

GROUP ACTIVITY THERAPY WITH LEARNING DISABLED PREADOLESCENTS
EXHIBITING BEHAVIOR PROBLEMS

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This study was designed to determine the effectiveness of group activity therapy as a school based intervention with fourth and fifth grade preadolescents with learning disabilities experiencing behavior problems. The group activity therapy intervention followed humanistic principles and was designed to address the cognitive and social emotional needs of this population. The preadolescents were provided a variety of developmental appropriate materials and activities to encourage self expression and group interaction.

The 24 volunteer preadolescents were randomly assigned to the experimental group ($n=12$) and to the control group ($n=12$). The treatment group preadolescents were divided into groups of three and participated in group activity therapy one hour per week for 12 weeks. The participants were assigned to groups according to individual needs and personality traits. The control group received no treatment during the study. Pre and post test data were collected from parents using the Child Behavior Checklist (CBC) and the Behavior Assessment System for Children (BASC).

Analysis of Covariance (ANCOVA) was utilized to determine statistical significance between the treatment group and the control group on the post-test means for each hypothesis. In each case, the post-test specified in each hypothesis was used as the dependent variable and the pre-test as the covariate. Specifically, the preadolescents in the treatment group showed statistically significant decreases in

total behavior problems on the BASC ($p=.05$) and decreases in internalizing problems on both the BASC and CBC ($p=.03$, $p=.05$, respectively). While not statistically significant, positive trends were noted on the CBC total behavior scale ($p=.08$) and on the CBC externalizing scale ($p=.09$). In addition, Cohen's d effect size was calculated for each hypothesis and post hoc analysis of the subscales to determine practical significance of the treatment on the experimental group when compared to the control group. A large treatment effect size was found on the BASC ($d=.91$) and CBC ($d=.82$) total behavior problems scales and on the BASC ($d=1.03$) and CBC ($d=.90$) internalizing problems scales. A moderate to large treatment effect size ($d=.78$) was found on the CBC externalizing problems scale and a medium treatment effect size ($d=.53$) was found on the BASC externalizing problems scale. Qualitative data was also examined to determine clinical significance of the intervention. This study determined that group activity therapy is an effective intervention for preadolescents diagnosed with a learning disability.

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CHAPTER I

INTRODUCTION

Children's mental health is a growing concern in this country (U.S. Public Health Service, 2001). With the tragedy of September 11, 2001 and the subsequent war on terrorism, children are being exposed to more brutality than ever before through media coverage as well as personal experiences. In addition, the increase in school violence in recent years, such as the shootings at Columbine, Colorado in 1999, has brought attention to the dire consequences of ignoring the social-emotional needs of our youth. The recent Surgeon General's report (U.S. Public Health Service, 2001) emphasized the lack of children's mental health services, describing the shortage as a national health crisis. "Growing numbers of children are suffering needlessly because their emotional, behavioral, and developmental needs are not being met" (U.S. Public Health Service, 2001, p.3). It is estimated that, 1 in 10 children in the United States endure mental health problems causing some type of impairment; however, only one in five receive mental health services. According to the report, the institutions created to care for children and families only provide fragmented treatment services and have missed opportunities for identification, prevention, and intervention. The increased need for mental health services for children must be met by those institutions responsible for children's mental health services including child welfare, the juvenile justice system, and schools (U.S. Public Health Service, 2001).

“Mental health is a critical component of children’s learning and general health. Fostering social and emotional health in children as part of healthy child development must, therefore, be a national priority” (U.S. Public Health Service, 2001, p. 5). Expanding counseling services in schools offers significant possibilities for addressing the shortage in children’s mental health services by providing access to all children. It is imperative that schools and other institutions provide developmentally appropriate and proven effective mental health services with a focus on early intervention. Play therapy and activity therapy are interventions that are sensitive to the developmental needs of children and preadolescents and, therefore are suitable for use in schools.

Play therapy and activity therapy provide children and preadolescents with a developmentally appropriate and comfortable means of expressing feelings and experiences (Bratton & Ferebee, 1999; Ginott, 1975; Landreth, 1991; Schiffer, 1969; Slavson, 1945; Solomon, 1940). Unlike adults, who most naturally communicate verbally, children naturally communicate through play and activity (Landreth, 1991). Play materials and activities are used to facilitate the development of a therapeutic relationship with children in a non-threatening environment. By bridging the gap between concrete and abstract thought processes, play therapy allows children to make sense of their world. In this environment, children are able to learn new ways of coping with and resolving their problems.

For decades, play therapists have utilized play and creative expression with children with social-emotional or behavioral problems; however, schools have been slow to embrace this modality (Alexander, 1964; Landreth, 1987; Landreth, 1993) and critics

have questioned its efficacy (Lebo, 1953; Phillips, 1985). A recent meta-analysis of 94 play therapy outcome studies, however, quelled critics by proving that play therapy interventions produce large treatment effects when compared to control or comparison groups ($d = .80$). The majority of the studies reviewed focused on children under 10 years of age, with an average age of 7.1 years (Ray, Bratton, Rhine, & Jones, 2001). Although research has shown play therapy to be an effective mode of treatment for children with a variety of presenting issues (Bratton & Ray, 2000), little research exists on the therapeutic use of play and activity with preadolescent children (10-12 years of age), individually or in groups.

While play therapy has been widely used as a developmentally appropriate mode of treatment for children, preadolescents may find the toys in a conventional playroom juvenile (Ginott, 1961). Slavson (1945) first suggested the need for a specialized treatment for preadolescents, one that provides a setting and activities consistent with the developmental needs of this age group (Bratton & Ferebee, 1999; Krall & Irvin, 1973; Schiffer, 1969). Although cognitively preadolescent children are in the concrete operational stage they are beginning to develop the capacity for abstract thought (Piaget, 1964). Ginott (1961) suggested activity therapy with preadolescents as a way to bridge the gap between verbalization and play.

Utilizing a group activity format with preadolescents is consistent with the socio-emotional needs of this age group. In preadolescence, children become more aware of and are influenced by opinions of other people beyond their family, particularly their peers (Bratton & Ferebee, 1999). According to Erikson (1968), this stage of socio-

emotional growth is characterized by the development of industry versus inferiority and requires learning the rules of society. While learning the rules of society does not eliminate feelings of inferiority, understanding and abiding by societal rules facilitates appropriate interactions with others. Inferiority, on the other hand, can manifest itself as low self-esteem, a sense of incompetence, depression, anxiety in social and school situations, withdrawal, and difficulty with peer, sibling, and parental relationships. Because preadolescents see school as their social world, underdeveloped social skills can affect the school experience (Yasutake & Bryan, 1995). When children are too anxious or sad to interact with peers or form meaningful relationships, they become less focused on the learning process. School becomes a source of anxiety. The inability to develop meaningful social relationships can affect children throughout life (Johnson, 1988). Group activity therapy can provide preadolescents with the opportunity to form relationships and to practice new social and coping skills in a safe, developmentally appropriate environment. Providing this intervention in the school setting offers the therapeutic environment to more children and allows the intervention to take place within existing dynamics.

Academic struggles and feelings of being different or inferior when compared to peers compound the typical difficulties of preadolescents with learning disabilities. Some difficulties include awkwardness, feelings of loneliness, depression, anxiety, and isolation. In addition, preadolescents with learning disabilities struggle with low self-esteem and feelings of inferiority due to failures both academically and socially. These

failures or perceived failures make it difficult to master the developmental task of industry (Yasutake & Bryan, 1995).

Awareness of others is needed to have meaningful relationships. Children with learning disabilities often have difficulty identifying emotions from facial expressions and other non-verbal cues, contributing to their social ineptitude (Holder & Kirkpatrick, 1991). Because of their inability to interpret nonverbal cues and understand others, children with learning disabilities often exhibit a range of behavior problems, including impulsivity, anxiety, depression, aggression, and withdrawal. These behaviors are a source of frustration for teachers, parents, and other children. Children with behavior problems tend to become isolated from adults and peers and become depressed and anxious. This isolation magnifies the awkwardness of preadolescent children and causes the chasm of social difficulties to grow.

Group activity therapy is a mode of helping preadolescents address problematic behavior that takes into account the cognitive and social-emotional needs of preadolescents (Bratton & Ferebee, 1999; Ginott, 1961; Kottman, Strother, & Deniger, 1987; Schiffer, 1952; Slavson, 1945) by providing preadolescents with both verbal and nonverbal means to develop relationships and work through and resolve conflicts (Kottman et al., 1987).

A review of the literature acknowledged and identified problems for preadolescents. However the literature review also indicated that there is clearly a need for further outcome research in the area of developmentally sensitive therapeutic interventions for preadolescents. Child and adolescent researchers have also examined

the need for research focusing on a specific population or presenting issue. This study addressed these needs by examining the effectiveness of group activity therapy with preadolescents diagnosed with learning disabilities exhibiting behavior problems both at home and at school. Furthermore, this study proposed a counseling intervention that can be used in schools with student populations that are at risk for developing more severe problems. Offering treatment and intervention strategies in the school setting is one way to make mental health services available to a wider range of students who might not receive counseling otherwise. In light of the increase of outbreaks of violence and the realization that in most cases, the instigators struggled with depression, acceptance, and fitting in at school, proven interventions that are developmentally appropriate and that target the emotional, social, and behavioral needs of students are critical. Group activity therapy is one such intervention and offers hope as an effective treatment for children exhibiting a variety of behavior problems that put them at risk for becoming social misfits, which often leads to violence against others.

Purpose of the Study

The purpose of this study is to determine the effectiveness of group activity therapy on the behavior of preadolescents diagnosed with a learning disability. This study is designed to determine the effectiveness of group activity therapy in 1) reducing total behavior problems of preadolescents with learning disabilities, 2) decreasing the internalizing problems of preadolescents with learning disabilities, 3) decreasing externalizing problems of preadolescents with learning disabilities.

Synthesis of Related Literature

The following is a synthesis of relevant literature and research related to the following areas: 1) history and rationale for play therapy and activity therapy; 2) preadolescent development; 3) children with learning disabilities; 4) group activity therapy; 5) play/activity therapy outcome research on internalizing behaviors; and 6) play/activity therapy outcome research on externalizing behaviors.

History and Rationale for Play and Activity Therapy

Conventional talk therapy is not appropriate for children. They do not have the cognitive development to express themselves verbally. Instead, play is the child's language (Landreth, 1991). Children project thoughts and emotions onto toys using their natural language of play. When in the playroom with a trained professional, children have the opportunity to work through their personal challenges in their own medium of expression.

The first documented use of play as a method of working with children is Sigmund Freud's account of "Little Hans" in 1909 (Landreth, 1991). Freud met with Hans for one session and subsequently advised the child's father to gather data about the child's play. Through information about the child's play, Freud was able to make a diagnosis and offer therapeutic advice to Hans' father.

Hermine Hug-Hellmuth (1921) was one of the first therapists to reject adult methods of therapy with children. Hug-Hellmuth emphasized play as an essential to child analysis. She believed in the therapeutic use of toys as a means for children to express themselves.

In 1919, Melanie Klein (1955) began to use play much in the same way her contemporaries used free association with adults. With children under six, Klein conducted analysis, substituting play for verbalized free association. She believed play revealed the child's unconscious mind and encouraged children to express fantasies, anxieties, and defenses. Klein believed that interpreting the child's unconscious and preconscious thoughts through the symbolism of play was the main function of therapy.

Anna Freud (1965) viewed the purpose of play differently from Klein. Freud used play as a way for the child and therapist to form a therapeutic relationship. Once the relationship was formed, Freud would then interpret, however minimally, the unconscious motivation behind the child's play.

Another major contributor to play therapy was David Levy (1938). Levy developed release play therapy, a way to use play to facilitate the abreaction of anxiety provoking experiences. Children reenacted traumatic events allowing the child to release the anxiety and pain associated with the event. Gove Hambidge (1955) expanded on Levy's work utilizing a more direct approach called Structured Play Therapy. Hambidge's model consisted of establishing a therapeutic relationship, recreating the anxiety-producing situation, playing out the situation, then allowing the child to have free play so that they could recover from the anxiety producing experience.

The emergence of relationship play therapy developed by Jesse Taft (1933) and Fredrick Allen (1934) marked another major development in the history of play therapy. Taft and Allen's work is based upon the work of Otto Rank (1936) which emphasized the present, de-emphasized the past, and placed a significant amount of importance on the

development of a therapist-client relationship. Allen and Taft viewed children as individuals capable of assuming responsibility in the growth process and capable of altering their own behavior.

Virginia Axline (1947) expanded upon the work of Carl Rogers and applied nondirective principles to children. Axline believed in the capacity of the child for self-awareness and made no efforts to control or change the child's behavior. In this approach, children have the choice to play or not play, talk or not talk. The play therapist actively reflects the child's feelings, thoughts, and actions. Through these reflections, the therapist conveys acceptance. When the child's feelings are accepted, the child is free to deal with them. Garry Landreth (1991) expanded on and refined the work of Axline coining the phrase child-centered play therapy. Additionally, Landreth is one of the most prolific researchers in the area of play therapy.

The development of guidance programs in schools was another major accomplishment in the wide spread use of play. Until the 1960s, counseling and treatment of children was thought to be only for maladjusted children. However, in the 1960s counselors were placed in elementary schools throughout the United States and many of these counselors described their experiences in play therapy with all children, not just those who were considered maladjusted (Alexander, 1964; Landreth, 1972, Landreth, Allen, & Jacquot, 1969; Muro, 1968; Myrick & Holdin 1971; Nelson, 1966; Waterland, 1970).

In 1961, psychoanalytically trained Haim Ginott wrote about the use of non-directive group play therapy with children. However, since that time only a few articles,

chapters, and one other group play therapy text have been written (Landreth, 1999). In group play therapy, children are given the opportunity to interact with the play materials, one another, and the therapist (Landreth, 1991). There is no group cohesion or group goals. According to Ginott, children learn to modify their behavior in order to be part of the group. Ginott (1961) stated that this “social hunger” is the basic requirement for group.

Slavson and Redl (1944) first introduced the concept of Group Therapy (AGT). Using a non-directive approach based upon psychoanalytic principles, children were allowed the opportunity to release their unconscious desires. Slavson modified the materials in the room to be more appropriate for the population with which he worked. Schiffer (1952) wrote about his group experiences describing the way in which the group moved from isolation, to group destruction, to group cohesion. Both Slavson and Schiffer emphasized the importance of the permissiveness of the therapist and believed that it is through permissiveness that the child is free to develop the transference necessary for growth (Schiffer, 1952).

While the therapeutic use of play in therapy has been acknowledged for decades, preadolescents may not feel comfortable with the materials in a conventional playroom. While these children are not developmentally ready to verbalize their emotions, their developmental stage must also be considered when planning an appropriate milieu.

Preadolescent Development

Developmental level is an important consideration when working with children (Krall & Irvin, 1973). Preadolescents face their own unique set of developmental tasks.

They are stuck in a world between childhood and adolescence. The language used, the materials and toys used, and activities selected must all be developmentally appropriate for preadolescents. At this age, children struggle with dependency and striving to be independent cognitively, psychosocially, morally, and physically.

Cognitive development. Piaget (1977) divided cognitive development into four stages. The sensorimotor phase, which extends from birth to 2 years old, is characterized by the movement from reflexive responses to goal-directed responses. Children at this stage learn to use their movements intentionally. They also begin to learn object permanence, the concept that objects still exist even if they are out of view. In the preoperational stage, ages 2 to 7, children lack the concept of conservation. Children at this stage determine things based upon what they see. For example, if two equal amounts of water are presented in two different sized containers, one thin and tall and one short and wide, the child will state that the short wide container has more water. They are not capable of imagining the water in a different form. Furthermore, preoperational children can only think of one aspect of a problem and lack the capacity to verbalize difficulties. Instead, they act out their emotional stressors and their perception of the problem via play (Landreth, 1991).

According to Piaget (1977), around the age of 7 children move from preoperational to the concrete operational stage of cognitive development. Generally, children at this stage no longer have difficulty with the concept of conservation. They have also mastered reversibility, which gives them the ability to understand that because the water was once a certain volume, changing its appearance does not change the

volume. They are able to realize that if the action were reversed, the volume of water would be the same. While preoperational children respond to visual cues, the concrete operational child is able to respond to inferred reality. They can conceptualize parts becoming a finished product and see things in different contexts. The concrete operational child can form concepts and see relationships between objects and situations. Things can now be ordered by attributes rather than haphazardly. With this increased insight into concepts and movement toward abstract thinking, children are able to see other's perspectives and become less egocentric. By understanding new views of the world and by expanding their perceptions, preadolescents have the capacity to reorganize their experiences.

With the development of formal operational thought processes (11 to adult) comes the ability for abstract thought and to think about potential or hypothetical situations (Piaget, 1977). Individuals are gaining the ability to think about concepts. Understanding this phase is important for clinicians working with preadolescents, because they are on the cusp of formal operational thought.

Psychosocial development. Erikson (1980) identified eight stages of psychosocial development. Each stage presents the individual with tasks and issues that must be resolved in order to successfully face future challenges. While the stages are not discrete, unresolved issues in one stage will continue to pose challenges in the following stages. Stages include: Trust versus Mistrust, Autonomy versus Doubt, Initiative versus Guilt, Industry versus Inferiority, Identity versus Role Confusion, Intimacy versus Isolation, Generativity versus Self Absorption, and Integrity versus Despair. If children do not form

attachments early in life, and do not learn to trust, they will have difficulty trusting and being trust worthy until the psychosocial task is resolved.

Erikson (1980) described the preadolescent's task as one of industry versus inferiority. At this stage of psychosocial development, children begin to broaden their world. Teachers become important influences in children's lives as they enter school. Preadolescents begin to believe that they are what they learn. Industry in children is manifested in the desire to make things. Children either become industrious and learn the rules of society (school) or perceive themselves as inferior. Failing at the task of industriousness creates anxiety, depression, and a negative self-image. This failure does not have to be an actual failure, but a perceived inability to measure up to peers. This sense of inferiority creates a sense of inadequacy that impacts learning.

Moral development. According to Piaget (1977), between the ages of 6 and 10 children develop the ability to acknowledge rules. While they acknowledge rules, they are not always inclined to follow them. This can be extremely frustrating for adults and other children. Children can be playing the same game, and be playing by different rules. When the rules continually change or are not being followed, it is difficult to engage in a relationship.

Kohlberg (1969) studied how people respond to the rules and laws that govern them. Kohlberg determined that while every individual moves through the stages of moral development at different rates, by preadolescence, (9 years of age) children have passed from the preconventional stage into the conventional stage of moral reasoning. Relationships with peers and working with others are key components of this stage.

Preadolescents are beginning to be capable to empathize with other people's experiences and consider others when making decisions. In addition, preadolescents are looking for external praise. They are motivated by receiving praise from others and therefore, work to please. They are also more aware of and consider other people's feelings in their actions.

Physical development. When children reach preadolescence, they experience physical changes. With the development of primary and secondary sexual characteristics, they begin to look more adult. However, while preadolescents begin looking more mature, they do not possess the formal operational thought processes needed to think abstractly and to meaningfully verbalize their concerns. Parents and teachers struggle to communicate with this age group. Adults tend to believe this age group is capable of talking about their problems and stressors. This difference in communication style leads children to feel misunderstood and can leave adults frustrated by the child's apparent defiance.

Children with Learning Disabilities

Children with learning disabilities can be found in every school. Lokerson (1992) summarized Public Law 94-142, as amended by Public Law 101-76 the Individuals with Disabilities Education Act (IDEA):

Specific learning disability means a disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written, which may manifest itself in an imperfect ability to listen, think, speak, read, write, spell, or do mathematical calculations. The term includes such

conditions as perceptual handicaps, brain injury, minimal brain dysfunction, dyslexia, and developmental aphasia. The term does not include children who have problems that are primarily the result of visual, hearing, or motor disabilities, or mental retardation, emotional disturbance, or of environmental, cultural, or economic disadvantage (Lokerson, 1992, p. 158).

While federal law governs the definition of learning disabilities and requires that schools identify and provide academic services to children with learning disabilities, individual states and school districts vary in how they identify and label children as learning disabled (Lokerson, 1992). Fessler, Rosenberg, and Rosenberg (1991) stated that there are not adequate guidelines to differentiate between children with learning disabilities and behavioral or emotional disturbances. Some schools have identified a range of scores on an intelligence test to qualify children as learning disabled. Still others require that there is significant difference between actual achievement and aptitude. Due to the varying definitions of learning disabilities, this population is difficult to identify.

Landreth, Jacquot, and Allen (1969) used the term learning disability to describe children who have average or above average intelligence, but experience difficulties in an academic environment. One child may have difficulty reading, while another child has a speech problem, while still another may have emotional issues, all of which may prevent academic achievement. This discrepancy between intelligence and achievement typically qualifies children for the label of learning disabled regardless of the area in which the discrepancy occurs (Lokerson, 1992).

While previous definitions of learning disabilities have been restricted to academic potential versus achievement, some researchers are interested in creating a learning disabled category with social interaction skill deficits as a primary learning disability (Gresham and Elliot, 1989). Because children with learning disabilities are often behaviorally awkward in social situations, researchers are trying to determine if the difficulties in social interaction is caused by poor academic achievement or vice a versa. In their article, Gresham and Elliot (1989) stated the reasons including difficulties with social interactions as a primary learning disability are based upon the following:

1. Students with learning difficulties often face challenges forming positive relationships;
2. There has been an outgrowth of research regarding appropriate interactions of children with learning differences due to the relative newness of the concept that social interaction deficits could be a primary learning disability;
3. The inclusion of social interaction deficits as a learning disability encourages further research and understanding of the problem;
4. Including social interaction deficits as a primary reason for qualifying students for services would give the development of appropriate social interactions the same needed attention as the development of academic and language skills (Gresham & Elliot, 1989).

With the inclusion of social interaction deficits as a primary learning disability, the number of children identified as having problems would increase. An increase in the number of students identified would result in a need for increased funding. It would also

provide early intervention for these children so that they could benefit from improved social interactions and prevent future problems that might arise, including feeling alienated from peers and, ultimately society (Johnson, 1988).

All preadolescents face many developmental challenges. Those diagnosed with learning disabilities have an additional set of struggles such as depression, anxiety, impulsivity, and feeling as though they do not fit in (Johnson, McLeod, & Fall, 1997). They are at higher risk for social and emotional problems. Social deficits can cause additional academic problems as well as emotional problems (Johnson, 1988). Children who are anxious, depressed, and isolated do not experience successful and meaningful peer relationships and do not interact appropriately with teachers and other adults. They therefore experience difficulty communicating and attaining the information necessary to be successful in the classroom. Additionally, learning disabled children have difficulty taking in information auditorially (Bolea, 1986) which often results in teachers becoming frustrated when giving verbal directions to these children. In social situations, the child may state understanding, but do the opposite of what was communicated thereby, alienating themselves from their peer group (Bolea, 1986). Children who do not feel they are part of a peer social group will feel lonely and depressed. These feelings, if not dealt with appropriately, will metastasize into feelings of unhappiness and isolation. Children who experience social isolation are at risk for becoming aggressive, angry, and at higher risk for violence (Bolea, 1986).

Children with learning disabilities often receive feedback that they are not competent which contributes to feelings of inferiority and inadequacy. These children

have past experiences with being impulsive, impatient, using inappropriate judgment, and lacking intuition (Guernsey, 1979). Teachers and parents often remind these children of their academic and social inadequacies and failures. When children repeatedly hear the message that they are not capable, they internalize this message. Internalization of negative messages leads the child to believe the message. Children learn not to trust themselves or others. They believe they are inferior and incapable both academically and socially, which makes it difficult to master the developmental task of “industry” which is crucial to this age group. Children and preadolescents often lack the ability to verbalize their feelings and instead take their aggression, anxiety, anger, and frustration out on others or themselves. Children often either internalize or externalize their feelings. Internalization of feelings is the child coping with angst by turning inward, becoming withdrawn, sad, worried, and easily frustrated. Children who externalize problems act out their inner feelings often taking the form of yelling, hitting, or seeking out of attention through fits or name-calling.

Group Activity Therapy

Preadolescents may become bored with the toys in a conventional playroom (Ginott, 1961), and talk therapy is inappropriate for this age group. It is therefore necessary to develop a mode of treating this population that is effective, developmentally appropriate, and appealing. Slavson and Redl (1944) recognized the need to develop a model of treatment that met these needs. They designed a method of working with preadolescents that was developmentally sound for this population. The following is a review of the literature that addresses group activity therapy.

Session structure. On the average, group activity therapy models that are non-directive recommend three to six group members, depending on space, for 1 hr 30 min to 2 hour sessions on a weekly basis (Gerstein, 1974; Slavson, 1945). While the longer time frame is ideal for a group of preadolescents, it is not practical in a school setting (Nicol & Parker, 1981). While Slavson's model of activity group therapy was entirely non-directive, except for snack time, other researchers have presented models of activity therapy for this age group with varying degrees of structure and therapist initiated activity (Bratton & Ferebee, 1999; Hillman, Penczar, & Barr, 1975; Schachter, 1974). Structure of the sessions as recommended by Bratton and Ferebee (1999) included 15 to 20 minutes of an activity loosely structured by the therapist, 20 to 25 minutes of free activity selected by the group members, and 15 minutes of snack time (Hillman et al., 1975; Troester & Darby, 1976). The therapist's introduction of a semi-structured activity provides a microcosm for every day experiences, introduces group interaction, and can provide a means to reduce anxiety in the preadolescents. According to Bratton (2001), the focus of the activity is not on the outcome or product, but rather on group members' interaction and affect. During the semi-structured activity, the preadolescents can choose to participate or choose not to participate in the activity. Inclusion of a snack time to bring closure to the session provides an opportunity for preadolescents to have an enjoyable reason to share and act out family experiences (Troester & Darby, 1976). In addition, the giving of food is another means for the therapist to express unconditional positive regard for the clients (Troester & Darby, 1976).

Selection of group members. According to Ginott (1975) the need to be accepted by one's peers, social hunger, is a basic requirement for group members. If a child lacks social hunger, the child will not be willing to modify behavior to achieve acceptance. For children to choose to modify their behavior, they should be exposed to children who have different coping skills. Experts recommend heterogeneous grouping of children (Ginott, 1961; Slavson & Redl, 1944) and that group members be selected carefully (Ginott, 1975). It is important that group members be selected based upon their personalities and how the individual's personality will complement one another in a therapeutic nature (Slavson, 1945). Placing a child who doubts self in a competitive group will only reinforce the feelings of failure and inadequacy. Similarly, a child who is small and shy will feel overpowered and overshadowed if placed in a group with larger, more outgoing children. A good match would be a child who is inhibited but has good impulse control paired with a child who is more assertive but lacks impulse control. The children would impact one another, and provide perspective into one another's behavior and experience.

Age and gender of group members is another aspect to consider when recommending children for group. Preadolescents should be of the same gender and their ages should not differ by more than one year (Ginott, 1975).

While most preadolescents could benefit from group activity therapy, there are some instances where group counseling would be contraindicated. Children who have been the victim of sexual abuse and are subsequently acting out would not be appropriate for group. Children with attachment disorders whose need for a secure attachment with a significant adult would take priority would likely benefit from individual counseling. In

addition, children exhibiting sociopathic behavior should not be placed in a group, instead, individual therapy would be recommended. Once the child's individual needs are met in individual counseling, the child could be transitioned into group counseling for continued growth and interaction. Siblings can benefit from group activity therapy with the exception of those experiencing significant sibling rivalry. While a developmentally appropriate mode of treatment, not all children should initially be placed into a group therapy format.

The activity room. Preadolescents need adequate space and materials with which to express themselves. Schiffer (1969) suggested a room of about 300 square feet. This size room provides enough room for preadolescents to be active, roam, create, and explore. Ginott (1975) recommended the room be 400 square feet for a group of five to eight individuals. Space is important so that children have opportunities to utilize self-control and experience therapeutic limits (Schiffer, 1952). Too little space can lead to overcrowding, anger, and aggression among group members. While it is ideal to have a large space, Bratton and Ferebee (1999) have found the room size that Ginott (1975) and Slavson and Redl (1944) recommend to be generally unavailable in clinical settings or in school settings. They stated that a well planned room of 200 square feet, with moveable equipment, can be adequate to handle three to four adolescents.

In addition, materials should be carefully selected to provide the freedom for the child to be expressive in a variety of creative ways, while keeping space limitations in perspective. Important materials include a puppet theater, wood working table, sandtray and miniatures, shelves to store additional games and toys, a multipurpose game table

(convertible to accommodate pool, ping pong, etc.), crafts, easel, paints, a variety of dress-up items (appropriately sized for the children in the room), and tables large enough for more than one child to work on a project at a time (Bratton & Ferebee, 1999; Ginott, 1975, Slavson, 1945). It is helpful if the larger items have wheels on the bottom so the children can rearrange the room to meet their needs. This also allows for more materials to be available in a smaller space; the therapist or children can bring in what is needed or remove what is not being used.

Toy and game selections should be made with several considerations in mind. The age of the activity group is one area to consider. Toys and games should be age appropriate. Preadolescents can process more rules than younger children. Toys and games should stimulate interaction between the children, creative expression, encourage exploration, and encourage the free expression of the children. In addition, opportunities should exist for the children to spontaneously act out concerns and solve problems (Bratton & Ferebee, 1999). Toys and materials may be varied based upon interests of the children. Preadolescents may enjoy artwork, leather working, sewing, beadwork, power tools, and other materials (Ginott, 1975). Crocker and Wroblewski (1975) proposed the use of games with preadolescents to provide the opportunity to deal with rules which can be considered a metaphor for living within societal norms and to learn specific coping skills.

Play Therapy and Group Activity Therapy Research

Play therapy is effective for children experiencing emotional and behavioral problems; however, the research focuses mainly on young children. There has been little

research on group activity therapy with preadolescent-aged children. Ray and Bratton (2001) reported 7.1 years of age as the mean age of play therapy research with the majority of the studies with children under the age of 10. While there are research studies with older children, the intervention methods focus on cognitive-behavioral and directive interventions (Bratton & Ray, 2000). Preadolescents have been all but neglected by humanistic play therapy researchers.

Lev (1983) described the use of activity group counseling in an in-patient psychiatric setting. The on-going activity groups described involved children from 9-11 years of age. Groups were for one hour each week. The primary goal of the group was to provide an opportunity for group members to form relationships and experience meaningful interaction, group members showed increased acceptance of others and more appropriate interactions with peers and staff. Group activity therapy was evaluated as an effective means of facilitating interaction.

Kottman, Strother, and Deniger (1987) described the outcome of 12 weeks of activity therapy with a preadolescent male. The client was referred for externalizing behavior and helplessness. In initial sessions, the child asked the therapist for assistance constantly and became frustrated when it was suggested that he attempt to do things for himself. The client expressed his anger by testing the limits in the activity room. Eventually, the client began to take more control and responsibility for the activities in the activity room. The authors noted an increase in verbalization as the client became more involved in various activities. Just before termination, the client's behavior regressed to previous ways. The client acted out his frustration in the session by throwing

and stomping. In a follow-up session a few weeks later, the client's demeanor had returned to being more positive. The client reported he had become frustrated but he had learned he could control his own behavior.

Pope, Edel, and Lane (1974) used puppets with children diagnosed with a learning disability. Puppets offer children the opportunity to experience interactions in a new way through the safety of the puppets. Three to nine children attended the puppet workshop with one master puppeteer and one assistant. Initially the children were impulsive, clumsy, aggressive, and had poor attention spans. After meeting in the puppet workshop one time per week, each child was able to contribute to the show in a positive way. The children demonstrated positive relationship skills, which generalized to better behavior at school and home. According to the authors, the children experienced change because of experienced success, pleasure, and an increase in self-esteem.

Madonna and Caswell (1991) used activity group therapy with five children 12 to 14 years of age. The children were referred to group counseling for acting out and aggressive behavior. Several had been suspended from school and one was in trouble with the law. The group met every other week for a total of 40 sessions. The sessions lasted for 90 minutes. The sessions were structured with 30 minutes of talking, 30 minutes of either cooperative or aggressive play, and a 30-minute snack time. Aggressive activities included dart guns, slingshots, and swords. Cooperative activities included group balance games, ring toss, and board games. By the end of the first year, the children's parents reported receiving more cooperation at home. The parents also reported a more pleasant attitude from the children. Unfortunately, these results were not

generalized to the school setting. During the second year, the children began to accept the leaders of the group. The children no longer mocked the leaders in a malicious way. The members of the group began to seek positive interactions and praise from the leaders. The second year of treatment brought about changes in attitudes towards feelings. The children became more able to acknowledge and understand feelings and how their behavior was related to how they were feeling.

Play Therapy Outcome Research on Internalizing Behaviors

Anxiety and depression. In order for children to form meaningful relationships, they must possess the skills necessary to approach people and share of themselves. Children who are anxious are often isolated, fearful of interaction, and withdrawn. Play therapy has been proven to alleviate anxiety and depression. For example, in a study of 114 children, ages 5 to 12, Clatworthy (1981) utilized play therapy to help children cope with the stress of being hospitalized. A control group, receiving no treatment, and a treatment group, receiving daily play therapy were formed. The children receiving daily play therapy experienced less anxiety than the children who did not receive play therapy. Forty-six hospitalized children ages 5 to 10 were placed in four groups. One group received child-centered therapeutic play therapy, one received diversionary play, one received verbal support, and a control group received no intervention. On the third day of hospitalization, the children were post-tested. Of the four groups, those children who received child-centered therapeutic play therapy demonstrated significantly less fear as compared to the other three groups (Rae, Worchel, Upchurch, Sanner, & Daniel, 1989).

Tyndall-Lind (1999) examined the anxiety level of children living in a domestic violence shelter. After 12 child-centered sibling group play therapy sessions conducted daily, the treatment group experienced a statistically significant reduction in anxiety and depression when compared to a control group.

Johnson and Stockdale (1975) utilized puppet shows to reduce the anxiety of 43 children ages 5 to 8 who had been hospitalized for operative procedures. Authors found that children who viewed and then interacted with the puppets demonstrated a significant reduction in anxiety when compared to the control group. Milos and Reiss (1982) researched 64 children ages 2 to 6 with separation anxiety participating in either free play, directive play, or modeling (not play therapy). Results indicated that the children who participated in three sessions of any of the treatment groups experienced dramatic reductions in anxiety when compared the nonintervention control group. Rae, Worchel, Upchurch, Sanner, and Daniel (1989) studied 46 hospitalized children ages 5 to 10 and determined that the children who participated in two child-centered play therapy sessions experienced a reduction in anxiety when compared to children who participated in verbal support groups, children who played in a non therapeutic environment with toys, and a control group.

Burroughs, Wagner, and Johnson (1997) compared five play therapy sessions to counseling sessions using the board game “My Two Homes” with 21 children ages 7 to 17 whose parents were divorced or divorcing. Researchers found that both groups of children experienced a decrease in depression as determined by the parent form of the Child Depression Inventory and a decrease in scores on the internalizing scale of the

Child Behavior Checklist. Springer, Phillips, Phillips, Cannady, and Kerst-Harris (1992) found that male and female children experienced less depression and hyperactivity and the male children experienced a decrease in aggression and delinquent behavior. The study examined 132 children ages 7 to 17 identified as having at least one parent suffering from substance abuse problems. The children in the experimental group participated in an average of 11 peer groups and 9 family play and art activity groups.

Withdrawn behavior. Children who experience withdrawn behavior often have difficulty interacting with others and forming relationships. Research demonstrates that play therapy is an effective way to facilitate interaction between children. Clement and Milne (1967) researched the effect of token play groups in which the participants received tokens for appropriate target behavior, verbal play therapy groups in which the participants received verbal reinforcement for appropriate interactions, control group A in which children went into a play room in groups, and control group B in which the children went into a play room by themselves. Sixteen 2nd and 3rd graders were randomly assigned to one of the four groups. Results indicated that the students who participated in the token play groups achieved more gains in target behavior than the other groups. Findings were maintained at a one-year follow up. Seeman, Barry, and Ellinwood (1964) found that 16 2nd and 3rd graders who were identified as maladjusted on aggression and withdrawal experienced marginal improvement on teacher rating scales after participating in nondirective play therapy for 37 weeks.

Play Therapy Outcome Research on Externalizing Behaviors

Social interaction. Play therapy offers children the opportunity to grow and facilitates change in many areas. In order for children to experience successful social relationships, they must be able to interact appropriately. For example, children must be able to approach others, take turns, and not overpower one another.

Cox (1953) examined client-centered play therapy with 52 orphans, ages 5 to 13 years old. The children received 10 weeks of play therapy then a 13-week follow-up period. Those who participated in the play therapy experienced gains in their ability to interact socially, as compared to a control group. Because of the children's living situation, and the fact that the intervention was the only difference between the two groups, the change in behavior was attributed to play therapy.

Sokoloff (1959) examined the effects of play therapy on children with cerebral palsy and found that those children who participated in the study increased their social maturity. Schmidtchen and Hobrucker (1978) studied 50 children ages 9 to 13 and found that the children in the child-centered play therapy treatment group became more able to handle changes and were generally more flexible in social situations. Additionally, they experienced a decrease in anxiety, compared to two untreated control groups.

Quayle (1991) found that children participating in child-centered play therapy were more able to assert themselves in social settings and demonstrated an increase in their cognitive skills. When working with "socially immature" children, Pelham (1972) determined that the children in the play therapy treatment group made strides in improving their social maturity as compared to the control group. Fleming and Snyder

(1947) compared the use of nondirective play therapy with male and female children identified as maladjusted. The females who received the treatment showed improvement in personal adjustment. The males, however, did not show any change. Thombs and Muro (1973) studied 36 second graders identified by peers on a sociometric instrument as socially isolated. The researchers divided the children into three groups of 12 students. One group received relationship play therapy, one group received talk therapy, and the other group received no intervention. The two treatment groups were further divided into two groups of six and received treatment for 30 minutes per day for 15 days. At the end of the 15-day period the same sociometric instrument was given. The children who participated in some type of treatment, either talk therapy or play therapy experienced significant gains in sociometric status. Additionally, the children in the treatment group receiving play therapy experienced more social gains than those children who received talk therapy.

Tyndall-Lind (1999) and Kot (1998) utilized child-centered play therapy with children witnesses of domestic violence living in a shelter. The children participated in 2 weeks of intensive child-centered play therapy. In both studies the experimental group of 11 children experienced reductions in behavior problems. Additionally, Tyndall-Lind found that group and individual play therapy were both useful methods for effecting change in behavior problems for children in the treatment groups when compared to the control group.

While many studies have indicated growth in social abilities of children through play therapy, studies with less favorable results are found. For example, an investigation

of Adlerian teacher training versus play therapy with 78 students ages 5-9 identified as socially immature found no statistical significance between the groups when looking at social maturity. The children participating in play therapy did, however, demonstrate more willing to risk and try new things (Amplo, 1980).

Non-directive play therapy, directive play therapy, and no treatment were compared using a population of 20 abused children ages 1 to 7 years. While both the non-directive treatment group and the directive treatment group achieved higher scores on personal-social adjustment after eight weeks of intervention. There were no significant differences found between the two treatment groups (Saucier, 1986).

Aggression. Dogra and Veeraraghavan (1994) studied 20 students ages 8 to 12 diagnosed with aggressive conduct disorder. The children received 16 sessions of nondirective play therapy and the parents attended counseling sessions as well. The children in the experimental group experienced a significant decrease in the number of negative responses and higher positive responses when compared to the control group. The experimental group also had fewer reports of fighting, bullying, and temper tantrums.

Hannah (1986) conducted research using a time-series design to determine the effects of play therapy over an 11-week time. Eight of the nine children participating in play therapy experienced a significant decrease in target behavior including: aggression, and distractibility. Using a role playing game, Johnson and Nelson (1978) found that juvenile delinquents who participated in the game showed an increase in interactions with

the counselor and in general. The control group, who participated in counseling with out the game, experienced a decrease in their communication skills.

The Surgeon General (U.S. Public Health Service, 2000) recently stated that preadolescence is the stage of child development in which children experience connection to others or experience isolation. Children who experience connection, continue to progress through the stages of development. While they do experience growing pains such as relationship stress, stress associated with individuation, and transitioning from elementary school to middle school then on to high school, these children possess the skills necessary to make friends and cope with the stressors. Children who do not connect with others feel alone and become angry. They do not possess the skills necessary to develop meaningful relationships. Without meaningful relationships, they are at risk for becoming social misfits. With the recent violence in schools, it is paramount that research examines methods to facilitate the skills necessary to develop relationships and to cope with life's disappointments.

Summary

In summary, play has been recognized for decades as a valuable form of expression for children with emotional or behavioral problems. While play therapy has been proven as a developmentally appropriate treatment for children, preadolescents may not appreciate the materials in a conventional playroom and therefore not feel free to play. Yet developmentally, they are not ready to express themselves through traditional talk therapy. Preadolescents need a therapeutic setting and activities consistent with their developmental needs, one of which is the formation of healthy peer relationships.

Preadolescents diagnosed with learning differences often feel inferior to peers and exhibit a variety of behavior problems that inhibits appropriate social interaction and further sets them apart from their peers. Group activity therapy provides a developmentally appropriate means for children to express their thoughts and emotions, learn and practice new behaviors and social skills, and form healthy relationships in a safe, therapeutic environment. While play therapy is a highly effective and well-researched form of treatment for children, little outcome research exists on the effectiveness of group activity therapy.

CHAPTER II

METHODS AND PROCEDURES

This study examined the effect of group activity therapy on the internalizing and externalizing behaviors of preadolescent students diagnosed with a learning disability utilizing a pre-test/post-test control group design. Volunteer 4th and 5th grade students who met the specified criteria were randomly assigned to either the experimental group or the control group. The experimental group received 12 weeks of group activity therapy in groups of three. After the collection of post-test data, the control group students received treatment. This chapter outlines the methods and procedures used and includes definitions of terms, hypotheses, instrumentation, selection of participants, collection of data procedures, and statistical analysis.

Definition of Terms

Aggression refers to externalizing behaviors including tendency to act in a hostile manner, to argue, and tease others. For the purpose of this study, aggression was operationally defined by the Aggressive subscale of the Child Behavior Checklist (CBC).

Anxiety refers to the measurement of the tendency to be nervous, fearful, or worried. For the purpose of this study, anxiety was operationally defined by the Anxiety subscale of the Behavior Assessment System for Children (BASC).

Anxious/depressed refers to feelings of nervousness, loneliness, sadness, and guilt. For the purpose of this study, anxious/depressed was operationally defined by the Anxious/Depressed subscale of the CBC.

Attention problems refer to the tendency of an individual to daydream, lose focus easily, have difficulty remaining still, and being impulsive. For the purpose of this study, attention problems were operationally defined by the Attention Problems subscale of the CBC.

Behavioral Symptom Index refers to the composite score that reflects an overall level of problem behavior. For the purpose of this study, the Behavioral Symptom Index was operationally defined by the Behavior Symptom Index score on the BASC.

Delinquent Behavior refers to behavior such as lying to avoid punishment, feeling no remorse or guilt. For the purpose of this study, delinquent behavior was operationally defined by the Delinquent Behavior subscale of the CBC.

Depression refers to feelings of unhappiness, sadness, and isolation. For the purpose of this study depression was operationally defined by the Depression subscale of the BASC.

Externalizing behavior problems refers to the outward expression of internal problems. Behaviors include, aggression, hyperactivity, and conduct problems. For the purpose of this study, externalizing behavior problems was operationally defined by the Externalizing Behavior scale score on the CBC and the Externalizing Problems scale of the BASC.

Group activity therapy was conceptually defined in this study as a therapeutic modality in which a trained play therapist provides developmentally appropriate play materials and activities to facilitate the development of a therapeutic relationship in a safe, non-threatening environment in which preadolescent children can connect through

the medium of play/activities and develop a better understanding of self and others in order to prevent or resolve psychosocial difficulties and achieve optimal growth and development, including the development of meaningful relationships (Bratton, Ray, Rhine, & Jones, 2001; Landreth, 1991; Slavson, 1944).

Humanistic Psychotherapy was conceptually defined as the philosophy of working with people that believes in the individuals' desire and capacity for developing a greater understanding of self, others, relationships, and personal empowerment. The therapist's role is one of guide, not expert. The environment for therapy is one of empathy and caring in which individuals can develop a sense of personal choice and freedom and respect for self and others through the existence of the limits of reality and the therapeutic relationship. Humanistic psychotherapy is "holistic and based in a view of the therapeutic process as a dialogical activity, which occurs through person-to-person conversations and through intersubjective symbolic activities" (Task Force for the Development of Guidelines for the Provisions of Humanistic Psychosocial Services, 1997, p. 65).

Hyperactivity refers to behaviors such as over activity, rushing through work, and a tendency to act without thinking. For the purpose of this study, hyperactivity was operationally defined by the Hyperactivity subscale of the BASC.

Internalizing behaviors can be described as behaviors used to cope with experiences. These behaviors can include: withdrawal, anxiety, depression, and suicidal ideation. For the purpose of this study, internalizing behavior problems were

operationally defined by the Internalizing Behavior scale score on the CBC and the Internalizing Problems scale of the BASC.

Learning Disability was operationally defined by the Winston School. “Learning Differences occur in people with average to superior intelligence and become apparent when a person has difficulty cognitively processing information because of a disorder in auditory, visual, or motor skills. As a result, language, math, reading, and writing are often below potential, causing frustration and low self-worth” (The Winston School, 2001).

Preadolescence refers to the period in child development preceding adolescence. For the purpose of this study, preadolescence was operationally defined as children between the ages of 9 and 12 (Slavin, 1991).

Somatic complaints is the tendency to be overly sensitive to and complain about relatively minor physical ailments. For the purpose of this study, somatic complaints was operationally defined by the Somatic Complaints subscales of the CBC and BASC.

Hypotheses

Hypotheses for this study included:

1. The experimental preadolescent group will attain a statistically significant lower mean score on the Behavioral Symptom Index on the Behavior Assessment System for Children-Parent Report Form (BASC-PRF) post-test than will the participants in the control group.

2. The experimental preadolescent group will attain a statistically significant lower mean score on the Total Behavior Problems Scale on the Child Behavior Checklist-Parent Report Form (CBC-PRF) post-test than will the participants in the control group.

3. The experimental preadolescent group will attain a statistically significant lower mean score on the Internalizing Problems Scale on the Behavior Assessment System for Children-Parent Report Form (BASC-PRF) post-test than will the participants in the control group.

4. The experimental preadolescent group will attain a statistically significant lower mean score on the Internalizing Scale on the Child Behavior Checklist-Parent Report Form (CBC-PRF) post-test than will the participants in the control group.

5. The experimental preadolescent group will attain a statistically significant lower mean score on the Externalizing Problems Scale on the Behavior Assessment System for Children-Parent Report Form (BASC-PRF) post-test than will the participants in the control group.

6. The experimental preadolescent group will attain a statistically significant lower mean score on the Externalizing Scale on the Child Behavior Checklist-Parent Report Form (CBC-PRF) post-test than will the participants in the control group.

Instrumentation

Child Behavior Checklist Teacher and Home Rating Form (CBC-TRF and PRF) (Achenbach & Edelbrock, 1991) is a measure filled out by the parents and teachers of the child. It examines the perceptions these individuals have of the social abilities, behavior functioning, and behavior problems of the children measured. The CBC is a well

established and recognized instrument used to identify behavioral difficulties in children. The CBC can be used for children 4 to 18. There are 120 items, which require a fifth grade reading level to complete. The instrument takes approximately 20 minutes to complete and can be scored by hand or computer. It is a self-administering test, meaning the individual answering the questions can do so without assistance. Statements are made on the questionnaire to which the individual indicates acknowledgement of the behavioral symptoms by circling 0, 1, or 2. The number 0 indicates that the behavior is not true for this child with 2 indicating that the behavior is often seen in the child. The checklist was originally developed by Achenbach and Edelbrock (1986), for this study, the 1991 revised instrument will be used.

Reliability of the CBC is well established. Reliability was assessed using internal consistency, inter-rater reliability, and test-retest reliability. Cronbach's alpha was determined to demonstrate internal consistency. For females, Cronbach's alpha was determined to be 0.90 and 0.93 for internalizing and externalizing behavior respectively. For males, Cronbach's alpha was 0.89 and 0.93 for internalizing and externalizing behaviors respectively.

Inter-rater reliability of items was established at 0.96. Intraclass correlations from three matched samples of children showed a high level of reliability between raters, indicating that scores obtained for each item are relative to scores obtained for each other item.

Test-retest reliability was established at 0.89 for internalizing behavior and 0.93 for externalizing behavior problems. After two years, scaled scores were evaluated to

establish long-term stability, which was determined to be 0.70 and 0.93 for internalizing and externalizing behaviors respectively. Scores were found to have a downward trend in children who were receiving mental health services. This indicates that the instrument is sensitive to minor changes in children's behavior.

Content validity of the CBC is also well established. At the .01 level of significance, all items on the instrument were significantly associated with clinical status. Non-referred and referred children were effectively recriminated by the CBC, thus supporting its criterion validity.

The CBC is comprised of three scales measuring internalizing problems, externalizing problems, and total problems. Additionally, the instrument has 8 subscales measuring withdrawal, somatic complaints, anxiety/depression, social problems, thought problems, attention problems, delinquent behavior, and aggressive behavior. The Internalizing scale of the CBC measures withdrawal, somatic complaints, anxiety/depression, thought problems, and attention problems. The Externalizing scale measures social problems, delinquent behavior, and aggression.

Behavior Assessment System for Children Teacher and Parent Rating Form (BASC-TRF and PRF) rates the child's behavior at home and school. The instrument has two scales: Adaptive and Clinical Scales. The Adaptive Scale measures positive behaviors such as social skills, leadership, adaptability, and study skills. The Clinical Scale measures maladaptive behaviors, which includes hyperactivity, aggression, conduct problems, anxiety, depression, somatization, atypicality, withdrawal, attention problems, and learning problems.

Reliability for the BASC is well established. Reliability for the BASC was determined using internal consistency and, test-retest reliability. The BASC-PRS internal-consistency reliabilities of the composite scores are in the middle 0.80s to low 0.90s indicating the composite score is highly reliable. The most reliable subscales include social skills and Leadership. The test was shown to be reliable with both genders. Overall, the scale reliabilities average in the mid 0.70s.

Test-retest reliability was also shown to be high, indicating that the questions are clear and unambiguous and therefore, responses will not vary greatly. While a parent or teacher's response may vary based upon the child's recent behavior, the responses tend to be consistent. The median value of 0.88 which indicate a high degree of reliability indicating that parents and teachers are consistent with how they interpret the items.

Behavior Assessment System for Children Self-Report of Personality (BASC-SRP). The BASC-SRP (Reynolds & Kamphaus, 1992) rates children's perceptions of themselves and their behavior. The instrument has two scales, the Clinical Scale and the Adaptive Scale. The Clinical Scale includes information about maladjustment including: anxiety, attitude to school, attitude to teachers, atypicality, depression, locus of control, sensation seeking, sense of inadequacy, social stress, and somatization. The Adaptive Scale measures positive adjustment including: interpersonal relations, relations to peers, relations with parents, self-esteem, and self-reliance.

Two types of reliability have been evaluated for the BASC-SRP scales and composites. Internal consistency measures how well the instrument's scales measure the construct they are designed to measure. Internal consistency for the scales is high,

averaging 0.8 for each gender at both child and adolescent age levels. Test-retest reliability is also high, indicating that the questions on the instrument are clear and unambiguous. The test-retest correlations have a median value of 0.76 at each age level.

In addition, content validity of the BASC-SRP is well established. All items on the instrument were significantly associated with clinical and adaptive status. Non-referred and referred children were effectively recriminated by the BASC-SRP, thus supporting its criterion validity.

The BASC (Reynolds & Kamphaus, 1992) has 8 subscales and 4 larger composite scales. The subscales measure hyperactivity, aggression, conduct problems, anxiety, depression, somatic complaints, atypicality, withdrawal, attention problems, adaptability, social skills, and leadership. These smaller subscales are combined into larger domains. The hyperactive, aggression, conduct problems, anxiety, depression, somatization, atypicality, withdrawn, and attention subscales are combined to determine a clinical scales overview or Behavioral Symptom Index (BSI). The adaptability, social skills, and leadership subscales are combined to create the Adaptive Skills composite. The anxiety, depression, and somatization subscales compose the Internalizing Problems composite, while the hyperactivity, aggression, and conduct problems subscales create the Externalizing Problems composite.

Selection of Participants

The volunteer participants were recruited from a private school located in a large urban city. The school specializes in the education of children with learning disabilities. The participants were 4th and 5th grade students ranging in age from 10 to 12 years old described by parents or teachers as experiencing behavioral difficulties. All 4th and 5th grade students at the school who met the specified criteria were invited to participate. Prior to contacting parents, the researcher contacted the school administrators and teachers concerning the needs of their students and to determine whether or not the school was interested in participating in the study. Consistent with the literature, teachers and administrators identified social skill deficits, self-esteem, and classroom behavior as areas of concern. The researcher contacted the parents of all 4th and 5th grade students enrolled at the school by mailing an information letter through the school notifying them of the study criteria, of the opportunity for their children to participate, and inviting them to the mandatory parent meeting. At the meeting, informed consent was obtained from parents. The researcher received approval to use human subjects from the University of North Texas Internal Review Board. Thirty students who met the following criteria volunteered to participate in the study.

1. The student must be a 4th or 5th grade student diagnosed with a learning disability and identified by parent or teacher as having behavioral difficulties;
2. The student must have full consent of the parent or legal guardian and given his or her assent to participate;

3. The student must be able to participate in 12 weeks of group activity therapy.

Because of the group format and the inability for the student to make up the experience if absent, students missing more than two sessions were eliminated from the study.

Participants were randomly assigned to the experimental group ($n=15$) or the control group ($n=15$). Of the 30 students who volunteered to participate in the study, six were dropped from the study. One child in the experimental group was absent three times and therefore did not meet the stated criteria; and two experimental group members and three control group members failed to complete post-testing data.

The demographic information for the 24 students completing the study is given in Table 1.

Table 1.

Demographic information for the students participating in the study.

	Experimental Group <i>n</i> =12	Control Group <i>n</i> =12
Gender		
Male	10	8
Female	2	4
Ethnic Group		
Caucasian	12	10
African American	1	0
Hispanic	0	1
Grade		
Fourth	4	3
Fifth	8	9

Table 1 shows that the number of males randomly assigned to the experimental and control groups is 10 and 8, respectively. The number of females randomly assigned to the experimental and control group is two and four, respectively. One African American student was randomly assigned to the experimental group and one Hispanic student was randomly assigned the control group. There were seven 4th graders who participated in the study, four in the experimental group and three in the control group. Additionally, there were 17 5th graders who participated in the study, eight in the experimental group and nine in the control group. This gender, ethnic, and age

divergence is consistent with the population of the school in which the study was conducted.

Data Collection

Prior to the study, parents and teachers were asked to complete pre-test instruments. After receiving a full explanation of the procedures of the study and signing the informed consent form, the parents were asked to fill out a Behavior Assessment System for Children-Parent Report Form (BASC-PRF) and the Child Behavior Checklist-Parent Report Form (CBC-PRF). Free childcare was provided at the school while the researcher met with the parents and while the parents completed the pre-test data. Teachers were also asked to complete a Behavior Assessment System for Children-Teacher Report Form (BASC-TRF) and a Child Behavior Checklist-Teacher Report Form (CBC-TRF). The researcher substituted for the teachers in the classroom to provide them time to fill out the instruments during the school day without distractions. The researcher or research assistants administered the Behavior Assessment System for Children-Youth Self Report of Personality (BASC-YSR) and had the preadolescents fill out an assent form to participate. All participants were assigned a random code number for use in all data collection to ensure confidentiality.

The BASC-TRF, CBC-PRF, BASC-PRF, CBC-TRF, and BASC-YSR were used as screening devices to determine if, according to the instrument, the teachers, parents, and students concerns were consistent with their verbal reports. Although concerns related to home, school, and social behavior problems were reported verbally by teachers and parents, the teachers' scores on the BASC and CBC as well as the students' self

report on the BASC failed to show these as areas of concern with mean scores in the average range. Therefore, the BASC-TRF, CBC-TRF, and BASC-YSR were not used as an outcome measures to determine results of the treatment. Parent ratings on the CBC and BASC indicated areas of concern on internalizing, externalizing, and total behaviors and therefore were retained as outcome measures to determine the effects of group activity therapy of the preadolescents' behavior.

Qualitative data was gathered from the CBC-PRF as well as from comments from the parents', teachers', the researcher's observations, as well as participants' comments to determine clinical significance of the study. Immediately following each session, the researcher completed the group play therapy session summary specifically noting group interaction and verbalizations. Significant verbalizations were recorded with quotation marks. Additional qualitative data, including parent, teacher, and preadolescents' comments as well as the researcher's direct observations were recorded in order to analyze the clinical significance of the treatment.

In addition to the qualitative data received from the CBC, additional qualitative data was gathered through face-to-face interviews with each teacher and all parents that were available. In the interview, the researcher asked the following two open-ended questions to solicit spontaneous feedback; "Do you have any questions for me?" and "Is there any thing else you would like me to know?" Additionally, during the study, the researcher recorded any comments made by the teachers.

Post-test data was collected from parents at the completion of treatment following the same procedures used to collect pre-test data. Qualitative post-treatment data was

collected from parent comments on the CBC as well as through face-to-face interviews with each teacher and with all available parents. Questions asked after the study included: “Do you have any feedback for me?” and “Is there anything else you would like me to know?”

Treatment

The 15 experimental group preadolescents were divided into groups of three and participated in group activity therapy one hour per week for 12 weeks. Although 15 participated in the entire study, one student’s data was dropped for absences, and two student’s data were dropped for failing to complete post-testing.

As suggested in the literature (Ginott, 1975; Slavson & Redl, 1944), participants were assigned to a group according to individual needs and personality traits. The activity therapy group format, procedures, and materials followed the suggestions of Bratton and Ferebee (1999) and drew from the work of Landreth (1991), Schiffer (1969), Slavson (1944) and Ginott (1975); however, modifications were necessary to accommodate the school setting. Because the school day is structured around one-hour time blocks and to minimize the preadolescents’ time away from academics, school administrators required the researcher to limit the groups to one hour in length rather than the 1 hr 30 min to 2 hrs typically recommended (Bratton & Ferebee, 1999; Schiffer, 1969; Slavson & Redl, 1944). The format generally included time for self or group-directed activities, semi-structured activities, as needed, and a snack time. As is typical of many school settings, sharing space is often required. Therefore, the activity therapy groups met in a multi-purpose classroom space that was available Monday and Friday morning, thus

equipment and materials were modified to move and store with ease. See Appendix E for a listing of materials and equipment.

Humanistic principles were utilized in the activity groups including a) a belief in the preadolescent's desire for mastery, growth, and maturity; b) a belief in the preadolescents' capacity for self-understanding, self-direction, and socialization; c) the importance of the therapeutic relationship between therapist and group members; and d) the need of children to belong and be connected with others (Bratton & Ray, 2002; Task Force for the Development of Guidelines for the Provisions of Humanistic Psychosocial Services, 1997). The relationship between therapist and each group member as well as the relationships between group members provided the environment through which the individual tapped their innate capacity for growth and change.

This group activity therapy model provided opportunities for the preadolescents to have a variety of self-directed and group-directed experiences. Self-directed activities provided opportunities for group members to make decisions, learn self-control through testing limits, and learn about themselves and their world (Landreth, 1991). In addition, it is during self-directed play that children gain a sense of self-control.

Self-directed play fosters an internal locus of control; providing children control where often they feel powerless. Self-directed play, additionally, provided a forum for the preadolescent's current coping and relationship skills to become apparent (Schachter, 1974). When coping methods became apparent during the groups, the therapist was able to facilitate awareness and understanding within and between group members. With new understanding, preadolescents choose to modify their behavior in order to become part of

the group (Ginott, 1975). Through self-directed activities, preadolescents learned new ways of coping and had the opportunity to practice new skills in a safe environment.

Semi-structured activities were introduced by the therapist as needed to serve as a catalyst for self-exploration and group interaction. (See Appendix D for one example of semi-structured activity used in this study). The purpose of the semi-structured activity was not to focus on a completed product or necessarily to direct the preadolescents' play, but rather a) facilitated group cooperation and collaboration (Ginott, 1961), b) facilitated group members' comfort in interacting with each other both verbally and nonverbally, and c) focused on process in order to reduce anxiety particularly for those children who have difficulty joining in or who tend to be withdrawn (Hillman, Penczar, & Barr, 1975). While the semi-structured activity was presented, students were free to choose not to participate. In addition, Bratton and Ferebee (1999) proposed that the introduction of open-ended activities could serve the additional purpose of exposing group members to a variety of expressive art materials.

Schiffer (1969) recognized the significance of snack time as an opportunity for children to spontaneously share their experiences from both in and outside of the session. In addition, ending the session with a snack time provides closure and promotes transition back to the classroom setting ((Nickerson, 1973). After checking with the parents to ascertain food allergy information and to respect any dietary limitations of the children, a variety of snacks were offered to the students with approximately 10-15 minutes remaining in the group time. When possible, the students were allowed the opportunity to be active participants in making the snack. For example, the children decorated cookies

and crackers or mixed their own punch. The group facilitator announced snack time, placed the items on a round table, and then allowed the children to choose whether to participate. As the children ate and talked, the facilitator reflected the happenings at the table. If the children chose not to partake in snack time, the facilitator reflected their actions and respected the decision of the group. A limit was established that snacks were not to leave the group room.

The activity groups were facilitated by a doctoral level graduate counseling student with advanced training in play therapy, group therapy, group play therapy, and group activity therapy. The facilitator ascribes to the humanistic philosophy of therapy with adults and children. Specifically, that individuals have a desire and an innate capacity for growth, self-direction, self-understanding, and social connection. Additionally, these desires direct people, through an internal process to what they most need. The therapist's role is one of guide and fellow traveler; to be a facilitating part of, not the director of, the counseling process.

Analysis of Data

Following the completion of the study, pre-test and post-test data were scored by a research assistant using the computer scoring software available for the Child Behavior Checklist (CBC) and the Behavior Assessment System for Children (BASC). The results were analyzed using SPSS. Statistical analysis of the data indicated that it met the assumptions for ANCOVA, specifically the test for homogeneity. Analysis of Covariance (ANCOVA) was utilized to determine statistical significance between the experimental group and the control group on the post-test means for each of the hypotheses. In each

case, the post-test specified in each of the hypotheses was used as the dependent variable and the pre-test as the covariant. ANCOVA adjusted the means on the post-test on the basis of the pre-test, thus statistically equating the experimental and control groups. Significance of the difference between means was tested. The .05 level was established to test the significance of the change between the pre and post-test scores. The .10 level was utilized as the threshold to identify any trends in the differences between the change of pre and post-test scores. On the basis of the ANCOVA, the hypotheses was either rejected or retained. Post hoc analysis was done for each of the subscales of the CBC and BASC using ANCOVA. In addition, Cohen's *d* effect size was also calculated for each hypothesis and post hoc analysis of the subscales to determine the practical significance of the treatment on the experimental group when compared to the control group. Qualitative data was examined and recorded to determine clinical significance of the intervention.

CHAPTER III

RESULTS AND DISCUSSION

This chapter presents the results of the analysis of data including analysis of post hoc data and qualitative data for each hypothesis tested in this study. Also included is a discussion of the results, implications, and recommendations for future research.

Results

The results of this study are presented in the order the hypotheses were tested. Analysis of covariance (ANCOVA) was performed on all appropriate data to test hypotheses. The assumptions for ANCOVA, specifically, homogeneity of regression slopes were tested and met in order to appropriately utilize ANCOVA. An a priori .05 level of significance was established as a criterion for either retaining or rejecting the hypotheses. The .10 level was established as the threshold to note positive trends indicating a gain in target behavior for the experimental group when compared with the control group. Additionally, Cohen's *d* effect size was calculated to determine practical significance. Practical significance allows the reader to see the amount of change experienced by the experimental group that is caused by the intervention when compared to the control group. Clinical significance, "whether the intervention makes a real (e.g., genuine, palpable, practical, noticeable) difference in everyday life to the clients or to others with whom the client interacts," is also reported using parent, teacher and researcher observations (Kazdin, 1999, p. 332).

Hypothesis 1

The experimental preadolescent group will attain a statistically significant lower mean score on the Behavioral Symptom Index on the Behavior Assessment System for Children-Parent Report Form (BASC-PRF) post-test than will the participants in the control group.

Table 2 presents the pre and post-test means and standard deviations for the experimental and control groups. Table 3 presents the mean gain scores, showing the difference between experimental and control groups. Table 4 presents the analysis of covariance data; the level of statistical significance of the difference between the experimental and control groups' post-test mean scores, statistical power, and Cohen's *d* effect size.

Table 2

Mean scores on the Behavior Symptom Index of the experimental and control groups on the Behavior Assessment System for Children-Parent Report Form (BASC-PRF)

	<u>Experimental Group <i>n</i>=12</u>		<u>Control Group <i>n</i>=12</u>	
	Pretest	Posttest	Pretest	Posttest
Mean	58.29	52.23	54.77	54.67
SD	12.06	9.32	10.11	10.71

Note: A decrease in the mean score indicates improvement in behavior.

Table 3

Mean gain scores of the experimental and control groups for the Behavioral Symptom Index on the Behavior Assessment System for Children-Parent Report Form (BASC-PRF)

	Experimental (n=12)	Control (n=12)
Gain Mean	-4.85	0.008
SD	5.65	6.02

Note: A decrease in the mean score indicates improvement in behavior.

Table 4

Analysis of covariance of the experimental and control groups for the Behavioral Symptom Index on the Behavior Assessment System for Children-Parent Report Form (BASC-PRF)

Source of Variation	Sum of Squares	df	Mean Square	F Ratio	p*	d	Power
Covariate (pre test)	1601.27	1					
Between Groups	124.84	1	124.84	4.31	.05	.91	.51
Error	607.89	21	28.95				
Total	2334.00	23					

*Computed using alpha=.05

Table 4 shows the *F* ratio for the main effects was statistically significant at the .05 level, $F=4.31$, $p=.05$, indicating that there was a statistically significant decrease in the experimental groups' Behavior Symptom Index as measured by the BASC-PRF when compared to the control group. On the basis of this data, hypothesis 1 was retained.

Additionally, a treatment effect size was calculated to determine practical significance and determined to be large ($d=.91$) indicating that group activity therapy had a large treatment effect on the experimental group when compared to the control group (Cohen, 1969; Schumacker & Akers, 2001).

Hypothesis 2

The experimental preadolescent group will attain a statistically significant lower mean score on the Total Problems scale on the Child Behavior Checklist-Parent Report Form (CBC-PRF) post-test than will the participants in the control group.

Table 5 presents the pre and post-test means and standard deviations for the experimental and control groups. Table 6 presents the mean gain scores, showing the difference between experimental and control groups. Table 7 presents the analysis of covariance data; the level of statistical significance of the difference between the experimental and control groups' post-test mean scores, statistical power, and Cohen's d effect size.

Table 5

Mean scores on the Total Problems scale of the experimental and control groups on the Child Behavior Checklist-Parent Report Form (CBC-PRF)

	<u>Experimental Group <i>n</i>=12</u>		<u>Control Group <i>n</i>=12</u>	
	Pretest	Posttest	Pretest	Posttest
Mean	58.67	53.64	55.31	56.17
<i>SD</i>	11.42	11.55	6.74	7.58

Note: A decrease in the mean score indicates improvement in behavior.

Table 6

Mean gain scores of the experimental and control groups for the Total Problems scale on the Child Behavior Checklist-Parent Report Form (CBC-PRF)

	Experimental (<i>n</i> =12)	Control (<i>n</i> =12)	Total (<i>n</i> =24)
Gain Mean	-4.64	0.33	-2.04
<i>SD</i>	5.70	5.94	6.27

Note: A decrease in the mean score indicates improvement in behavior.

Table 7

Analysis of covariance of the experimental and control groups for the Total Problems scale on the Child Behavior Checklist-Parent Report Form (CBC-PRF)

Source of Variation	Sum of Squares	df	Mean Square	F Ratio	p*	d	Power
Covariate (pre test)	1188.07	1					
Between Groups	121.44	1	121.44	3.50	.08	.82	.43
Error	693.44	20	34.67				
Total	2002.95	22					

*Computed using alpha=.05

Table 7 shows the *F* ratio for the main effects was not statistically significant at the .05 level, $F=3.50$, $p=.08$, indicating that there was not a statistically significant decrease in the experimental groups' Total Problems as measured by the CBC-PRF as compared to the control group. On the basis of this data, hypothesis 2 was rejected. The results did, however, indicate a positive trend ($p=.08$) in the decrease of total behavior problems when compared with the control group. The positive trend suggests that further research with a larger sample size may produce statistical significance and is warranted. Additionally, a treatment effect size was calculated to determine practical significance and determined to be large ($d=.82$) indicating that group activity therapy had a large treatment effect on the experimental group's total behavior problems when compared to the control group (Cohen, 1969; Schumacker & Akers, 2001).

Hypothesis 3

The experimental preadolescent group will attain a statistically significant lower mean score on the Internalizing Behavior Problems scale on the Behavior Assessment System for Children-Parent Report Form (BASC-PRF) post-test than will the participants in the control group.

Table 8 presents the pre and post-test means and standard deviations for the experimental and control groups. Table 9 presents the mean gain scores, showing the difference between experimental and control groups. Table 10 presents the analysis of covariance data; the level of statistical significance of the difference between the experimental and control groups' post-test mean scores, statistical power, and Cohen's *d* effect size.

Table 8

Mean scores on the Internalizing Behavior Problems scale of the experimental and control groups on the Behavior Assessment System for Children-Parent Report Form (BASC-PRF)

	<u>Experimental Group <i>n</i>=12</u>		<u>Control Group <i>n</i>=12</u>	
	Pretest	Posttest	Pretest	Posttest
Mean	56.00	47.38	48.62	48.42
<i>SD</i>	17.21	11.46	8.62	9.50

Note: A decrease in the mean score indicates improvement in behavior.

Table 9

Mean gain scores of the experimental and control groups for the Internalizing Problems scale on the Behavior Assessment System for Children-Parent Report Form (BASC-PRF)

	Experimental (n=12)	Control (n=12)	Total (n=24)
Gain Mean	-5.54	0.42	-2.68
SD	7.02	6.46	7.28

Note: A decrease in the mean score indicates improvement in behavior.

Table 10

Analysis of covariance of the experimental and control groups for the Internalizing Behavior Problems scale on the Behavior Assessment System for Children-Parent Report Form (BASC-PRF)

Source of Variation	Sum of Squares	df	Mean Square	F Ratio	p*	d	Power
Covariate (pre test)	1587.56	1					
Between Groups	191.78	1	191.78	5.53	.03	1.03	.61
Error	728.62	21	34.70				
Total	2507.96	23					

*Computed using alpha=.05

Table 10 shows the *F* ratio for the main effects was statistically significant at the .05 level, $F=5.53$, $p=.03$, indicating that there was a statistically significant decrease in the experimental groups' Internalizing Problems as measured by the BASC-PRF as

compared to the control group. On the basis of this data, hypothesis 3 was retained. Additionally, a treatment effect size was calculated to determine practical significance and determined to be large ($d=1.03$) indicating that group activity therapy had a large treatment effect on the experimental group's internalizing behavior when compared to the control group (Cohen, 1969; Schumacker & Akers, 2001).

Hypothesis 4

The experimental preadolescent group will attain a statistically significantly lower mean score on the Internalizing scale on the Child Behavior Checklist-Parent Report Form (CBC-PRF) post-test than will the participants in the control group.

Table 11 presents the pre and post-test means and standard deviations for the experimental and control groups. Table 12 presents the mean gain scores, showing the difference between experimental and control groups. Table 13 presents the analysis of covariance data; the level of statistical significance of the difference between the experimental and control groups' post-test mean scores, statistical power, and Cohen's d effect size.

Table 11

Mean scores on the Internalizing scale of the experimental and control groups on the Child Behavior Checklist-Parent Report Form (CBC-PRF)

	<u>Experimental Group n=12</u>		<u>Control Group n=12</u>	
	Pretest	Posttest	Pretest	Posttest
Mean	58.67	53.09	54.08	55.58
SD	13.02	13.16	8.76	9.64

Note: A decrease in the mean score indicates improvement in behavior.

Table 12

Mean gain scores of the experimental and control groups for the Internalizing scale on the Child Behavior Checklist-Parent Report Form (CBC-PRF)

	Experimental (n=12)	Control (n=12)	Total (n=24)
Gain Mean	-6.36	0.58	-2.74
SD	6.67	7.59	7.85

Note: A decrease in the mean score indicates improvement in behavior.

Table 13

Analysis of covariance of the experimental and control groups for the Internalizing scale on the Child Behavior Checklist-Parent Report Form (CBC-PRF)

Source of Variation	Sum of Squares	df	Mean Square	F Ratio	p*	d	Power
Covariate (pre test)	1542.17	1					
Between Groups	218.46	1	218.46	4.24	.05	.90	.50
Error	1030.85	22	51.54				
Total	2791.48	24					

*Computed using alpha=.05

Table 13 shows the *F* ratio for the main effects was statistically significant at the .05 level, $F=4.24$, $p=.05$, indicating that there was a statistically significant decrease in the experimental groups' Internalizing Problems as measured by the CBC-PRF as compared to the control group. On the basis of this data, hypothesis 4 was retained. Additionally, a treatment effect size was calculated to determine practical significance and determined to be large ($d=.90$) indicating that group activity therapy had a large treatment effect on the experimental group's internalizing problems when compared to the control group (Cohen, 1969; Schumacker & Akers, 2001).

Hypothesis 5

The experimental preadolescent group will attain a statistically significant lower mean score on the Externalizing Behavior Problems scale on the Behavior Assessment

System for Children-Parent Report Form (BASC-PRF) post-test than will the participants in the control group.

Table 14 presents the pre and post-test means and standard deviations for the experimental and control groups. Table 15 presents the mean gain scores, showing the difference between experimental and control groups. Table 16 presents the analysis of covariance data; the level of statistical significance of the difference between the experimental and control groups' post-test mean scores, statistical power, and Cohen's *d* effect size.

Table 14

Mean scores on the Externalizing Behavior Problems scale of the experimental and control groups on the Behavior Assessment System for Children-Parent Report Form (BASC-PRF)

	<u>Experimental Group <i>n</i>=12</u>		<u>Control Group <i>n</i>=12</u>	
	Pretest	Posttest	Pretest	Posttest
Mean	51.79	48.69	52.69	53.58
<i>SD</i>	12.08	12.53	11.14	11.87

Note: A decrease in the mean score indicates improvement in behavior.

Table 15

Mean gain scores of the experimental and control groups for the Externalizing Behavior Problems scale on the Behavior Assessment System for Children-Parent Report Form (BASC-PRF)

	Experimental (n=12)	Control (n=12)	Total (n=24)
Gain Mean	-2.38	0.033	-1.08
SD	4.37	5.53	5.05

Note: A decrease in the mean score indicates improvement in behavior.

Table 16

Analysis of covariance of the experimental and control groups for the Externalizing Behavior Problems scale on the Behavior Assessment System for Children-Parent Report Form (BASC-PRF)

Source of Variation	Sum of Squares	df	Mean Square	F Ratio	p*	d	Power
Covariate (pre test)	2744.05	1					
Between Groups	37.77	1	37.77	1.48	.24	.53	.21
Error	535.14	21	25.48				
Total	3316.96	24					

*Computed using alpha=.05

Table 16 shows the *F* ratio for the main effects was not statistically significant at the .05 level, $F=1.48$, $p=.24$, indicating that there was not a statistically significant decrease on the experimental groups' Externalizing Behavior Problems scale score as

measured by the BASC-PRF as compared to the control group. On the basis of this data, hypothesis 5 was rejected. While no statistical difference between groups was noted at the $p=.05$ level of significance, a treatment effect size was calculated to determine practical significance and determined to be medium ($d=.53$) indicating that group activity therapy had a moderate treatment effect on the experimental group when compared to the control group (Cohen, 1969; Schumacker & Akers, 2001).

Hypothesis 6

The experimental preadolescent group will attain a statistically significant lower mean score on the Externalizing scale on the Child Behavior Checklist-Parent Report Form (CBC-PRF) post-test than will the participants in the control group.

Table 17 presents the pre and post-test means and standard deviations for the experimental and control groups. Table 18 presents the mean gain scores, showing the difference between experimental and control groups. Table 19 presents the analysis of covariance data; the level of statistical significance of the difference between the experimental and control groups' post-test mean scores, statistical power, and Cohen's d effect size.

Table 17

Mean scores on the Externalizing scale of the experimental and control groups on the Child Behavior Checklist-Parent Report Form (CBC-PRF)

	<u>Experimental Group <i>n</i>=12</u>		<u>Control Group <i>n</i>=12</u>	
	Pretest	Posttest	Pretest	Posttest
Mean	53.27	46.91	53.85	53.85
<i>SD</i>	10.20	9.60	7.01	8.55

Note: A decrease in the mean score indicates improvement in behavior.

Table 18

Mean gain scores of the experimental and control groups for the Externalizing scale on the Child Behavior Checklist-Parent Report Form (CBC-PRF)

	Experimental (<i>n</i> =12)	Control (<i>n</i> =12)	Total (<i>n</i> =24)
Gain Mean	-4.91	-0.83	-2.78
<i>SD</i>	6.43	5.18	6.50

Note: A decrease in the mean score indicates improvement in behavior.

Table 19

Analysis of covariance of the experimental and control groups for the Externalizing scale on the Child Behavior Checklist-Parent Report Form (CBC-PRF)

Source of Variation	Sum of Squares	df	Mean Square	F Ratio	p*	d	Power
Covariate (pre test)	1186.50	1					
Between Groups	108.28	1	108.28	3.15	.09	.78	.39
Error	686.70	20	34.34				
Total	1981.48	22					

*Computed using alpha=.05

Table 19 shows the *F* ratio for the main effects was not statistically significant at the .05 level, $F=3.15$, $p=.09$, indicating that there was not a statistically significant decrease in the experimental groups' Externalizing Problems as measured by the CBC-PRF as compared to the control group. On the basis of this data, hypothesis 6 was rejected. However, the *F* ratio for the main effects did indicate a positive trend ($p=.09$) in the decrease of externalizing problems when compared with the control group. However, the positive trend suggests that further research with a larger sample size may produce statistical significance and is warranted. While not statistically significant at the $p=.05$ level of significance, an effect size was calculated to determine practical significance and determined to be moderate to large ($d=.78$) indicating that group activity therapy had a moderate to large treatment effect on the experimental group's externalizing problems when compared to the control group (Cohen, 1969; Schumacker & Akers, 2001).

Discussion

The statistical, practical, and clinical results of this study, including the comments of the participants, their teachers and parents, as well as this researcher's observations, provide information regarding the effectiveness of a group activity therapy model that is based upon humanistic and developmental principles. The results examine the internalizing and externalizing behaviors of 4th and 5th grade students diagnosed with a learning disability. Through group activity therapy, the preadolescent children with learning disabilities were able to experience a therapeutic social environment, which allowed them to express and work through their feelings and experiences and modify their behavior in relation to peers, teachers, and parents. Of the six hypotheses, three were retained at the .05 level of significance. However, of the three rejected hypotheses, two showed positive trends ($p < .10$) indicating a gain in target behavior for the experimental group when compared to the control group. Additionally, Cohen's d for effect size was calculated to determine the practical significance of the results. Cohen's d effect size "is essentially the average amount of change in standard deviation units achieved by individuals in a treated group versus the change achieved by members of a control/comparison group for a particular study. An effect size of 1.00 represents 1 standard deviation" (Bratton, Ray, Rhine, & Jones, 2001). Cohen (1969) established the criteria for interpreting effect size as $d = .20$ represents a small effect size, $d = .50$ represents a medium effect size, and $d = .80$ represents a large effect size. Thompson (2000) stated that effect sizes should be interpreted by comparing effect sizes within a field of study. Four of the six hypotheses tested showed a large effect size ($d > .80$) one

showed a moderately large effect size ($d=.78$), and the other hypothesis had a medium effect size ($d=.53$) for indicating the practical significance of the treatment on the experimental group when compared with the control group. The overall effect size for study was computed and determined to be large ($d=.83$). The effect size of this study is consistent with the body of play therapy outcome studies ($d=.80$) and better than the body of play therapy outcome studies where professionals were the therapeutic agents ($d=.73$)(Ray et al., 2001). Additionally, the effect size is consistent with child psychotherapy research ($d=.78-.70$)(Kazdin, Ayers, Bass, & Rodgers, 1990; Weisz, Weiss, Alicke, & Klotz, 1987; Weisz, Weiss, Han, Granger, & Morton, 1995). An interpretation of these results follows. Please note that for all clinical examples, pseudonyms were used to protect the confidentiality of group members.

Total Behavior

Behavior Assessment System for Children (BASC). The Behavioral Symptom Index (BSI) of the BASC combines 9 clinical scales into one index score. The subscales on the BSI include: the Hyperactivity, Aggression, Conduct Problems, Anxiety, Depression, Somatization, Atypicality, Attention Problems, and Withdrawal subscales. Tables 2-3 show that, according to parents' reports, the preadolescents participating in group activity therapy for 12 weeks, demonstrated a statistically significant difference in their pre and post-test scores on the BSI of the BASC at the 0.05 level of significance. Table 2 shows that the experimental group demonstrated a decrease in mean scores (-4.85) and, while the control group demonstrated a change, that change was negligible

(-0.008). Cohen's d was calculated to determine the practical significance of the findings and determined to be large ($d=.91$) indicating that the experimental group experienced a large treatment effect when compared to the control group which indicates substantial improvements in the experimental groups' behavior due to the intervention.

Child Behavior Checklist (CBC). Based upon parent ratings of the preadolescent's behavior on the Total Problems scale of the CBC, Table 7 shows that no statistical difference existed between the experimental group and the control group at the 0.05 level of significance. However, there was a positive trend in the scores with statistical significance at the 0.08 level of significance indicating that further investigation of this hypothesis is deserved. A positive trend on this hypothesis demonstrates a decrease in the total problems of the experimental group when compared to the control group. As shown in Tables 5-6, the experimental group experienced a 4.64 decrease in their mean score compared to the control group whose mean scores increased 0.33. Cohen's d was calculated to determine treatment effect size and facilitate the interpretation of practical significance and determined to be large ($d=.82$) indicating that group activity therapy had a large treatment effect on the behavior of those students in the experimental group when compared to the control group.

The overall composite scores for the BASC yielded statistical significance while the CBC indicated a positive trend with a gain in target behavior for the experimental group when compared to the control group. As important as statistical significance is practical significance, which was also calculated is as important. Group activity therapy was found to have a large treatment effect on the experimental group as compared to the

control group as determined by parent ratings of their children's behavior on the BASC and CBC (BASC $d=.91$, CBC $d=.82$). This practical significance indicates that group activity therapy is an effective intervention to modify preadolescents' total behavior. These results are particularly noteworthy because the two different measures of behavior produced similar results.

Internalizing Problems

Behavior Assessment System for Children (BASC). As indicated in Tables 8-9, the experimental group experienced a statistically significant ($p=.03$) reduction on the Internalizing Problems Composite scale of the BASC (mean decrease -5.54). Conversely, the control group experienced a slight increase in score (0.42) on the Internalizing Problems Composite scale. Additionally, treatment effect size was determined to be large ($d=1.03$) indicating the significant impact the intervention had on the experimental group's internalizing problems when compared to the control group. The Internalizing Problems Composite of the BASC measures anxiety, depression, and somatic complaints. Post hoc analysis of subscales found that preadolescents in the experimental group experienced a statistically significant reduction in anxiety at the $p=.01$ level of significance and a statistically significant reduction in depression at the $p=.05$ level of significance. Practical significance was also found on the Anxious and the Depressed subscales with large effect sizes ($d=1.28$ and $d=.92$, respectively) indicating that children who participated in 12 weeks of group activity therapy experienced a practically significant reduction in depression and anxiety when compared to the control group. The preadolescents in the experimental group also had a moderate reduction of physical

complaints as determined by effect size analysis of the Somatic Complaints subscale ($d=.54$). The results of this post hoc analysis indicate that preadolescents in the experimental group are less likely to state that they feel lonely, have suicidal ideation, complain of unfounded physical ailments, state that they have no friends, and have higher self-esteem according to their parents.

Child Behavior Checklist (CBC). As indicated in tables 11-12, the experimental group experienced a statistically significant ($p=.05$) reduction of internalizing problems as measured by the CBC, while the control group experienced a slight increase in their internalizing problems (-6.36 and 0.58, respectively). Effect size was calculated and determined to be large ($d=.90$) indicating that group activity therapy had a profound effect on the internalizing behaviors of the experimental group when compared to the control group. The Internalizing Problems scale of the CBC measures withdrawal, somatic complaints, and anxiety/depression. Post hoc statistical analysis of subscales on the CBC found statistically significant reductions in the experimental group on the Anxious/Depressed subscale ($p=.04$). These findings suggest that the preadolescents in the experimental group notably increased their ability to internally cope with their problems, be less lonely, nervous, sad, cry less, and experience improved self-concept. Specifically, on the Anxious/Depressed subscale of the CBC the students in the experimental group had a mean decrease of 4.18 while the control group had a mean increase of 1.25. An effect size was also calculated and determined to be large ($d=.98$). This suggests that group activity therapy improves the coping skills of preadolescents while those untreated may become more anxious and depressed. The Somatic Complaints

subscale, while not statistically significant, did indicate practical significance (medium effect size, $d=.53$) indicating a moderate decrease in the experimental groups tendency to complain about imaginary illnesses. A medium effect size ($d=.56$), was found during the post hoc analysis of the Attention subscale indicating practical significance. This suggests that the preadolescents in the experimental group experienced a moderate increase in their ability to maintain focus and self-control when compared to the control group.

Both the BASC and the CBC internalizing composite scales found both statistical significance ($p=.03$ and $p=.05$, respectively) and practical significance ($d=1.03$ and $d=.90$, respectively). These positive results on the internalizing behaviors of preadolescents are similar to other play therapy studies utilizing humanistic play therapy techniques found by Brandt (1999), Tyndall-Lind (1999), Kot (1995), and Rhine (2000). In both studies, through play therapy, the students in the experimental group learned different coping skills and decreased their mean score on the internalizing scale, while the control group showed a slight increase in their mean score. Post hoc analysis of subscales found statistical and practical significance on the Anxiety and Depression subscales of the BASC and the Anxious/Depressed subscale of the CBC. Students participating in group activity therapy showed a marked decrease in anxiety and depression. The somatic complaints measures of both of the instruments, while not statistically significant at the 0.05 level, demonstrated a moderate treatment effect indicating that those who participated in the groups were less likely to complain of stomach aches, headaches, and nausea. Analysis of the Attention Problems subscale of the CBC also showed a moderate

treatment effect indicating that the students in the group activity therapy showed an increase in their ability to remain on task, exercise self-control, and improve school work.

The statistical and practical significance found on the Internalizing subscales of the BASC and CBC is supported by teacher and parent comments as well as by observations of the researcher. Anxiety was identified as an area of concern for several students as reported by parents on the CBC and BASC and supported by comments from the teachers. Anxious behavior, along with withdrawal and isolation, caused many preadolescents to have difficulty forming relationships with teachers and peers. The researcher observed several children move from anxiety and withdrawal to confidence and engaging during the group activity sessions as well as during classroom observations.

For example, in session 1, one student (Don) remained isolated, rarely smiled, and seemed uncomfortable by the actions of the other group members. The two other group members (Brian and John) were actively engaged with one another, while Don chose only to observe. This example focuses on therapist responses to the anxious/withdrawn child (Don). Although not included, appropriate responses were made to the other group members to facilitate personal insight and group dynamics.

(Brian and John were actively play fighting with plastic swords while Don looked on.)

Counselor: Don, you're not sure what to do.

(Brian comes precariously close to Don with the sword. Don leans away, with a frightened look on his face.)

Counselor: Don, you were scared by that.

Don: Yeah, he came really close to my head.

John: Brian, watch what you're doing.

Counselor: John, you want to make sure no one gets hurt.

John: Yeah, he came really close to hurting me too.

Counselor: (Looks over at Brian to see how he is receiving the feedback from the others.) Sometimes when you're really into what you are doing, it's hard to be aware of what is going on around you.

Brian: Yeah.

(John gets up and resumes sword fighting with Brian. Brian begins to verbalize instructions on how to fight to John. Don continues to sit near the counselor and shy away from the other two's movements but looks at the action longingly.)

Counselor: (Looks over at Don.) You just decided to stay over here and watch Brian and John.

Don then gets up, picks up a plastic knife, and begins to make attempts to join in the exchange. As he does, Brian's intensity does not lessen. Don continues to play, but is anxious and overwhelmed by the intensity of Brian's play.

Counselor: (Looks at Don to see how he is coping with the intensity of Brian's play.) Don, this all seems kind of overwhelming to you.

At the end of session 1, as the group was leaving the room, Brian looked at Don and said, "I know I was kind of overwhelming." During the next session, Brian was able to modify his behavior with more marked improvements by session 4. This change allowed Don to be more comfortable and more engaged in the group activities. In session 4, the group

played a game where they took turns “buying” things and setting up “forts.” In this session, Brian continually instructed Don how he thought things should be used. Don acquiesced to Brian’s direction. By session 6, however, Don began to state his needs: “No, Brian, I like it the way I’m doing it.” He was no longer anxious and withdrawn, but rather was engaging, smiled frequently, and was able to express his desires.

This example was substantiated by Don’s teachers who reported that after completing the activity groups he was, “more outgoing and interacted more in class;” and was able to laugh and share his sense of humor. Don’s mother also reported that he was more outgoing with children in the neighborhood and more able to stand up for himself rather than going with the crowd. Don’s mother further reported that he no longer participated or sanctioned when his friends acted in ways that he did not agree with. Instead he told his friends that he did not agree with their actions and chose not to join. Parents and teachers for several students reported similar results.

Another issue that the parents and teachers expressed concern about is depression. Reports indicated that some students, because of their sadness, experienced difficulty engaging others. The researcher observed students who avoided interaction initially, become less withdrawn and more engaging with the other group members. For example, one preadolescent, Mark, who remained to himself in sessions 1 through 5, in session 6, began to ask the other children questions about what they were doing. The counselor reflected the child’s curiosity and interest in what the others were doing. By session 8, Mark began to approach the others directly and suggested a way to make their clay

sculpture more stable. In subsequent sessions, the child began to initiate activities with the other group members.

Mark's teachers and parents also reported less depressed and loner type behavior from him. For example, one teacher commented that Mark was, "more engaging with others" and "Mark seems happier in general." Mark's parents reported he was invited to friends' homes more often and seemed to be happier. While this example focuses on Mark, similar comments were obtained from parents and teachers of other students who participated in the activity groups.

Many preadolescents with learning difficulties have problems paying attention and controlling impulses without constant reminders from parents and teachers. These concerns are exemplified in the literature and were confirmed by parents and teachers of the preadolescents in the study. The researcher also observed situations in which students initially acted impulsively and were eventually able to, through an internal locus of control, improve their ability to utilize impulse control. After a particularly rowdy session in which the preadolescents played tag with pieces of paper propelled through straws, as the group was leaving, they began to put paper and straws into their pockets. The counselor stated, "Guys, I know you would like to take that stuff back to your classroom, but the items in the room are for staying in the room," then walked to the door. The students followed, opened the door, and began walking back to class. About half way down the hall, one of the students dramatically exclaimed, "I can't do it!" From his pockets, he removed paper and a straw. The counselor (matching the students' affect) reflected, "Even though you could have snuck those out, you just couldn't do it." The

student returned the items to the room. Through his own sense of responsibility and control, the preadolescent was able to respect the limit and leave the items in the room.

Another example of the students' ability to control their impulses and be responsible for their own actions occurred when the preadolescents expressed interest in a piano that was stored in the room (note: The room used for the activity groups was a multipurpose classroom. Many items including a piano were stored in the room). In session 1, the students would approach the piano, open the lid and began playing notes.

Counselor: Freddie, I know you are interested in that, but the piano is not for playing, you can choose to play any of those musical instruments (pointing to instruments on the shelf).

Freddie: But we get to play it in music.

Counselor: Freddie, you're disappointed; you wish you could play it now.

Ralph: I know how to play it.

Counselor. Ralph, you're letting me know you won't hurt it, but the piano is not for playing during our group time. You can choose to play the musical instruments or you can pretend something else is a piano.

Malcolm: Come on, let's do this (pointing to the clay).

Freddie and Ralph: Okay

Counselor. Ya'll figured out something you could all do together.

In following sessions, while the students still showed interest in the piano, they remembered the limit set in previous sessions, helped one another remember the limit, and choose not to play with the piano. For example in session 5:

Freddie: (looking at the piano, walking up to it and lifting the lid)

Ralph: Freddie, remember, we're not supposed to touch that.

Freddie: Yeah, I know. I was just looking at it. (He then picked up a ball and threw it at the basketball net.) Aw, I was close!

Teacher comments reflected similar observations with statements such as “much improvement in stopping inappropriate behavior,” and “enormous improvement in classroom behavior and self-control.”

Externalizing Problems

Behavior Assessment System for Children. As indicated in tables 14-15, preadolescents in the experimental group did not experience a statistically significant decrease at the a priori level in externalizing behavior problems when compared to the control group. However, while not statistically significance, the results did have practical significance. An effect size was calculated and determined to be medium ($d=.53$) indicating that group activity therapy had a moderate treatment effect on the externalizing behaviors of the experimental group when compared to the control group. Behaviors measured on this composite scale include: hyperactivity, aggressive behavior, and conduct problems. While the externalizing problems scale did not show statistical significance at the .05 level, post hoc analysis of the Hyperactivity subscale demonstrated significance ($p=.05$) with an average mean decrease of 4.17 for the experimental group and an increase of 1.42 for the control group. This result indicates that with intervention the experimental group was able to control behavior more effectively while children in the control group, left untreated became more hyper. Practical significance was also

found to be large ($d=.89$) indicating that the treatment had a profound effect on the experimental groups ability to be more patient, be less active, interrupt less, less loud, and less restless.

Child Behavior Checklist. As indicated in tables 17-18, preadolescents in the experimental group did not experience a statistically significant decrease at the a priori level in externalizing behavior problems when compared to the control group. The results did, however, indicate a positive trend ($p=.09$) in the decrease of externalizing problems when compared with the control group. An effect size was calculated to determine practical significance and determined to be moderate to large ($d=.78$) indicating that group activity therapy had a moderate to large effect on the externalizing behavior of the experimental group when compared to the control group. The Externalizing Problems scale measures the preadolescents' tendency to act outwardly their inner emotions. Behaviors measured include: behaviors and thoughts perceived as different from other children, aggressive behavior, and delinquent behavior. While the Externalizing Problems scale did not show significance at the .05 level, post hoc analysis of the subscales indicated that the Delinquent Behavior subscale found statistical significance ($p=.03$) with an average mean gain decrease of 3.09 for the experimental group and an increase of 3.00 for the control group. The effect size calculated to determine practical significance was large ($d=1.04$) indicating that students in the control group are less likely to lie to avoid punishment, use inappropriate language and behavior, and more likely to feel remorse for inappropriate actions. On the Aggressive subscale, the effect size was determined to be moderate to large ($d=.71$) also indicating that students participating in

group activity therapy for 12 weeks were less likely to argue, fight, threaten others, or be mean to others. With the increasing concern about school violence, reductions in delinquent behavior and aggression are important

The externalizing composite score of the BASC and CBC yielded a medium and large effect size, respectively, indicating that students in the experimental group learned appropriate ways of dealing with their feelings instead of acting those feelings outwardly. For example, preadolescents in the experimental group were less over active, more patient, and more socially courteous of others (waiting their turn, not interrupting). Additionally, a large effect size on the Delinquent Behavior subscale indicates that students who participated in the activity groups were more aware and sensitive to the feelings of others, less likely to lie to get out of trouble, found appropriate ways to deal with dissatisfaction, and made better choices in friends while those in the control group demonstrated a gain in delinquent behavior. A medium effect size was also found on the Aggression subscale of the CBC indicating a meaningful change in teasing, arguing, destroying property, fighting, and being mean in general for the students in the experimental group as compared to those in the control group.

Statistical results were supported by parent and teacher comments and observations. For example, many of the preadolescents seen in group activity therapy had been diagnosed with Attention Deficit Hyperactivity Disorder (ADHD). Teachers and parents expressed concerns regarding the students' over activity, difficulty delaying gratification, and inexhaustible energy. Through group activity therapy, the students were able to learn to be more patient and use their energy constructively to accomplish goals.

For example, the researcher observed the students being more able to delay gratification by controlling their impulses and learning to take turns in order to work together as a group. One popular activity for all groups was basketball. While there were several balls in the room, there was only one hoop and often, all group members want to play at the same time. The preadolescents quickly learned that if they impulsively threw the balls all at once, it was difficult for any one to get the ball in the hoop. For example, all five groups were able to negotiate with one another to devise a way to work this out so that one student would shoot and the other two would retrieve the ball. Teachers also reported that the students were “less impulsive in class” and “he is more patient when waiting his turn in games or in the lunch line,” “she doesn’t yell out the answers in class, but now waits to be called upon.” Several parents also made similar comments: “he’s less frustrated and more patient when we go places,” and “she’s able to save her energy for playing outside instead of running through the house.”

Many teachers and parents expressed concern for the preadolescents’ tendency to act aggressively. Initial concerns and comments reflected that when the students became frustrated they often acted aggressively towards others. Group activity therapy provided the students with the opportunity to play out aggressive feelings using the play materials. For example, in one group all three members initially spent much of the session punching and kicking the BoBo (an inflatable bop bag) often having difficulty sharing:

(Bob is the first to get to BoBo and punches and kicks it hard.)

Counselor: Bob, you really like beating up on the BoBo.

Bob: Yeah, he’s really going to get it now.

Counselor: You're really going to show him who is boss.

Joel: I want to beat him up, too.

Chris: I want to go next.

Counselor: You both want a chance to beat him up.

Bob: Just one more time.

Counselor: You all like to beat up BoBo.

Chris: Yeah, let's all beat him up together.

Bob: Okay.

Joel: Cool.

(All three take turns, and then begin jumping on the BoBo together.)

Counselor: You figured out a way to work together.

This example shows individual members aggression towards BoBo turning into a more collaborative, fun activity while still allowing group members to express their feeling and use pent up energy. Additionally, the counselor's reflections facilitated problem solving and group cooperation through awareness of the other students' desires.

The following week, the teachers of two of the children in this group, Chris and Joel, commented that the students seemed calmer and more able to take direction. In subsequent sessions, there was a reduction in the groups' aggressive play to more constructive, cooperative interaction. Chris' mother, who during the parent information meeting expressed concerns that there was a constant power struggle, that Chris often refused to do what was asked of him, and that he would often get aggressive. After the

study, Chris' mother commented that he, while still stubborn and willful, was less defiant and angry.

Prior to the study, parents and teachers emphasized difficulties in social interactions describing specific behaviors including arguing, inappropriate interactions, and cliques within the classes. While the BASC contains a Social Skills subscale, the behaviors identified by parents and teachers as social problems, do not fit with in the purview of the behaviors they identified. Items on the BASC Social Skills subscales include items related to manners and not unsuccessful interpersonal relationships. The researcher observed improved social interactions between the students during the group activity sessions. Children who were not accepted by the other group members were able to modify their interactions in the group setting and therefore able to interact and play with other group members. Preadolescents stated that the group setting gave them the opportunity to meet and get to know people they would not have had the opportunity to know. These particular students stated that they had also begun to interact in the lunchroom and on the playground. Teachers observed similar new friendships develop stating that the students that went to the group together were hanging out together more than before. Parents reported that their preadolescents seemed to be making new friends and approaching other children with more ease.

Limitations

The following limitations are offered as possible confounding issues in this study.

1. The sample size of this research was small (experimental group $n=12$, control group $n=12$). A larger sample size would increase the power in retained hypotheses and validate findings.
2. The researcher conducted the groups. Therefore, researcher bias may exist.
3. Teachers and parents were aware of which students participated in the control group and the experimental groups. This Hawthorne Effect may have biased their perceptions of the students.
4. The participant selection was limited to volunteer subjects from one school located in Dallas, Texas. This limits the ability to generalize the results to other populations.

Implications

Three of the six hypotheses were found statistically significant and two of the six indicated positive trends, indicating a gain in target behavior for the experimental group when compared with the control group. Additionally, practical significance was indicated with five of the six hypotheses having a large effect size and one having a medium effect size. These positive results as well as parent, teacher, and researcher observations support the use of group activity therapy in schools. Preadolescents cope with a magnitude of challenges. Preadolescents with a learning disability face additional struggles. This study suggests that group activity therapy can have a profound effect on the behavior, coping, and interacting skills of preadolescents diagnosed with a learning disability. Further research is warranted to determine if the students who participated in the activity groups

continue to improve upon these skills and to determine if this model for working with preadolescents consistently results in statistically and practically significant changes in the behavior of preadolescents.

In addition, group activity therapy makes maximum use of the school counselor's time. By using a group model, the counselor is able to see more students and impact more lives. With group activity therapy taking place in the school, teachers are likely to observe changes more quickly as the students are interacting in group with the same people as in the classroom, lunchroom, and playground. Therefore, behaviors learned in group are more likely to generalize to these settings more easily and quickly.

Parents reported that their children enjoyed coming to the groups and expressed excitement to attend school on the days they were scheduled for therapy. Students also expressed excitement about coming to the groups. Many students would stop the counselor in the hall and ask if they could come to group activity therapy. In addition, many parents and students inquired regarding the availability of the program during the following school year.

Because this project's results are both statistically and practically significant the implementation of group activity therapy in schools is justifiable. Parents, teachers, the researcher's observations, and the students themselves supported these results.

Perhaps one of the most imperative suggestions stemming from this study is the call for continued research regarding anxiety and depression in preadolescents. Depression and Generalized Anxiety are two conditions that are diagnosed and treated in the United States with frightening regularity. Many times, signs of impending depression in

preadolescents are heralded in studies such as these. By identifying symptoms early and utilizing developmentally appropriate interventions, practitioners can be catalysts in assisting the client in a lifetime of meaningful interactions in lieu of facing the inter and intrapersonal ramifications brought on by years of living with anxiety and depression.

Recommendations for Further Research and Practice

Based upon results of this study, the following recommendations are offered:

1. Conduct a replication study using a larger sample size. A larger sample size would increase the power of the statistical measures.
2. Conduct a follow-up study to ascertain maintenance and generalizability of improved social skills and behavior.
3. Implement the Social Skills Activity Group model for a longer number of sessions. The larger number of sessions would allow the students more opportunities to learn and practice social interaction. Additionally, extending the time students participate in group activity would improve power and practical significance.
4. Extend the length of sessions of the activity groups. While this study was limited to one hour, an increase in time would allow students more time to transition back to the classroom and more time for snack.
5. Initiate more parent and teacher seminars to teach those who interact with the children basic activity therapy techniques. By teaching these techniques those who interact with the children, the children's school

and home experience would be consistent with the positive environment of the groups.

Concluding Remarks

The current review of the literature suggests that this study is the first experimentally designed project to focus on behaviors, coping skills, and interactions of preadolescents using a humanistic, developmentally sensitive model of intervention. The statistically and practically significant results as well as the comments of parents, teachers, the researcher, and the students oblige schools to implement the use of group activity therapy with preadolescents. Recommendations were made to encourage further research in this area.

APPENDIX A
GROUP PUPPETRY

Group Puppetry

1. Rationale for Group Puppetry: Using group puppetry provides a catalyst for self exploration and group interaction. This semi-structured activity does not focus on a completed product, but provides an opportunity to reduce group anxiety, facilitate comfort of group interaction verbally and non-verbally, and group cooperation and collaboration.

2. Materials:

- a. A variety of puppets are needed, including human and animal figures, both realistic and fantasy, and culturally diverse. While many puppets have a tendency to be "cute", it is important to provide scary puppets so that the preadolescents have the opportunity to express a variety of experiences and feelings. There should be enough puppets so that the preadolescents have the opportunity to make choices about which puppet they would like to use.
- b. A puppet theater is also needed for group puppetry. The puppet theater should be large enough for all of the preadolescents to fit behind. If a puppet theater is not available, a table, turned on its side, can also be used. The puppet theater allows preadolescents the opportunity to be invisible while the character speaks.

3. Procedure:

- a. Selection of Puppets. The first step in the use of puppetry with preadolescents is selection of the puppets. The therapist places a pile of puppets on the floor and introduces the activity by saying, "Here are some puppets, look through them and pick out one that you would like to play with."
- b. Introduction of puppets: The therapist then asks the group members to give their puppet a name and introduce the character to the group.
- c. Story formulation: The therapist then asks the group to tell a story using the puppets. The group is reminded that a story has a beginning, middle, and end. If the group is having difficulty getting started, the therapist might ask questions that would facilitate the development of a story. For example, the therapist might inquire about the setting of the story. After planning the story, the group members then perform their story for the therapist.
- d. Therapist interaction with puppets: During the fourth step, the therapist interacts briefly with each character in the story, reflecting content and feeling portrayed in the puppet show while the child maintains the emotional distance provided by the puppet and the puppet theater.

Note: While the semi-structured activity is introduced, if the preadolescents not to participate in the activity, the therapist is accepting of this decision. In contrast, if the preadolescents choose to continue the activity beyond what is presented, the therapist is also accepting of that choice as well.

APPENDIX B
LIST OF TOYS

List of Toys

Woodworking table
Hammer, nails, screwdriver, screws
Styrofoam
Wood
Paint
Glitter
Glue
Lunch trays
Beads
Plastic Cell Phones and Pagers
Binoculars
Kaleidoscope
Animal figures (domestic thru wild)
Human figures
Plastic Knife
Plastic Sword
Foam Sword
Army figures
BoBo (punching bag)
Basketball hoop
Foam balls
Bowling Pins and ball
Tambourine (musical instruments)
Drum
Puppets
Large paper
Scissors
Clay
Molding clay and tools (rolling pin, cookie cutters, press)
Bubbles
Art Cart (markers, crayons, yarn, feathers, ribbon, magazines, paper plates, Polaroid camera)
Board games

APPENDIX C
GROUP PLAY THERAPY SESSION SUMMARY

BIOFBK
SC

University of North Texas
Department of Counseling, Development and Higher Education
Counseling Program Clinical Services

Date/Session # _____ / _____

Code # _____

GROUP PLAY THERAPY SESSION SUMMARY

Page 1 of 3

Signature on bottom of each page required

Counselor _____ Theory _____

Specific Interventions Utilized _____

Children/Age A. _____ C. _____
B. _____ D. _____

I. SUBJECTIVE: (Feelings Expressed): Place letter above all that apply (including capitalized words). Indicate predominate feeling(s) by circling letter

HAPPY: relieved, satisfied, pleased, delighted, excited, surprised, silly

CONFIDENT: proud, strong, powerful, determined, free

SAD: disappointed, hopeless, pessimistic, discouraged, lonely

HESITANT: timid, confused, nervous, embarrassed, ashamed

ANGRY: impatient, annoyed, frustrated, mad, mean, jealous

CURIOS: interested, focused

AFRAID: vulnerable, helpless, distrustful, anxious, fearful, scared, terrified

FLAT: restricted, contained, ambiguous

II. OBJECTIVE:

A. TOYS/PLAY BEHAVIOR Place letter above all that apply, give brief description of play. In the blank, indicate meaningful/sustained play with a "*", indicate first time happenings with "1st", indicate discontinued play as "DP", indicate play disruption as "PD", and indicate any therapist initiated activity as "TH".

A. ___ B. ___ C. ___ D. ___ hammer/log/woodworking

A. ___ B. ___ C. ___ D. ___ sandbox/water/sink

A. ___ B. ___ C. ___ D. ___ puppets/theater

A. ___ B. ___ C. ___ D. ___ kitchen/cooking/food

A. ___ B. ___ C. ___ D. ___ easel/paint/chalkboard

A. ___ B. ___ C. ___ D. ___ riding car

A. ___ B. ___ C. ___ D. ___ bop bag/bean bag

A. ___ B. ___ C. ___ D. ___ dress up/jewelry/hats/masks/wand

A. ___ B. ___ C. ___ D. ___ crafts table/clay/markers/paints/etc.

A. ___ B. ___ C. ___ D. ___ doll house/doll family/bottle/ pacifier

A. ___ B. ___ C. ___ D. ___ cash register/money/telephone/camera/flashlight

A. ___ B. ___ C. ___ D. ___ medical kit/bandages

A. ___ B. ___ C. ___ D. ___ musical instruments

A. ___ B. ___ C. ___ D. ___ games/bowling/ring toss/balls/etc.

A. ___ B. ___ C. ___ D. ___ constructive toys (tinkertoys, etc.)

A. ___ B. ___ C. ___ D. ___ vehicles/planes

A. ___ B. ___ C. ___ D. ___ animals: domestic/zoo/alligator/dinosaurs/shark/snake

A. ___ B. ___ C. ___ D. ___ soldier/guns/knife/sword/handcuffs/rope

A. ___ B. ___ C. ___ D. ___ blocks/barricade

A. ___ B. ___ C. ___ D. ___ sandtray/miniatures

Counselor's signature with credentials
07/18/2002

D:Sue's Zip/Group Therapy/Group PT Session Summary.doc

B. **SIGNIFICANT VERBALIZATION:** CH= Child initiated (indicate which child by A, B, etc) TH= Therapist initiated
 Note significant interaction between children (ex: A to B.....)

C. **LIMITS SET:** Write limit set beside the category & indicate child's letter and # of times limit set. If ultimate limit was set, describe process.

PROTECT CHILD (HEALTH/SAFETY):

PROTECT THERAPIST/PROMOTE THERAPIST ACCEPTANCE:

PROTECT ROOM/TOYS:

STRUCTURING:

REALITY TESTING:

SOCIALY UNACCEPTABLE BEHAVIOR:

III. ASSESSMENT: General Impressions/Clinical Understanding

A. **DYNAMICS OF SESSION:** Rate 0=low, 10=high): Child's play/activity level: A. ___ B. ___ C. ___ D. ___
 Intensity of play: A. ___ B. ___ C. ___ D. ___ Inclusion of therapist/level of contact A. ___ B. ___ C. ___ D. ___
 Put child's letter beside appropriate level (#). Circle level # and Child's letter. (1 abc)

Destructive	1	2	3	4	5	6	7	8	9	10	Constructive
Messy	1	2	3	4	5	6	7	8	9	10	Neat

B. **PLAY THEMES:** place letter above all that apply (including capitalized words). Indicate predominate theme by circling letter.

EXPLORATORY: (not a true play theme – rather the way child gets comfortable & familiar with playroom)

RELATIONSHIP: connecting/approval seeking/manipulative/competitive/collaborative/testing limits

POWER/CONROL:

HELPLESS/INADEQUATE:

AGGRESSION/REVENGE:

SAFETY/SECURITY:

MASTERY: constructive/competency/integration/resolution

NURTURING: self-care/reparative/healing

DEATH/LOSS/GREIVING:

SEXUALIZED:

OTHER;

C. OVERALL, CHILD'S BEHAVIOR/AFFECT WAS: (refer to explanation of how to code child's behavior/affect)

Sad/depressed/angry	1	2	3	4	5	6	7	8	9	10	Content/satisfied
Anxious/insecure	1	2	3	4	5	6	7	8	9	10	Confident/secure
Low frustration tolerance	1	2	3	4	5	6	7	8	9	10	High frustration tolerance
Dependent	1	2	3	4	5	6	7	8	9	10	Autonomous/Independent
Immature/regressed/hypermature	1	2	3	4	5	6	7	8	9	10	Age appropriate
External locus of control	1	2	3	4	5	6	7	8	9	10	Internal locus of control (self-control)
Impulsive/easily distracted	1	2	3	4	5	6	7	8	9	10	Purposeful/focused
Inhibited/Constricted	1	2	3	4	5	6	7	8	9	10	Creative/Expressive/Spontaneous/Free
Isolated/Detached	1	2	3	4	5	6	7	8	9	10	Connected/Sense of Belonging

D. OVERALL, CHILD'S PLAY WAS:	OVERALL, GROUP'S PLAY WAS: <i>Collaborative, Connection facilitated, Partners in crime, Ego strengthening, Problem solving., Other</i>
A.	
B.	
C.	
D.	

E. GROUP INTERACTION: (% of play time spent)

IP = Individual Play _____ PP= Parallel Play _____ CP = Cooperative Play _____ CF = Conflict _____ *Note which child initiated conflict*

F. CONCEPTUALIZATION OF CLIENT AND CLIENT'S PROGRESS BASED ON THEORETICAL ORIENTATION:

- A.
- B.
- C.
- D.

IV. GROUP PLANS/RECOMMENDATIONS: (include talking with parent(s)/school—requesting records, etc.)

- A.
- B.
- C.
- D.

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