lead researcher provided a majority of the training to the high school mentors; this facilitator was an advanced doctoral level counseling intern and had completed advanced coursework and supervised practice in play therapy, filial therapy/CPRT, and supervision. The CMRT mentors also participated in 30-minutes of supervision in groups of 4 following their mentoring session. This immediate supervision allowed for 15-minutes of focused feedback provided as a result of the live viewing of the mentoring session as well as video playback of the mentoring session. Each subgroup of 4 CMRT mentors had a dedicated supervisor who remained throughout the intervention phase. Each of these supervisors were masters level counselors who had completed coursework and supervised practice in play therapy and filial therapy/CPRT while half of these supervisors were doctoral students with advanced training in supervision, play therapy, and CPRT. All supervisors were under the direct supervision of a licensed professional Ph.D. level counselor and supervisor who is an expert in CCPT, CPRT, and CMRT.

The lead researcher conducted on-site orientations at each of the mentees' schools before beginning the mentoring sessions. The purpose of this orientation was to better acquaint the high school mentors with the mentor procedures at each of the Head Start schools and elementary

schools where they would be holding their mentoring sessions, provide each mentor with the name of their two mentees and discuss specific study procedures. Following the mentors' orientation sessions at each school site they would be frequenting, I met with each of them a second time to collect pre-test MEACI data in mentor-mentee play sessions.

The CMRT intervention was comprised of 3 distinct phases and each phase is described below in greater detail. For ease of understanding the relationship between the structural format of CMRT and CPRT, I've included the CPRT equivalent session number alongside the CMRT phase.

Foundational training phase (CPRT equivalency sessions 1 – 4). Foundational CCPT/CPRT skills were taught during the high school mentors' peer helper class time. In this phase, a total of 9 hours of training broken down as seven 1-hour and 20-minute meetings over the course of three weeks. I taught the high school mentors through a mixture of didactic learning and experiential activities. The use of discussion, visual handouts, video as well as live demonstrations, the use of role-playing skills, understanding the importance of CCPT principles, attitudes, and skills were used in this phase to train the mentors. Important skills and attitudes taught in this phase include reflective listening, responding verbally and non-verbally to feelings and content, tracking responses, being present with the mentee, conveying the be-with attitudes (I am here, I hear you, I understand, and I care), how to follow the direction that the child has selected, and basic limit setting (Landreth & Bratton, 2006). The mentors were assigned and required to read the book, Dibs in Search of Self (Axline, 1964) in aid in connecting the mentors to the role in supporting their child mentees' affective expression and how share an example of how they can support self-directed play in their mentoring. Play kit selection and setup was

demonstrated and arranged to show mentors what to expect in terms of available toys and materials for their play mentoring sessions.

Mentoring and advanced training phase (CPRT equivalency sessions 5 – 10). This 7 week long phase marks the beginning of CMRT mentoring session held between the mentor and mentee. Each play mentoring session lasts 20-minutes and each mentor meets with the same two mentees consistently every week. Following mentoring, each CMRT subgroup meets together 30-minutes of small group supervision focused on immediate feedback on the previous mentoring sessions of the day. While mentoring has begun, the high school mentors hold 4 training classes focused on advanced instruction that total approximately 5 hours and 30 minutes over this phase on "A" weeks to support their continued development of CCPT attitudes and skills. Advanced training consists of learning complex skills that includes choice giving, self-esteem building responses, encouragement versus praise, and an understanding of why it makes a difference for mentees.

Mentoring and maintenance phase. High school mentors continue providing weekly mentoring sessions and are supported through continued supervision in this 8 week long phase. High school mentors continue to hold 2 mentoring sessions per week with their child mentee for 20-minutes followed by 30 minutes of supervision and feedback provided by their supervisor. Supervision shifts towards an increasing focus on dynamics in the mentor-mentee relationship, areas of continued growth for supervisees, sharing mentoring strengths, and arriving at optimal solutions to mentoring problems as a supervision group with support from other mentors. During this phase, there are 4 additional class times totaling approximately 5 hours and 30 minutes of advanced instruction on "A" weeks to encourage further depth and growth in understanding the importance of the mentoring relationship. Mentors also are able to share experiences or

difficulties they have had in mentoring to receive additional support from all of the CMRT mentors.

Supervisors provided on-site, live supervision to offer optimal support for mentors while noting offering treatment fidelity improves. Within supervision groups, the supervisor and mentors have opportunities to meaningfully address live mentoring moments or use video recordings to better reflect on what had occurred in the mentoring session. Due to school district policy, all mentoring session recordings have been asked to be destroyed after their immediate use. This policy prevented the play mentoring sessions from being recorded and maintained for future use as fidelity checks. Furthermore, two rotating supervisors provided an extra layer of support and treatment integrity across all of the CMRT mentors (15 mentors total).

Then range of sessions in the CMRT mentoring group was 12 to 15 while the mean number of sessions per mentor-mentee pair was 13.3 sessions. Sessions that were not held due to the temporary unavailability of the mentor and/or mentee were rescheduled to another date within the same week. In most instances, CMRT mentors were able to successfully reschedule and hold a make-up session with their child mentee.

Comparison Treatment PAL®: High School Mentors

High school mentors in the comparison group were taught the PAL® curriculum by a certified PAL® teacher at their high school conducted during their schedule 50-minute class period. This evidence-based program prepares high school mentors with relational skills for use as a peer helper that support the social-emotional health of the child mentee. The PAL® training protocol involves training the high school mentors in a skillset for use as a peer helper and includes effective communication, decision-making skills, cultural competency, and problem-solving skills (PAL Services, 2003). The high school mentors in the comparison group were

instructed to utilize their helping skills in their mentor sessions with their preschool/elementary school mentees.

PAL® mentoring involved a mentor-mentee session once weekly with both of their two child mentees for duration of 15 weeks. This specific group of high school mentors continued training through didactic learning and role-play practice. The facilitator of the PAL® treatment group is a certified PAL® instructor having previously received the required training needed to obtain the certified instructor certificate. This instructor has years of experiencing in training PAL® mentors. The CMRT intervention is comprised of 3 distinct phases and phase is described below in greater detail. For ease of understanding the relationship between the format of CMRT and CPRT, I've included the CPRT equivalency session number so those with an understanding of the CPRT protocol are able to more easily follow along.

Training phase. Prior to beginning the mentoring phase, PAL® training emphasized learning relational skills. These skill-building instructional classes were held over three week for a total of approximately 9 hours of training (1 hours and 20-minutes per training session). In addition to learning how to better relate to their child mentees, the certified PAL® instructor taught effective communication strategies and decision-making skills to use in their mentoring sessions (PAL Services, 2003). The learning sessions also included information and considerations specific to working with young children. The instructor lectured on common issues in mentoring and offered ideas on how the mentors may best encourage positive growth for the mentees. During the training phase, PAL® mentors received a workbook with puzzle worksheets, coloring pages, and simple games the mentors were informed that could use with their mentees. A few rudimentary puzzle games were present at some of the participating school

sites and these items were allowed by the PAL® instructor for use in their mentoring sessions if they chose to do so and the item was available.

Mentoring and advanced training phase. In this phase, mentors had begun mentoring sessions with both mentees while they received on-going consultation and support on their mentoring sessions from the certified PAL® instructor. High school mentors held 2 mentoring sessions per week, one with each of their mentees while the mentoring sessions lasted for 20-minutes. A research assistant functioned as the on-site school facilitator and was readily available if any major concern arose during their mentoring sessions. This role did not provide additional feedback or supervision, but it required being present to ensure the general safety of mentors and mentees through having an accessible adult nearby in case a situation arose that was outside of the scope of what a high school mentors should manage.

Consistent with and identical to the CMRT mentor group during their mentoring phase, PAL® high school mentors held 4 additional advanced training sessions (1 instructional session approximately every other week). This pattern was necessary for the mentors to properly address the A/B schedule with rotating classes. These advanced training sessions were provided by the certified PAL® instructor as the lead researcher did not have the appropriate certification for planning, training, and executing the PAL® model with fidelity to the protocol. A result of not being certified to teach the PAL® group is that the certified PAL® instructor is the only individual who was able to implement this model in a manner that maintained fidelity to the PAL® mentoring intervention as intended. Research assistants and I confirmed the PAL® treatment group did adhere to the frequency, length, and number of mentoring sessions we had previously discussed. The on-site facilitator's (a research assistant) role was emergency support for the mentor-mentee sessions if needed. The on-site facilitator and I urged PAL® mentors to

reschedule any mentoring sessions not attended by either the mentor and/or the mentee. The range of sessions in the PAL® mentoring group was 9 to 14 while the mean number of sessions per mentor-mentee pair was 12.2 sessions.

Data Collection

Prior to the study beginning, I collected data that included the informed consent, assent, and demographic information related to the participating high school mentors. A week before the beginning of CMRT and PAL® training phases, research assistants and I video recorded high school mentors for a 20-minute mentoring session with one of their mentors in a dedicated and moderately private space. Each mentor was given a toy kit with selected toys and materials available for use during the recorded mentor-mentee sessions.

All high school mentors regardless of group assignment were instructed to tell the child mentee at the outset of their first mentoring session, “We will have 20 minutes of special play time in this space together. Here, you can do many of the things you would like to do.” The high school mentors would then end the mentoring session and leave the play space with their child mentee once 20 minutes has passed. The recordings of mentoring sessions prior to beginning the intervention were completed by high school mentors in both the experimental group as well as the comparison group. After completion of the study, research assistants and I recorded a post-test video for the same mentor-mentee pairs that were recorded earlier. All video recordings were de-identified in terms of group assignment and in terms of points of measurement (pre and post). Independent observers analyzed and rated the all of the MEACI videos.

Pre-test data including the informed consent, assent, and demographic information related to the child participants was collected. I initially sent informed consent for child participants’ home for parents to complete. Upon receiving these documents back, I requested the child’s

teacher complete the CTRF/TRF. Teachers were blinded to the child's group assignment. After the study's completion, I collected post-test CTRF/TRF data from the child participants' primary teachers.

I coded all collected data and blinded raters to the assigned treatment group and points of measure to maintain the confidentiality of the participants. The names of the participants, group assignments, and points of measures were entered in a document that was kept in a secured and locked location during the study and will remains in this location until the data is destroyed in a manner that is consistent with best practice and university policy. The completed MEACI ratings, informed consents, demographic information, and the recorded videos are also kept in a secure and locked location that is separate from the document noted above.

Data Analysis

I collected data from pre- and post-test scores on the CTRF/TRF and the MEACI. I used computer software to score the CTRF/TRF and each assessment was scored twice to ensure accuracy of data entry. The MEACI video recordings were previously coded and de-identified by the researcher to blind the raters. MEACI raters were blinded to group assignment and time of measurement (pre- and post-test). Before rating, all raters were trained in the MEACI instrument and achieved an inter-rater reliability of 85% (Stover et al., 1971) or higher. Scoring followed the guidelines initially outlined by Stover et al. (1971) and further refined by Bratton (1993; Bratton et al., 2006).

APPENDIX C

UNABRIDGED RESULTS

In this appendix, I present the unabridged results. I intended to answer two research questions: (1) Based on independent observations, do CMRT high school mentors improve in their empathic behaviors towards child mentees as compared to PAL® high school mentors over time?; and (2) based on teacher report, do CMRT child mentees demonstrate a reduction in global behavior problems as compared to PAL® child mentees over time? The results of the data analysis are addressed below in the order that the research questions were tested.

I performed a two (treatment groups) by two (repeated measures) analysis of variance (ANOVA) of the scores on the MEACI Empathy scale and the CTRF/TRF Total Problems scale to test the differences in the means of the experimental (CMRT) group and the comparison (PAL®) group over time. Possible interaction effects with the treatment conditions as between-subjects variable and time as the within-subjects variable were of particular interest in this study. Dependent variables included mentors' empathic behaviors towards mentees and mentees' global behavior problems while I used the scores on the MEACI Total Empathy scale and the CTRF/TRF Total Problems scale as the dependent measurements respectively.

The MEACI and CTRF/TRF were administered prior to the beginning of treatment and at the end of the intervention. Following collection of MEACI data, independent raters, who were blinded to group assignment and time of measurement, scored all MEACI data after the completion of treatment. A reduction in scores on the MEACI and CTRF/TRF are indicative of improvements in high school mentors' empathic behaviors towards child mentees as observed by independent raters and child mentee global behavior problems as noted in teachers' report.

I evaluated the data with the Statistical Package for the Social Sciences (SPSS) to ensure that it met methodological assumptions for normality, sphericity, and homogeneity of variance for conducting a repeated measures ANOVA (Armstrong & Henson, 2005; Pallant, 2013).

Additionally, I ensured that skewness and kurtosis for the dependent variables were within normal limits. The independent variable was the treatment group type (CMRT/PAL®). I utilized an a priori alpha level of .05 for determining statistical significance (Thompson, 2002). I assessed the practical significance of the effects of the CMRT intervention as compared to the effects of the PAL® intervention through reporting partial eta-squared (?p2) effect sizes for each dependent variable. I am particularly interested in the differences between the two treatment conditions over time. I interpreted the effect size using recommendations established by Cohen (1988) and confirmed their appropriateness for use in school counseling research with recommendations made by Sink and Stroh (2006): .01 was considered a small effect, .06 was considered a medium effect, and .14 was considered a large effect. Table C.1 presents the pre- and post-mean scores and standard deviations for CMRT and PAL® groups for each dependent variable. Improvement is denoted by a reduction in scores on the MEACI and the CTRF/TRF.

Table C.1

Mean Scores and Standard Deviations for Treatment Groups

		Experimental CMRT (n = 15 mentors; 30 mentees)		TAU Comparison PAL® (n = 15 mentors; 30 mentees)	
		M	*SD*	*M*	*SD*
MEACI Total Empathy	Pre-Test	40.283	4.552	42.846	4.746
	Post-Test	33.250	5.253	46.539	5.438
CTRF/TRF Total Problems	Pre-Test	61.933	9.184	60.800	7.690
	Post-Test	57.700	9.607	59.733	11.114

Research Question 1: Mentors' Demonstration of Empathic Interactions with Child Mentees

Results of analysis for the dependent variable Total Empathy indicate a statistically significant interaction effect between treatment groups (CMRT/PAL®) over time (pre to post), F(1, 26) = 13.979, p < .001, ?p2 = .350, and treatment effect is considered very large. These findings indicate that according to raters blinded to mentors' group assignment, the CMRT mentors demonstrated statistically significant increase in empathic interactions with their mentees compared to PAL® mentors. A visual inspection of the graph of the mean scores for the CMRT and PAL® group supports the greater improvement of the CMRT group compared to the PAL® group over time (see figure C.1).

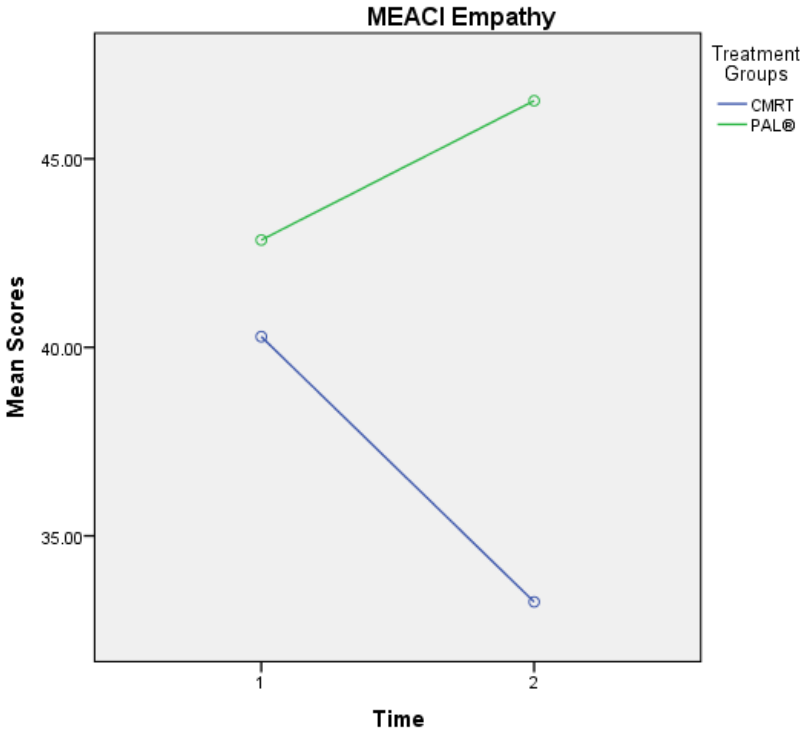

Figure C.1. Mean scores on MEACI Total Empathy Scale.

Research Question 2: Child Mentees' Global Behavior Problems

Results of analysis for the dependent variable Total Problems did not indicate a statistically significant interaction effect between treatment groups (CMRT/PAL®) from pre- to post-test, F(1, 58) = 3.251, p < .077, ?p2 = .053. These findings indicate CPRT demonstrated a moderate treatment effect on decreasing children's problem behaviors when compared to the PAL® intervention, although the difference between groups over time was not statistically significant. Results of the main effect for time showed statistically significant improvement in behavior problems when participants from experimental and control conditions were grouped together, F(1, 58) = 9.108, p < .004, ?p2 = .136), and the treatment effect was large.

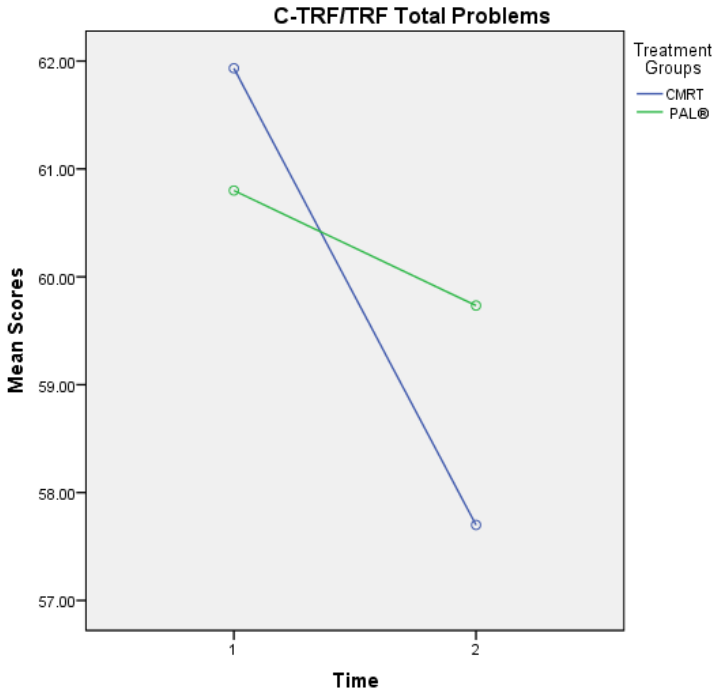

Figure C.2. Mean scores on CTRF/TRF Total Problems Scale.

Because the main effect for time was statistically significant and CMRT demonstrated a moderate treatment effect over the PAL® intervention, I calculated one-way repeated measures ANOVA for each treatment condition to further explore within group performance. Results of

the one-way ANOVAs indicated that the CMRT group demonstrated statistically significant reductions in behavior problems from pre- to post-test, $F(1, 29)$, $p < .006$, $?p2 = .234$, and the treatment effect size was very large, while the PAL® group did not demonstrate statistically significant improvement $F(1, 29)$, $p < .310$, $?p2 = .035$ and the treatment effect was small. A visual analysis of the graph of the mean scores for CMRT and PAL® treatment groups on the CTRF/TRF Total Problems (see figure C.2) supports the greater improvement of behavior problems in the CMRT treatment group over the PAL® treatment group.

APPENDIX D

EXTENDED DISCUSSION

Through this study, I investigated the effectiveness of Child Mentor Relationship Training (CMRT) as compared to Peer Assistance and Leadership (PAL®) with high school mentors and child mentees. More explicitly, this study explored the effects of the play-based CMRT mentoring model and the non play-based PAL® mentoring model on increasing mentor empathic behaviors towards mentees as measured by the Measurement of Empathy in Adult-Child Interactions (MEACI) and on decreasing mentee global behavior problems as measured by the Caregiver-Teacher Report Form/Teacher Report Form (CTRF/TRF). There is currently limited outcome research about mentoring interventions between high school mentors and young child mentees; this study adds further findings to this body of research.

The aim of this study was to augment the evidence base for the CMRT intervention through: (1) the use of methods similar to ones used by the Jones et al. (2002) study and (2) modifying the length of time the intervention phase of CMRT by half while retaining similar beneficial outcomes to high school mentor empathic behaviors towards child mentees and reduced global behavior problems. This was a notable reduction of length in the intervention and would enhance the efficacy of the school counselor further by allowing additional time to devote to other responsibilities as a school counselor as fits the needs of the school and students. Time is amongst the most limited resources for school counselors and best practices seek efficacy with effectiveness.

Due to the limited time, support, and resources school counselors can access for comprehensive school counseling programs, it is critical that all school counseling interventions are both effective and time efficient (American School Counseling Association [ASCA], 2012; Sink, 2011). For nearly 40 years, ASCA (1978; 2016) has released position statements indicating their support of well-designed and implemented peer helping programs as a means of enhancing

the reach and efficacy of school counseling programs. This has been supported by school counseling research reviews that reported peer helping programs as effective with reducing social, academic, and personal problems amongst students (McGannon, Carey, & Dimmitt, 2005; Whiston & Sexton, 1998).Additionally, peer mentoring programs address common limitations of school counseling programs related to a lack of available time and personnel to provide responsive services to all at-risk students (Erford, 2015).While a previous study explored these characteristics (Jones et al., 2002), this study augmented the research base for the CMRT model as an effective intervention. This study retained the rigorous procedures employed by the Jones et al. study with modifications to the length of the intervention to fit within a single semester for ease of implementation and to best meet the needs of the schools and students involved. The findings of this study corroborate CMRT as a promising peer mentoring intervention with growing empirical support in school settings to decrease mentee global behavior problems, increase mentor CCPT competency, and increase mentor empathic behaviors towards mentees.

The results and findings of this research study demonstrate support for CMRT as a mentoring approach for use in school settings. Particularly of import, similar findings were achieved as compared to the Jones et al. (2002) study despite the intervention phase lasting one semester in length as supposed to two semesters. This reduction in length of intervention phase is noteworthy and offers school counselors interested in utilizing this approach an opportunity to enhance the efficacy of their peer mentoring program. School counselors using the CMRT model with a shorter intervention phase have greater flexibility through the reduced time needed for deliver the intervention and applying the additional time to other elements of their comprehensive school counseling program offers additional benefits to students.

Effectiveness of CMRT on Mentor Empathic Behaviors

High school mentors' empathic behaviors towards child mentees as per independent rater assessment demonstrated the CMRT condition resulted in a statistically significant increase in their empathic behaviors as compared to the PAL® condition. Results of the CMRT treatment condition indicated the beneficial treatment effect was very large. The mean score changes in high school mentor empathic behaviors were a 7 point improvement in the CMRT group as compared to a -3.7 point decline in the PAL® group. Notably, this construct was measured using an instrument that required independent coders who were blinded to both the group assignment (CMRT/PAL®) as well as time of measure (pre- or post-test) when rating high school mentor empathic behaviors.

Results of the CMRT mentors' empathic behaviors towards their child mentees as compared to the PAL® mentors were substantial. This major finding of the study is reflective of the attention that is placed on the development of empathy in the CMRT treatment group by the mentor for the mentee. CMRT (as well as the more extensive CPRT literature) highlights the importance of the mentee experiencing the paraprofessional within the relationship as consistent, warm, and non-judgemental towards the child (Landreth, 2012). Landreth emphasized that when children have relationships where they feel understood and accepted for who they are, this leads to a relational environment of transformation that allows the child to create positive change. Empathy and compassion are qualities addressed in the mentoring literature as being essential for effective peer mentoring (Chan et al., 2013; Erdem et al., 2016; Raposa, Rhodes, & Herrera, 2016). Rhodes (2005) noted that mentoring relationships can be a corrective relationship for children's past experiences with significant people who may have had a relational rupture. Previous CPRT & CCPT-related research has shown similar results that demonstrated an

increase in paraprofessional empathic behavior towards children coinciding with a decrease in children's global behavior problems (Carnes-Holt & Bratton, 2014; Jones et al., 2002; Kidron & Landreth, 2010; Smith & Landreth, 2004).

Effectiveness of CMRT on Mentee Global Behavior Problems

Child mentees' global behavior problems as per teacher report demonstrated CMRT led to a greater reduction over the PAL® child mentees. Results of the CMRT condition indicated the beneficial treatment effect size was moderate as well as six times greater than the treatment effect for the PAL® condition. Mean score changes in child mentee global behavior problems were 4.2 point improvement in global behavior problems in the CMRT treatment group versus a 1.1 point improvement in global behavior problems in the PAL® treatment group. The results of this study were generally consistent with findings of the Jones et al. (2002) study as well as consistent with other CPRT & CCPT studies conducted in school settings (Bratton, Landreth, & Lin, 2010; Bratton et al., 2017; Ray & Bratton, 2015). This decrease in the CMRT treatment condition in child mentee global problem behaviors was statistically significant from pre-test to post-test. While the PAL® treatment condition modestly improved from pre-test to post-test, the decreased score was not statistically significant across time.

The central aim of the peer mentoring program with a primary focus on social-emotional well-being is to reduce and prevent behavioral problems amongst at-risk students (Erdem et al., 2016). School counseling researchers have identified that students identified as at-risk can be supported through the inclusion of responsive services to meet there needs as well as preventative school counseling programming (Amatea & West-Olatunji 2007; Johnson & Perkins, 2009; Keys, Bemak, & Lockhart, 1998). The use of efficacious early interventions supports both the behavioral success and academic achievement of at-risk students.

Understanding what comprises an effective peer mentoring program is essential to successfully meeting the needs of at-risk students.

An efficacious school-based mentoring program requires a strong theoretical foundation to support its usage as well as an established body of research that provides evidence of its success in addressing outcomes (Chan et al., 2013; DuBois et al., 2002). CMRT, as a mentor-adapted variant of CPRT, is backed by research that has supported its use with addressing the emotional and behavioral needs of child mentees (Jones et al., 2002) as well as CPRT-related research supporting the success of with reducing behavioral concerns of children with paraprofessionals including young mentors and teachers (Baggerly & Landreth, 2001; Helker & Ray, 2009; Morrison & Bratton, 2010; Morrison & Bratton, 2011). The findings of this study provided additional support to the evidence base for CMRT and show promise for this model as an effective intervention for the social-emotional of child mentees.

Limitations and Recommendations for Future Research

The findings of this study are encouraging and represent a meaningful addition to outcome research on CMRT and play-based mentoring in school settings. When considering the implications of research on a body of knowledge, it is equally important to address elements of and imperfections in the methodology and research design. This study has several limitations that need to be evaluated when considering these results and the interpretation of them advanced below.

The sample size limited the generalizability of this study to a broader population. Although the sample size was sufficient to detect difference between the two intervention groups, future replication studies with a larger sample size with similar findings would augment the level of confidence in the results obtained. Relatedly, was the geographical restrictions of this

study and later studies could also build reliability by producing the same results across multiple sites or in a disparate location.

An additional concern related to the sample for this study was the possibility for treatment contamination. Both treatment conditions were drawn from classes held in the same high school, and it is possible that a high school mentor from the control group could be exposed the training and treatment conditions of the other intervention through a member of the opposing treatment condition revealing the specific protocol used. While a situation of the nature is possible, it would require extensive effort and dedication to implement the opposing treatment intervention protocol and internalize the necessary attitudes without proper training. Additionally, it would have been highly likely that a supervisor in the experimental group or a site facilitator in the comparison group would have noticed and become privy to the use of the incorrect treatment group protocol during the intervention phase.

The researchers had limited control over the fidelity of the administration of the PAL® curriculum and maintenance of treatment fidelity to the PAL® curriculum in the intervention phase as the certified PAL® instructor provided the training and on-going support. This certified instructor had multiple years of experience in delivering the PAL® curriculum, had access to the PAL® manual, and additional supports surrounding the implementation and execution of the protocol. As PAL® is a SAMHSA evidence-based treatment that is manualized and requires the trainer of the comparison group to be certified it its specific protocol, it very likely the certified PAL® instructor provided training and execution that reflects the intended implementation of the model.

Related to limitations associated with the delivery of training protocol and maintaining treatment integrity, the lead researcher was extensively involved in participant recruitment and

training delivery processes. This had the potential to influence treatment results through experimenter bias. In an effort to minimize the potential of inadvertently effecting findings, the lead researcher met regularly with an expert in CPRT protocol to address the potential of introducing cofounding influences or biases related to the lead researcher's involvement in the study.

This present study may have not included additional sources of data that may have provided valuable perspectives that were examined in data collection. A parent report of global problem behaviors would provide a more inclusive perspective on the behavior change process for child mentees. Additionally, a parent report of global behavior problems may have substantiated or countered the teachers' report providing additional depth in better understanding the behavior change process as it relates to this study. Also, the use of an instrument capable of collecting data regarding the direct experience of the child mentees might also provide valuable data while taking into account considerations surrounding the collection of data from children may be problematic to access in an appropriate manner for quantitative research due to the difficulty of collecting valid and reliable information from young children that accurately reflects their experience.

I collected no data from the direct experience of the child mentees. This is limiting as children have a valuable perspective is problematic to access in a manner useful for quantitative research due to the difficulty of collecting reliable and measureable data from young children that accurately reflects their experience beyond the present moment.

Implications and Recommendations for Practice

As a mentor-adapted CPRT model that has built upon the empirical base supporting CPRT (Bratton & Lin, 2015; Landreth & Bratton, 2006), CMRT holds promise as an approach to

expand the direct impact of a comprehensive school counseling program and meet the varied social-emotional needs of students. In this present study, it is important to note that beneficial effects of this intervention were measured for both mentees as well mentors and that this benefit should be taken into consideration during implementation of CMRT. It is proactive model that may reduce or avert behavior problems that would otherwise require a more acute, reactive, and resource-intensive response from the school counselor without this preventative intervention. CMRT is an approach that is consistent with the ASCA National Model (ASCA, 2012) as well as ASCA's most recent position statement on the substantial value of peer helping as part of a comprehensive school counseling program. School counselors may find the program useful in better addressing social-emotional needs of students that are at-risk, but are not currently in need of a high tier response from the comprehensive school counseling program.

High school mentors in the CMRT group demonstrated a high amount of enthusiasm for mentoring, a deeply meaningful connection to the process of mentoring, and had verbalized concern for their child mentees more frequently than high school mentors in the PAL® group. The importance of proper preparation for the mentors cannot be understated. Previous research supports the need for well-trained and supported mentors as being critical to success in peer mentoring programs (Johnson & Perkins, 2009). Based on high school mentors' verbal feedback and the lead researcher's observation, some learning regarding how to best support the mentors for relational success with tier mentees included: (a) continued training on mentoring skills over the duration of the CMRT mentoring sessions; (b) consistent supervision that included a supervisor's live viewing of the mentoring session and immediate feedback after its completion; (c) an emphasis placed on mentoring attitudes towards their mentees with the development of an internalized understanding of why these attitudes matter in peer mentoring; and (d) having

dedicated time to address emergent concerns related to mentoring their mentees. Verbal report and confirmation of made a difference in mentors remaining connected to the mentoring process and received needed supports for relational success with their child mentees. The lead researcher emphasizes this aspect of the CMRT model as critical to the mentors' integration of the attitudes and skills. In turn, these supportive processes may have been responsible for the research outcomes and findings of this approach. School counselors implementing CMRT and supporting mentors in the program would be best served through ensuring they are available and accessible to the high school mentors not only during and immediately after their mentoring sessions, but also at specific times at least bi-weekly, if not more frequently to ensure they are receiving supervision and support consistent with the CMRT model.

A specific level of training is required to effective use the CMRT intervention and this is one practical consideration in terms of developing a CMRT program at a school. This model may add considerable support and help in an efficient manner to a school counseling program, but it is important to note the level of training that is necessary to deliver CMRT. Before a professional mental health practitioner is able to effective deliver this model, it requires an understanding of the principles and attitudes that guide CCPT, training in CPRT, and then adapting CMRT to the needs of a school within the context of establishing and executing a peer mentoring program. If additional protocol were created to support and manualized CMRT, implementation of CMRT by a school may feasibly only need CCPT and CMRT training to be adequately prepared to implement and deliver CMRT.

Conclusion

It is imperative for school counselors to develop comprehensive school counseling programs that effectively address the social-emotional needs of students through appropriate

interventions that are preventative (ASCA, 2012; Sink, 2011) and responsive to expanding the outreach of the program (ASCA, 2015). School counselors implement how they may best serve as a leader in their school through intentionally and strategically selecting school counseling approaches that are efficient by maximizing the number of students they directly impact and through the use of approaches that are have an established evidence base (Erford, 2015). This conceptual shift within a comprehensive school counseling programs refocuses interventions within the school from a position of reactivity to one of proactivity. The benefits of peer mentoring as an element of school counseling programs has been noted in comprehensive reviews of school counseling research (McGannon et al., 2005; Whiston & Sexton, 1998).

Well-designed peer mentoring programs require attention given to the delivery and execution and these factors are critical to positive outcomes. One of the important considerations is preparing mentors with a competently develop skillset that creates the environment and essential conditions needed to have an influential impact on reducing behavior problems on child mentees in school settings (Johnson & Perkins, 2009). Findings from this present study demonstrated the beneficial effects of CMRT on developing empathic behaviors within high school mentors that allows for the relational and environmental foundation necessary for problem behavior change in child mentees. The findings are similar to and support the results of the Jones et al. (2002) study, confirming the positive outcomes of CMRT as a mentoring model for use in schools and developing the evidentiary base of this model as a credible and effective intervention. This study's findings inform school counselors of a promising intervention for use as a component of a comprehensive school counseling program that supports students' social-emotional health in an effective manner.

Acknowledgments

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APPENDIX E

INFORMED CONSENT AND ASSENT

University of North Texas Institutional Review Board

Parent Informed Consent

Before agreeing to your child's participation in this research study, it is important that you read and understand the following explanation of the purpose and benefits of the study and how it will be conducted.

Title of Study: The Effectiveness of Peer Mentoring with High School Student Mentors and Child Mentees

Principal Investigator: Sue Bratton, Ph.D., Licensed Professional Counselor - Supervisor (LPC-S), Registered Play Therapist and Supervisor (RPT-S), University of North Texas, Department of Counseling & Higher Education.

Lead Student Research Assistant: Eric Dafoe, M.Ed., Licensed Professional Counselor - Intern (LPC-Intern), National Certified Counselor (NCC), University of North Texas, Department of Counseling and Higher Education.

Purpose of the Study:
You are being asked to allow your child to participate in a research study to explore the effectiveness of peer mentoring with high school student mentors and child mentees through examining high school mentor empathy and child mentee global behavior. Recent research shows that school-based mentoring has been beneficial in developing relational competencies, increasing academic engagement, enhancing the self-esteem, and increasing empathy in the mentor. A recent study found that school-based mentoring fostered a belief in the mentor that they have the ability to make a positive difference in the lives of others.

Study Procedures:
Upon your consent, your high school student will be assigned as a mentor to participate in one of two school-based peer mentoring programs designed to promote an increase the interest and empathy of the mentor. In either group interventions, your high school student will be paired with a child mentee who will meet with your high school student on a weekly basis and provide verbal support to the child, engage them in play-based activities, and express their understanding of the child's experiences and desires. All high school student mentors will receive additional training in peer mentoring and how they can best help the child while also being supervised by a supervisor trained in one of the peer mentoring program curriculum. Most high school student mentors find conversing and playing with their child mentees to be very enjoyable. Your high school student will meet with their child mentee for 30 minutes each week during their PAL© class time. Your high school student and their child mentee will continue to meet for 20 weeks during the course of their school day, and they will not be removed from any academic instruction during their mentoring time with their child mentee as it occurs during PAL© class time. Mentoring sessions will be video recorded in order for the high school student mentor to be supervised to ensure a high quality of mentorship.

Group 1: **Child Mentor Relationship Training (CMRT)** is a research-based peer mentoring program shown to be responsive towards the social, emotional, behavioral, and school needs of preschool and primary school children. The high school student mentors are trained in help the child mentees to express their experiences and emotions and utilized a play-based format if your child chooses to play. Peer mentors will provide a safe environment in which the child can feel supported, accepted, and encouraged. High school mentors are trained in the model that requires classroom lectures, experiential role-playing, and viewing demonstrations of CMRT. Additionally, high school mentors receive continuous support from master's degree level counselors with advanced training and supervision in CMRT. Previous research demonstrates mentors who learn this model may show increased empathy and enhanced self-esteem.

OR

Group 2: Peer Assistance & Leadership (PAL©) program is a peer mentoring program that helps reduce risk factors for a variety of problems and builds resiliency in children by pairing the child mentee with high school

student peer helpers who receive training and support from a certified PAL® teacher at their high school. The PAL® mentors will receive supervision regarding their mentoring with their assigned preschool/elementary school child mentee. The PAL® high school mentors act as guides, mentors, and mediators to younger students by utilizing skills learned through the PAL® curriculum including effective communication, decision-making, and resiliency building. Mentors may benefit from participating in this model and may display an increased school engagement and enhancing their capacity to help others.

Foreseeable Risks:
There are no significant personal risks foreseen as likely from involvement in this study. Your high school student's participation is completely voluntary. You may withdraw your high school student at any time during the course of the study. Possible risks may include one or more of the following:

1. Anything that is said or done during the mentoring sessions is considered confidential, meaning that the high school student mentor will not reveal anything that happens in the session to another school official or adult other than the high school student mentor's supervisor. However, if the child mentee discloses child abuse, neglect, exploitation or intent to harm another person, the high school mentor is required to report it to the appropriate authority.

2. Because the Because the primary focus of the mentoring sessions is the personal relationships that develop, your high school student may experience thoughts and emotions that could be strong or difficult for him/her. Each high school mentor will be supervised by an advanced doctoral level student to help him/her express and work through any experiences or emotions that arise as a result of mentoring. If any potential harmful effects upon your high school student are noted, supervision would be utilized to address this concern and the supervisor will consult with the principal investigator. In the very rare case, if mentoring this child is no longer in the high school mentor's best interest, the supervisor will meet with you to provide an appropriate referral.

Benefits to the Subjects or Others:
Possible positive outcomes for high school student mentors participating in the project may include increase in empathy, ability to connect relationally, personal engagement with those the student is involved with, and overall self-esteem as well as increase in understanding of others' feelings, thoughts, and needs. Additional benefits for high school mentors include increase in social skills, cooperation, strength-based coping strategies and problem solving. The results of this study may provide school counselors across the nation with knowledge that helps them enhance student's social, emotional, behavioral, and academic development so that high school students and young children develop relational competencies, increase academic engagement, enhance self-esteem, and increase the mentor's empathy.

Compensation for Participants: There is no compensation for participating in this study.

Procedures for Maintaining Confidentiality of Research Records:
Participants are assigned a code number prior to the study. All information on participants including assessment instruments will be recorded with a code number only. All information will be kept in a double-locked location in the Center for Play Therapy within the Counseling Program at the University of North Texas. Only the research team will have access to the list of the participants' names and code numbers stored in the double-locked location. Names of parents and students will not be disclosed in any publication or discussion of this material. The play sessions will be video recorded. The principal investigator/supervisor will observe the recordings to ensure the quality of the services your student is receiving. At the end of this study, the videos may possibly be shown in professional presentations for educational purposes. Identity information such as name, place of living, and other specific information will not be revealed when videos are shown in educational settings. However, you may choose to withdraw your consent at any time and the video recordings of your student will not be used.

Questions about the Study: If you have any questions about the study, you may contact Dr. Sue Bratton at (940) 565-3468 or Sue.Bratton@unt.edu.

Review for the Protection of Participants: This research study has been reviewed and approved by the UNT Institutional Review Board (IRB). The UNT IRB can be contacted at (940) 565-3940 for any questions regarding the rights of research subjects.

Research Participants' Rights: Your signature below indicates that you have read or have had read to you all of the above and that you confirm all of the following:

- You understand the possible benefits and the potential risks and/or discomforts of the study.
- You understand that you do not have to allow your high school student to take part in this study, and your refusal to allow your child to participate or your decision to withdraw him/her from the study will involve no penalty or loss of rights or benefits. The study personnel may choose to stop your student's participation at any time.
- You understand why the study is being conducted and how it will be performed.
- You understand your rights as the parent/guardian of a research participant and you voluntarily consent to your student's participation in this study.
- You understand you may keep a copy of this form.

_____
Printed Name of Child

_____
Printed Name of Parent or Guardian

_____ _____
Signature of Parent or Guardian Date

Student Assent Form

You are being asked to be part of a research project being done by the University of North Texas Counseling Program that may help young children reduce problem behaviors. Become more self-directed, develop greater self-responsibility, and positive emotional growth.

You will be asked to attend weekly trainings during your PAL® class and mentoring sessions once a week with a child for approximately 20 weeks. During the time together, you can do different types of play activity or talk with your mentee, depending on what your mentee would like to do. Your mentoring session will be video recorded so you can receive helpful feedback from a supervisor on the mentoring session.

Anything that the child says or does during the mentoring session is to be kept confidential outside of the training times and supervision times. If the child tells you that they have been hurt by someone or think someone might hurt them or if they are thinking of hurting someone, inform either your mentoring supervisor or PAL® instructor immediately.

If you decide to be part of this study, please remember you can stop any time you want. If you would like to be part of this study, please sign your name below.

_____
Printed Name of High School Student

_____ _____
Signature of High School Student Date

_____ _____
Signature of Research Assistant Date

University of North Texas Institutional Review Board

Parent Informed Consent

Before agreeing to your child's participation in this research study, it is important that you read and understand the following explanation of the purpose and benefits of the study and how it will be conducted.

Title of Study: The Effectiveness of Peer Mentoring with High School Student Mentors and Child Mentees

Principal Investigator: Sue Bratton, Ph.D., Licensed Professional Counselor - Supervisor (LPC-S), Registered Play Therapist and Supervisor (RPT-S), University of North Texas, Department of Counseling and Higher Education.

Lead Student Research Assistant: Eric Dafoe, M.Ed., Licensed Professional Counselor - Intern (LPC-Intern), National Certified Counselor (NCC), University of North Texas, Department of Counseling and Higher Education.

Purpose of the Study:
You are being asked to allow your child to participate in a research study to explore the effectiveness of peer mentoring on your child's classroom behavior. Recent research shows that school-based mentoring has been beneficial in supporting behavioral, social-emotional, and academic success in students as well as strengthening students' protective factors that aid in being better able to handle stressful situations that may occur. Recent studies found that school-based mentoring has fostered positive emotional growth and behavior change in children.

Study Procedures:
Upon your consent, your child will be assigned to participate in one of two school-based peer mentoring programs designed to promote a reduction in children's problem behaviors and help support their social and emotional growth. In both group interventions, your child will be paired with a high school peer mentor who will meet with your child on a weekly basis and provide verbal support to your child, engage them in play-based activities if your child chooses to do so, and connect with your child. Each high school mentor undergoes an extensive vetting process and were selected to participate in the study based on strong recommendations from both teachers and peers in their high school. The peer mentors receive additional training on how they can best help your child while they are supervised by their PAL° classroom instructor or other supervisors. Most children find the conversation and play with their mentors to be very enjoyable, however, your child's participation in play or discussion is voluntary. Your child will meet with their high school mentor for 30 minutes each week. Your child and their mentor will continue to meet for 20 weeks during the course of the school day. They will not be removed from critical academic instruction during their meeting time with their high school mentor and it will occur at a time approved by the school administration and teachers. The mentoring sessions will be video recorded in order for the high school mentor to be supervised to ensure a high quality of mentorship.

Group 1: **Child Mentor Relationship Training (CMRT)** is a research-based peer mentoring program shown to be responsive towards the social, emotional, behavioral, and school needs of preschool and elementary school children including building resilience and self-control. CMRT is supported by extensive research including randomized controlled studies. The high school mentors are trained in helping your child express their experiences and emotions and utilizing a play-based format. Peer mentors will provide an environment in which the child can feel supported, accepted, and encouraged. The high school mentors are trained and receive continuous support from master's degree level counselors with advanced training and supervision in CMRT.

OR

Group 2: Peer Assistance & Leadership (PAL°) program is a peer mentoring program that helps reduce risk factors in preschool/elementary children for a variety of behavioral concerns and builds resiliency in children by pairing the child with a high school peer helper who receives training and support from a certified PAL° teacher

at their high school. The PAL© mentors will receive supervision regarding their mentoring with their assigned preschool/elementary school child. The PAL© mentors act as guides, mentors, and mediators to younger students by utilizing skills learned through PAL© including effective communication, decision-making, and resiliency building.

Your permission also allows your child's homeroom teacher to fill out an assessment that requests the teacher to report his/her perception of your child's classroom behavior to assess the effectiveness of the mentoring program. The supervisor of the peer mentor will deliver the assessments to your child's teacher prior to the mentoring starting, again before the end of the fall semester (midpoint of the mentoring sessions), and again at the completion of the study.

Foreseeable Risks:
There are no significant personal risks foreseen as likely from involvement in this study. Your child's participation is completely voluntary. You may withdraw your child at any time during the course of the study. Possible risks may include one or more of the following:

1. Anything that is said or done during the mentoring sessions is considered confidential, meaning that the mentor will not reveal what happens in the session to school officials or adults other than the supervisors. However, if your child discloses child abuse, neglect, exploitation or intent to harm another person, the supervisor is required by law to report it to the appropriate authority.

2. It is possible your child may be pulled from an extracurricular experience that he/she enjoys (times are decided by the teacher and principal's approval). To minimize this risk, mentoring sessions will be offered at a variety of times during the school day. In no circumstance will students miss academic content or preparation for STAR testing. Still, it is possible that your child may miss an activity that they enjoy and feel excluded from the activity. In such cases, the counselor or PI will consult with you and your child to determine if it is in the child's best interest to remain in the mentoring program.

3. During the mentoring session, your child may experience thoughts and emotions that could be strong or difficult. The mentors are trained and have regular supervision on-site after their mentoring session with professionals who are experts in the CMRT and PAL curriculums to help your child express and work through these emotions. If any potential harmful effects upon your child are noted, the mentor's supervisor will consult with the principal investigator. If it is determined by the supervisor that remaining in the group would not be beneficial to your child, the supervisor will meet with you to provide an appropriate referral (for example, at your request your child may be offered individual counseling at the school or referred to community-based services).

Benefits to the Subjects or Others:
Positive outcomes for children participating in the project may include a decrease in classroom behavior concerns. Additional benefits may include increased self-regulation and self-control, increased academic success, an increased ability to solve problems, a reduction in internalizing problem behaviors, and a reduction in externalizing problem behaviors. The results of this study may provide school counselors and administrators with knowledge that could help them enhance other children's behavioral, social-emotional, and academic success.

Compensation for Participants: There is no compensation for participating in this study.

Procedures for Maintaining Confidentiality of Research Records:
Participants are assigned a code number prior to the study. All information on participants including assessment instruments will be recorded with a code number only. All information will be kept in a double-locked location in the Center for Play Therapy within the Counseling Program at the University of North Texas. Only the research team will have access to the list of the participants' names and code numbers stored in the double-locked location. Names of parents and students will not be disclosed in any publication or discussion of this material. The play sessions will be video recorded. The principal investigator/supervisor will observe the recordings to ensure

the quality of the services your child is receiving. At the end of this study, the videos may possibly be shown in professional presentations for educational purposes. Identifying information such as name, place of living, and other specific information will not be revealed when videotapes are shown in educational settings. However, you may choose to withdraw your consent at any time and the video recordings of your child will not be used.

Questions about the Study: If you have any questions about the study, you may contact Dr. Sue Bratton at (940) 565-3468 or email her at Sue.Bratton@unt.edu.

Review for the Protection of Participants: This research study has been reviewed and approved by the UNT Institutional Review Board (IRB). The UNT IRB can be contacted at (940) 565-3940 for any questions regarding the rights of research subjects.

Research Participants' Rights: Your signature below indicates that you have read or have had read to you all of the above and that you confirm all of the following:

- You understand the possible benefits and the potential risks and/or discomforts of the study.
- You understand that you do not have to allow your child to take part in this study, and your refusal to allow your child to participate or your decision to withdraw him/her from the study will involve no penalty or loss of rights or benefits. The study personnel may choose to stop your child's participation at any time.
- You understand why the study is being conducted and how it will be performed.
- You understand your rights as the parent/guardian of a research participant and you voluntarily consent to your child's participation in this study.
- You understand you may keep a copy of this form.

_____
Printed Name of Child

_____
Printed Name of Parent or Guardian

_____ _____
Signature of Parent or Guardian Date

Student Assent Form

You are being asked to be part of a research project being done by the University of North Texas Counseling Program that may help kids feel better about themselves, trust themselves more, and become more confident in the choices you make.

You will be asked to attend a 30 minute special time once a week with a high school friend for about 20 weeks. During the time together, you can do a lot of different types of play activity or talk with your friend, you can use the special time in a lot of different ways. Your special time will be video recorded so your high school friend can get help to do their best job as a friend.

Anything that you say or do during the special time with your friend is confidential, which mean it is top secret! You can decide what you what share about your special time with other people. Also, your high school friend will not tell other people what happens during the special time to school teachers or other adults unless you tell your friend that you have been hurt by someone or you are thinking of hurting someone.

If you decide to be part of this study, please remember you can stop any time you want. If you would like to be part of this study, please sign your name below.

_____

Printed Name of Child

_____ _____

Signature of Child Date

_____ _____

Signature of Research Assistant Date

APPENDIX F

INTERNAL REVIEW BOARD AND HUMAN SUBJECTS APPROVALS

UNT

A green light to greatness.

THE OFFICE OF RESEARCH INTEGRITY AND COMPLIANCE

September 22, 2015

Supervising Investigator: Dr. Sue Bratton
Student Investigator: Eric Dafoe
Department of Counseling and Higher Education
University of North Texas

Re: Human Subjects Application No. 15362

Dear Dr. Bratton:

As permitted by federal law and regulations governing the use of human subjects in research projects (45 CFR 46), the UNT Institutional Review Board has reviewed your proposed project titled "The Effectiveness of Peer Mentoring with High School Student mentors and Child Mentees." The risks inherent in this research are minimal, and the potential benefits to the subject outweigh those risks. The submitted protocol is hereby approved for the use of human subjects in this study. **Federal Policy 45 CFR 46.109(e) stipulates that IRB approval is for one year only, September 22, 2015 to September 21, 2016.**

Enclosed is the consent document with stamped IRB approval. Please copy and **use this form only** for your study subjects.

It is your responsibility according to U.S. Department of Health and Human Services regulations to submit annual and terminal progress reports to the IRB for this project. The IRB must also review this project prior to any modifications. **If continuing review is not granted before September 21, 2016, IRB approval of this research expires on that date.**

Please contact Shelia Bourns, Research Compliance Analyst at extension 4643 if you wish to make changes or need additional information.

Sincerely,

Chad R. Trulson, Ph.D.
Professor
Department of Criminal Justice
Chair, Institutional Review Board

CT/sb

UNIVERSITY OF NORTH TEXAS
1155 Union Circle #310979 Denton, Texas 76203-5017
940 369.4643 940 369.7486 fax www.research.unt.edu

UNT

A green light to greatness.

THE OFFICE OF RESEARCH INTEGRITY AND COMPLIANCE

November 6, 2015

Supervising Investigator: Dr. Sue Bratton
Student Investigator: Eric Dafoe
Department of Counseling and Higher Education
University of North Texas

Institutional Review Board for the Protection of Human Subjects in Research (IRB)
RE: Human Subject Application #15362

Dear Dr. Bratton,

The UNT IRB has received your request to modify the study titled "The Effectiveness of Peer Mentoring with High School Student Mentors and Child Mentees." As required by federal law and regulations governing the use of human subjects in research projects, the UNT IRB has examined the request to modify the study by adding the Play Therapy Attitudes, Knowledge and Skills Survey to the data collection process. This addition will add 30 minutes to participation time for high school mentors. The modifications to this study are hereby approved for the use of human subjects.

The IRB must review this project prior to any other modifications.

Please contact Shelia Bourns, Research Compliance Analyst, at (940) 565-4643 if you wish to make changes or need additional information.

Sincerely,

Chad Trulson, Ph.D.
Professor
Department of Criminal Justice
Chair, Institutional Review Board

CT/sb

UNIVERSITY OF NORTH TEXAS
1155 Union Circle #310979 Denton, Texas 76203-5017
940.369.4643 940.369.7486 fax www.research.unt.edu

University of North Texas Institutional Review Board

Parent Informed Consent

Before agreeing to your child's participation in this research study, it is important that you read and understand the following explanation of the purpose and benefits of the study and how it will be conducted.

Title of Study: The Effectiveness of Peer Mentoring with High School Student Mentors and Child Mentees

Principal Investigator: Sue Bratton, Ph.D., Licensed Professional Counselor - Supervisor (LPC-S), Registered Play Therapist and Supervisor (RPT-S), University of North Texas, Department of Counseling & Higher Education.

Lead Student Research Assistant: Eric Dafoe, M.Ed., Licensed Professional Counselor - Intern (LPC-Intern), National Certified Counselor (NCC), University of North Texas, Department of Counseling and Higher Education.

Purpose of the Study:
You are being asked to allow your child to participate in a research study to explore the effectiveness of peer mentoring with high school student mentors and child mentees through examining high school mentor empathy and child mentee global behavior. Recent research shows that school-based mentoring has been beneficial in developing relational competencies, increasing academic engagement, enhancing the self-esteem, and increasing empathy in the mentor. A recent study found that school-based mentoring fostered a belief in the mentor that they have the ability to make a positive difference in the lives of others.

Study Procedures:
Upon your consent, your high school student will be assigned as a mentor to participate in one of two school-based peer mentoring programs designed to promote an increase the interest and empathy of the mentor. In either group interventions, your high school student will be paired with a child mentee who will meet with your high school student on a weekly basis and provide verbal support to the child, engage them in play-based activities, and express their understanding of the child's experiences and desires. All high school student mentors will receive additional training in peer mentoring and how they can best help the child while also being supervised by a supervisor trained in one of the peer mentoring program curriculum. Most high school student mentors find conversing and playing with their child mentees to be very enjoyable. Your high school student will meet with their child mentee for 30 minutes each week during their PAL® class time. Your high school student and their child mentee will continue to meet for 20 weeks during the course of their school day, and they will not be removed from any academic instruction during their mentoring time with their child mentee as it occurs during PAL® class time. Mentoring sessions will be video recorded in order for the high school student mentor to be supervised to ensure a high quality of mentorship. An assessment will also be completed by the high school students measuring what they have learned during their PAL program classroom time at three time points, spending approximately 30 minutes total over the course of the study. Your high school student will not miss any additional instructional time as a result of their participation in the assessment.

Group 1: **Child Mentor Relationship Training (CMRT)** is a research-based peer mentoring program shown to be responsive towards the social, emotional, behavioral, and school needs of preschool and primary school children. The high school student mentors are trained in help the child mentees to express their experiences and emotions and utilized a play-based format if your child chooses to play. Peer mentors will provide a safe environment in which the child can feel supported, accepted, and encouraged. High school mentors are trained in the model that requires classroom lectures, experiential role-playing, and viewing demonstrations of CMRT. Additionally, high school mentors receive continuous support from master's degree level counselors with advanced training and supervision in CMRT. Previous research demonstrates mentors who learn this model may show increased empathy and enhanced self-esteem.

OR

Group 2: Peer Assistance & Leadership (PAL®) program is a peer mentoring program that helps reduce risk factors for a variety of problems and builds resiliency in children by pairing the child mentee with high school student peer helpers who receive training and support from a certified PAL® teacher at their high school. The PAL® mentors will receive supervision regarding their mentoring with their assigned preschool/elementary school child mentee. The PAL® high school mentors act as guides, mentors, and mediators to younger students by utilizing skills learned through the PAL® curriculum including effective communication, decision-making, and resiliency building. Mentors may benefit from participating in this model and may display an increased school engagement and enhancing their capacity to help others.

Foreseeable Risks:
There are no significant personal risks foreseen as likely from involvement in this study. Your high school student's participation is completely voluntary. You may withdraw your high school student at any time during the course of the study. Possible risks may include one or more of the following:

1. Anything that is said or done during the mentoring sessions is considered confidential, meaning that the high school student mentor will not reveal anything that happens in the session to another school official or adult other than the high school student mentor's supervisor. However, if the child mentee discloses child abuse, neglect, exploitation or intent to harm another person, the high school mentor is required to report it to the appropriate authority.

2. Because the Because the primary focus of the mentoring sessions is the personal relationships that develop, your high school student may experience thoughts and emotions that could be strong or difficult for him/her. Each high school mentor will be supervised by an advanced doctoral level student to help him/her express and work through any experiences or emotions that arise as a result of mentoring. If any potential harmful effects upon your high school student are noted, supervision would be utilized to address this concern and the supervisor will consult with the principal investigator. In the very rare case, if mentoring this child is no longer in the high school mentor's best interest, the supervisor will meet with you to provide an appropriate referral.

Benefits to the Subjects or Others:
Possible positive outcomes for high school student mentors participating in the project may include increase in empathy, ability to connect relationally, personal engagement with those the student is involved with, and overall self-esteem as well as increase in understanding of others' feelings, thoughts, and needs. Additional benefits for high school mentors include increase in social skills, cooperation, strength-based coping strategies and problem solving. The results of this study may provide school counselors across the nation with knowledge that helps them enhance student's social, emotional, behavioral, and academic development so that high school students and young children develop relational competencies, increase academic engagement, enhance self-esteem, and increase the mentor's empathy.

Compensation for Participants: There is no compensation for participating in this study.

Procedures for Maintaining Confidentiality of Research Records:
Participants are assigned a code number prior to the study. All information on participants including assessment instruments will be recorded with a code number only. All information will be kept in a double-locked location in the Center for Play Therapy within the Counseling Program at the University of North Texas. Only the research team will have access to the list of the participants' names and code numbers stored in the double-locked location. Names of parents and students will not be disclosed in any publication or discussion of this material. The play sessions will be video recorded. The principal investigator/supervisor will observe the recordings to ensure the quality of the services your student is receiving. At the end of this study, the videos may possibly be shown in professional presentations for educational purposes. Identity information such as name, place of living, and other

For IRB Use Only	
File Number:	
Approval	

Renewal Request and Progress Report

University of North Texas Institutional Review Board

Submission and approval of this form is required annually for all studies approved by Expedited or Full Board review that will continue beyond the initial year of approval. Please submit this form 25 to 30 days prior to the expiration of your current approval period. All recruitment, data collection, and analysis of identifiable data must cease on the expiration date unless renewal has been approved.

Filling Out and Saving the Form
Save this file as a Word document on your computer, answer all questions completely within Word, and submit it along with all supplemental documents to the IRB Office as described on page 2.

Please type in the blue fields and use a font size of 11. Check "No" or "Yes" on items #7 & 8 and elaborate on "yes" answers as indicated.

For Mac Users: To select your response for each check box, click on the appropriate check box and then hit the space bar to place an "X" in the box to indicate your answer.

1. IRB Number:

15-362

2. Title of Study

Must be identical to the title of any related internal or external grant proposal.

The Effectiveness of Peer Mentoring with High School Student Mentors and Child Mentees

3. Investigator (or Supervising Investigator for Student Studies)

First Name	Last Name	Email Address
Sue	Bratton	Sue.Bratton@unt.edu

UNT Department	UNT Building & Room Number	Office Phone Number
Counseling & Higher Education	Welch St. Complex 2, #100	(940)565-3864

4. Student Investigator (if applicable, for student studies such as theses and dissertations)

First Name	Last Name	E-mail Address
Eric	Dafoe	Eric.Dafoe@unt.edu

UNT Department	Degree Program
Counseling & Higher Education	Ph.D. in Counseling

Form designed and maintained by UNT ORIC, 940. 565.4643. Last updated on August 2013

5. Study Beginning and End Dates

Date Last Approved by IRB
September 21, 2016

Project Beginning Date
September 22, 2015

Anticipated Project End Date
December 21, 2016

6. Subject Recruitment

Total number of subjects enrolled in a study as of this date
84

Approximate number of subjects who will be enrolled
84

Total number of subjects enrolled since last IRB Review
84

7. Since the last IRB review, have any injuries, adverse events, or any other unanticipated problems involving risks to subjects or others occurred?

☒ No

☐ Yes – Provide a description of each event and explain how the event was handled.

8. Do you have a signed informed consent form for every subject that has participated in your study? (If your study involved a waiver of signed informed consent, please describe briefly how the informed consent process was conducted.)

☐ No – Describe any problems you have had obtaining informed consent and please attach a copy of the form that you are currently using.

☒ Yes

High school mentor participants were given informed consent forms to take home to their parents in they were under 18. High school mentors participants over 18 could sign their own informed consent. High school mentors participants of all ages were informed of the contents of the informed consent by the student investigator. The informed consent letter informed parents of this opportunity for their high school student to deliver school-based peer mentoring and directed them to provide their name and phone number if they were interested. Parents were provided phone contact information for the PI and lead student researcher, Eric Dafoe, both of whom were available to meet in a confidential setting with the parent/guardian during convenient times for the parents/guardians in order to answer questions and review the consent form. In rare cases where a parent/guardian could not come to the school, consent forms were sent home to parents/guardians who express interest and the researchers followed up with a phone call to review the consent form and answer questions. Next, the researchers met with high school students whose parents provided consent to explain the study and obtained student assent.

After the child mentee participants were identified as per the typical procedures for recruiting PAL® program mentees, a parent information letter was sent home with child mentee participants. The letter informed parents of the opportunity for their child to receive school-based peer mentoring and direct them to provide their name and phone number if they were interested and would like to be contacted with more information about the peer mentoring services. Parents were provided phone contact information for the PI and lead student researcher, Eric Dafoe, both of whom were available to meet in a confidential setting with the parent/guardian at their child's respective school during convenient times for the parents/guardians in order to answer questions and review the consent form. In rare cases where a parent/guardian could not come to the school, consent forms were sent home to parents/guardians who express interest and the researchers followed up with a phone call to review the consent form and answer questions. After obtaining parent consent and student assent, researchers obtained teacher consent from the homeroom teachers of study child participants for the purpose of administering assessments to teachers pre and post

intervention to measure the effects of intervention.

Investigator or Supervising Investigator Certification

☒ By checking this box and e-mailing this Renewal Request and Progress Report Form to the UNT IRB from my UNT e-mail account, I am certifying that I am requesting the renewal of this research for an additional one year period. I certify that the information provided about this study is complete and correct.

Submission of your Renewal Request and Progress Report

Please e-mail the form (including a copy of the informed consent form currently in use) to untirb@unt.edu. Please insert "Renewal Request and Progress Report" in the subject line of your email.

If you have questions about your Renewal Request and Progress Report, please contact The Office of Research Integrity and Compliance at (940) 565-4643 or untirb@unt.edu.

DENTON
INDEPENDENT SCHOOL DISTRICT

Dr. David Hicks, Area Superintendent ■ 1307 N. Locust Street, Denton TX 76201
Phone: 940-369-0052 FAX: 940-369-4983

September 14,, 2015,

Dr. Sue Bratton & Eric Dafoe
425 S Welch Street, Complex 2
Dentor, TX 76203

Dr. Bratton & Mr. Dafoe:

I have reviewed and approved your research proposal, "The Effectiveness of Peer Mentoring with High School Student Mentors and Child Mentees". This will be done at Ann Windle School for Young Children and Hodge Elementary Schoo . Best wishes with your research.

Sincerely,

David Hicks

Dr. David Hicks
Area Superintendent
Denton ISD

APPENDIX G

CHILD MENTOR RELATIONSHIP TRAINING KIT - TOYS AND MATERIALS LIST

	CMRT Play Mentoring Kit Contents
1	Medical Kit & Medical gloves & 'dust' mask
2	Puppet-one nurturing and one aggressive
2	Baby doll (1 darker skin, 1 lighter skin)
1	Magic Wand
1	Musical Instrument
1	Mask – plastic
1	Deck of Cards
1	Ring Toss
1	Bag of dishes, plastic food & baby bottle
1	Bag of blocks and styrofoam ball
1	Bag of family
1	Bag of animals, nurturing and aggressive
1	Bag of cars, army men, handcuffs, rope
1	Bag cell phone, binoculars & play money
1	Bag of beauty supplies
1	Bag of art supplies: construction paper, scissors, glue stick, tape, craft sticks, playdoh, crayons, markers

COMPREHENSIVE REFERENCE LIST

Achenbach, T. M., & Rescorla, L. A. (2001). *Manual for the ASEBA School-Age Forms & Profiles*. Burlington, VT: University of Vermont, Research Center for Children, Youth, & Families.

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Allan, J. (1988). *Inscapes of the child's world: Jungian counseling in schools and clinics*. Dallas, TX: Spring.

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