

EFFECTIVENESS OF GROUP ACTIVITY PLAY THERAPY ON INTERNALIZING AND  
EXTERNALIZING BEHAVIOR PROBLEMS OF PREADOLESCENT

ORPHANS IN UGANDA

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Dissertation Prepared for the Degree of  
DOCTOR OF PHILOSOPHY

UNIVERSITY OF NORTH TEXAS

December 2011

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Ojiambo, Deborah. Effectiveness of Group Activity Play Therapy on Internalizing and Externalizing Behavior Problems of Preadolescent Orphans in Uganda. Doctor of Philosophy (Counseling), December 2011, 156 pp., 5 tables, 8 figures, references, 127 titles.

This pilot study investigated the impact of group activity play therapy (GAPT) on displaced orphans aged 10 to 12 years living in a large children's village in Uganda. Teachers and housemothers identified 60 preadolescents exhibiting clinical levels of internalizing and externalizing behavior problems. The participants' ethnicity was African and included an equal number of females and males. Participants were randomly assigned to GAPT ( $n = 30$ ) or reading mentoring (RM;  $n = 30$ ), which served as an active control. Preadolescents in both treatment groups participated in an average of 16 sessions, twice weekly with each session lasting 50 minutes. Sessions were held in the school located within the village complex. A two (group) by two (repeated measures) split plot ANOVA was used to analyze the data. According to teacher reports using the Teacher Report Form (TRF) and housemother reports using the Child Behavior Checklist (CBCL), children receiving the GAPT intervention demonstrated statistically significant decreases ( $p < .025$ ) in internalizing behaviors (TRF:  $p < .001$ ; CBCL:  $p < .001$ ) and externalizing behaviors (TRF:  $p = .006$ ; CBCL:  $p < .001$ ) from pretest to posttest compared to children who received RM. The GAPT intervention demonstrated a large treatment effect on reducing orphaned children's internalizing problems (TRF:  $\eta_p^2 = .213$ ; CBCL:  $\eta_p^2 = .244$ ) and a moderate to large treatment effect on reducing externalizing problems (TRF:  $\eta_p^2 = .121$ ; CBCL:  $\eta_p^2 = .217$ ). The statistical, practical, and clinical significance of the findings provided strong, preliminary support for using GAPT as a developmentally and culturally responsive school-based intervention for troubled Ugandan orphans.

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## ACKNOWLEDGEMENTS

Getting through this project has been a culmination of efforts from many people who have been part of my journey. I thank my lord and savior, Jesus Christ: Your amazing grace and love has sustained me through each day of this mission. I am grateful to my family and friends: I appreciate your support, encouragement, and sacrifices you made to allow me pursue my goals.

I want to express my gratitude to my committee. Dr. Sue Bratton, thank you for your support, guidance, and for the time you invested throughout this project. Dr. Dee Ray, your wisdom, commitment, and encouragement have been a precious asset in my personal growth and professional development: Thank you. Dr. Lindo, thank you for your insight and support. I would also like to thank the rest of the faculty and staff of the counseling program for all they have done to provide a valuable educational experience for me.

I want to acknowledge and thank my cohort and the world life team for helping and supporting me in amazing ways; without their involvement, this task would have been more difficult. To the children of Uganda who faced terrifying experiences associated with armed conflict: thank you for allowing me to part of your life changing stories, this project belongs to you. To everybody who has been involved in this venture: I thank you.

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## Introduction

Recent reports (e.g., *Children on the Brink*; UNAIDS, 2004; UNICEF, 2006) have indicated that Africa has the greatest population of orphaned children in the world, estimated at 48 million. Both UNAIDS (2004) and UNICEF (2006) cautioned that despite the increasing number of orphans, there was negligible response to orphaned children's mental health needs. Urgent concerns about the socio-economic needs of orphaned children in Africa in the last decade have overshadowed the psychological impact of orphanhood (Atwine, Cantor-Graae, & Bajunirwe, 2005).

Uganda has been particularly plagued by armed conflict, HIV/AIDS and other diseases that have led to a proliferation of internally displaced children. Displaced orphans are children who have been forced, as a result of war, death of family members, or natural disaster, to leave their original settlement areas and homes. An estimated 2.3 million children, who constitute 14% of Uganda children, are orphans (UNICEF, 2006). The significance of this statistic is highlighted by the fact that 50% of Uganda's population is made up of children under 15 years of age (Uganda Bureau of Statistics, 2006). The rapid increase in number of parentless children has resulted in a corresponding rise in the number of children living in orphanages (Ministry of Gender, Labour, and Social Development, 2004; Uganda Bureau of Statistics, 2006; Wakhweya et al., 2002). However, orphanages have been unable to provide for the attachment, social integration, and acculturation needs of the orphaned children in their care (Wakhweya et al., 2002).

An exhaustive review of the literature revealed a paucity of studies conducted with displaced orphan children. The few studies available were mainly focused on identifying mental health problems and symptoms expressed by orphaned children and offered limited attention to interventions (Atwine et al., 2005; Betancourt, Speelman, Onyango, & Bolton, 2009; Derluyn,

Broekaert, Schuyten, & Temmerman, 2004; Gupta, 2000; Morgos, Worden, & Gupta, 2007; Musisi, Kinyanda, Nakasujja, & Nakigude, 2007; Pfefferbaum et al., 2008; Yule, 2000; Wolff & Fesseha, 1999, 2005). Researchers identified a host of emotional and behavioral symptoms exhibited by displaced orphans including anxiety, developmental delays, sleep disturbances, behavioral problems, social isolation, depression, sadness, hopelessness, suicidal ideation, decreased interest in activities, and learning difficulties (Atwine et al., 2005; Harms, Jack, Ssebunnya, & Kizza, 2010; Musisi et al., 2007; UNICEF; 2006; Wakhweya et al., 2002). Children living in orphanages face additional stressors as a result of being isolated from their families and communities, and must cope with further challenges associated with being forced to adjust to life with new caregivers (Wakhweya et al., 2002). Wakhweya et al. emphasized the magnitude of the problem, stating that the psychological effects on orphaned children were widely underestimated.

The dire need for psychological services in on-going efforts to help Ugandan orphans has been widely recognized, but remains largely overlooked due to the greater focus on services related to socioeconomic need (Atwine et al., 2005; Musisi et al., 2007; Harms et al., 2010; UNICEF; 2006; Wakhweya et al., 2002). Wakhweya et al. (2002) found that only 9% of the institutions they surveyed provided care for orphans that included some form of counseling services. On a positive note, Wakhweya et al. found that 87% of orphans were attending school, with the greatest proportion of orphans in primary Grades 1 through 5. Thus, schools have the potential to play an active role in providing developmentally responsive interventions to meet the growing mental health needs of the orphans in Uganda.

Child-centered play therapy (CCPT) is a developmentally sensitive intervention that has been successfully applied in schools in the United States to address children's early mental health concerns (Bratton, 2010). Numerous controlled outcome studies, the majority of which

were school-based and targeted children under 10 years of age, have demonstrated CCPT's effectiveness as a developmentally and culturally responsive intervention for treating varied social, emotional, behavioral, and learning difficulties (Bratton & Ray, 2000; Bratton et al., 2005; Ray & Bratton, 2010). However, limited research has been conducted on the effects of play therapy with older children. Of the few well-designed, preliminary studies targeting preadolescents, a group play/activity-based approach has been shown to be effective as a developmentally responsive intervention to meet the mental health needs of this population (Flahive & Ray, 2007; Packman & Bratton, 2003; Shen, 2003, 2007; Shen & Armstrong, 2008).

#### Developmental Needs of Preadolescents

The preadolescent phase of growth includes ages 9 to 12 years old (Bratton & Ferebee, 1999; Packman & Bratton, 2003; Packman & Solt, 2004). According to Piaget's (1977) theory of cognitive development, children in the preadolescent stage are developmentally in transition of moving from the concrete operational stage to the formal operational stage of thinking (Wadsworth, 1979). As a result, preadolescent children may have difficulty fully expressing their thoughts and feelings through verbal means alone, particularly children developmentally regressed for their age. Ray (2011) posited that providing concrete materials to preadolescent children within the context of play therapy fostered their process of creating meaning of their world.

In consideration of preadolescents' valuing and being greatly influenced by peers, Gerrity and DeLucia-Waack (2007) and Kulic, Dagley, and Horne (2001) proposed the use of group counseling for this age group and supported the use of activity and play as developmentally responsive. For preadolescents, growing positive peer relationships is a vital developmental step which influences later stages along the lifespan (Bratton & Ferebee, 1999). Akos, Hamm, Mack, and Dunaway (2007) argued for group work with preadolescents as a means for them to

experience feeling accepted and valued, develop a sense of belonging, improve social skills, and enhance interpersonal relationships. Through the group experience, preadolescents are afforded opportunities to adjust their perceptions regarding self, others, and the world as they work out new roles and resolutions within the safety of the therapeutic milieu (Bratton & Freebee, 1999).

Counseling interventions that provide age appropriate play materials and activities within a group format have been recommended as consistent with the developmental needs of preadolescents (Bratton, Ceballos, & Freebee, 2010). Additionally, the inclusion of creative and expressive media offers group members with a concrete yet flexible means to express themselves through making and sharing creations (Bratton & Freebee, 1999).

#### Group Activity Play Therapy

Slavson (1945) was one of the first to propose the use of activity therapy as a specialized treatment for preadolescents to bridge the gap between concrete and abstract thinking. Ginott (1961, 1994) emphasized that children in this age range need a setting and materials consistent with their developmental level and cautioned clinicians that preadolescents might view traditional play therapy as childish. A few contemporary authors have built on Slavson's and Ginott's work and described benefits and procedures for the use of activity/play therapy-based approaches with preadolescents (Bratton et al., 2010; Bratton & Freebee, 1999; Kottman et al., 1987). While research on this approach is in its infancy, a handful of well-designed controlled outcome studies have shown beneficial effects of group activity therapy-based interventions on externalized behavior problems, internalized behavior problems, moral reasoning, self esteem and emotional strength (Flahive & Ray, 2007; Packman & Bratton, 2003; Paone, Packman, Maddux, & Rothman, 2008; Shen, 2007; Shen & Armstrong, 2008). These studies had several similar features: (a) humanistic intervention, (b) used a group format, (c) emphasized the need

for screening group members, and (d) stressed the importance of developmentally-responsive, expressive materials and activities.

#### Child-Centered Approach to Group Activity Play Therapy

Child-centered play therapy (Axline, 1947; Landreth, 2002) is founded on person-centered theory developed by Rogers (1951). Rogers believed that individuals and groups have the innate capacity to set their own goals and work toward their own progress in counseling (Raskin, Rogers, & Witty, 2011). Person-centered counselors who work with children believe that the provision of a counseling relationship in which children experience genuineness, caring, and profound nonjudgmental understanding helps them attain constructive change (Bratton, Ray, Edwards, & Landreth, 2009; Landreth, 2002; Ray & Schottelkorb, 2009; Ray, 2011).

Ray (2011) clearly articulated the child's therapeutic progression within child/person-centered philosophy. Ray explained that child-centered therapy operated on the premise that within an accepting climate provided by the therapist, the child experiences no threat to the self-structure; hence, the child is able to examine experiences perceived as inconsistent with self-structure and then work toward revising and including those experiences. As the child feels positively regarded, he/she is able to behaviorally express and explore feelings and thoughts of incongruence through play/symbolic expression. In this self-exploration process the child is able to integrate a new awareness of self and develop full functioning.

A non-directive/humanistic approach to group activity/play-therapy with preadolescents is the most prevalent theoretical orientation mentioned in the literature (Bratton et al., 2009; Flahive & Ray, 2007; Packman & Bratton, 2003; Shen & Armstrong, 2008; Wilson & Ryan, 2005). In fact, the few outcome research studies examining the effects of play-based interventions with this population all specified a humanistic orientation. Early proponents of activity therapy espoused a non-directive approach based on a belief that preadolescents would

more freely express themselves and benefit from directing their own activities (Slavson & Redl, 1944; Slavson & Schiffer, 1975). Drawing from their humanistically-oriented clinical experience with preadolescents, Bratton et al. (2009) emphasized that opportunities for spontaneous and self-directed creative expression is the primary source of intra- and inter-personal growth and lasting change within an activity group format. Bratton and Freebee (1999) described this on-going self-creative process as one in which preadolescents develop inner resources that they can draw from in dealing with future challenges. Additionally, Davis (2002) emphasized that in the context of a non-directive approach using expressive arts, preadolescents should be allowed opportunities for spontaneous creation without pressure from the therapist to move in a certain direction.

The provision of semi-structured activities within a non-directive, humanistic context has received considerable focus in the relatively small body of literature focused on play therapy approaches with preteens (Bratton et al., 2010; Bratton & Freebee, 1999; Kottman et al., 1987; Wilson & Ryan, 2005). There seems general agreement that the benefits of providing semi-structured activities include: (a) facilitating connections and interaction between group members, (b) reducing anxiety and establishing sense of comfortableness, (c) fostering opportunities for group cooperation and collaboration; and (d) to a lesser degree, exposing participants to a variety of expressive art materials with which they might not be familiar (Bratton et al., 2010). Davis (2002) emphasized the value of structuring expressive art activities within a person-centered approach as a means of facilitating psychological contact.

Wilson and Ryan (2005) supported the provision of structured activities with this population, but cautioned that activities needed to be used in response to what preadolescent children were conveying and experiencing during play therapy as opposed to being utilized as planned techniques in a directive way. They posited that the therapist needed to provide a

therapeutic relationship or climate in which children would be able to change the course and process of play during structured activities like they do in other activities. They concluded that while using structured activities, non-directive play therapists needed to be flexible, empathic and responsive to children's emotional communication.

### Screening and Selection of Group Members

Group participants should be selected based on their level of interest in the group, their capacity to form peer relationships, and their desire to be accepted by the group (Ginott, 1975). Ginott (1975) emphasized the importance of screening group members due to the potential for harm being enhanced in a group modality. Bratton et al. (2010) and Chad et al. (1998) suggested that preadolescents experiencing high levels of anxiety and significant difficulty in connecting with others and those who have experienced previous traumatic events, such as sexual abuse, would likely benefit from individual therapy prior to participating in a group intervention. In selecting children for groups, heterogeneous groups composed of participants whose personality characteristics, presenting problems, and coping styles complement each other have been recommended as potentially therapeutic (Bratton et al., 2009; Bratton & Ferebee, 1999; Ginott, 1975; MacLennan, 1983; Packman & Bratton, 2003). For preadolescents, several authors have recommended that groups be composed of members not more than one year apart in developmental level and of the same gender (Bratton et al., 2009; Kulic et al., 2001; Salloum et al., 2009; Sullivan, 1953).

### Statement of the Problem

Without treatment, behavior problems exhibited by orphans have been predicted to lead to more serious behavior problems across their lifespan and to a negative impact on Uganda's social system and economic development. A key priority policy for Uganda, as stated by Ministry of Gender, Labour, and Social Development (2004), is that mental health services must

be provided to orphans. Given the magnitude of the rapidly increasing orphan problem in Uganda and the absence of interventions for problem behaviors exhibited by preadolescents, a group activity play therapy-based approach offers promise as an intervention to meet the mental health needs of orphans. The handful of controlled, outcome studies investigating treatment modalities with preadolescents identified in the literature were conducted in the United States (Flahive & Ray, 2007; Packman & Bratton, 2003; Shen & Armstrong, 2008). A review of the literature revealed no controlled outcome studies had been conducted with the population of children living in orphanages in Uganda.

#### Purpose of the Study

The overarching aim of this study was to identify an effective mental health intervention that was developmentally and culturally responsive to the needs of a growing population of displaced Ugandan children living in orphanages. Specifically, the purpose of this pilot study was to explore the effectiveness of group play activity therapy (GAPT) as a treatment for preadolescent orphans in Uganda exhibiting significant behavioral problems. Two main questions were of concern in this study:

1. Will GAPT decrease internalizing problems of orphaned preadolescent students living in Uganda when compared to reading mentoring (RM)?
2. Will GAPT decrease externalizing problems of orphaned preadolescent students living in Uganda when compared to reading mentoring (RM)?

#### Methods

##### Participants

Participants were students from one elementary school located in an orphanage in the central region of Uganda. The school's enrollment was 624 students in prekindergarten to seventh grade and considered to be among the country's highest risk children (Wakhweya et al.,



2002). The orphanage serves children displaced as a result of losing their parents primarily as a consequence of armed conflict, HIV/AIDS, and other tragedies. Due to varied factors associated with the experiences of orphaned children, such as being economically disadvantaged, they start school late, experience developmental delays, and often have a history of trauma. Upon receiving research approval from the Ugandan National Council for Science and Technology (UNCST), the participating orphanage, and the university's institutional research board, a 3-step process for identifying participants was established. First, teachers and house mothers were asked to identify children who were experiencing behavioral difficulties such as disruptive behavior in class, rule breaking, difficulty getting along with others, aggression, withdrawal, and signs of anxiety or sadness. Next, house mothers gave their approval for the identified children's participation, and last, the orphanage's education team leader, as the designee of guardianship, gave official consent for the children to participate in the study. The purpose of the study was explained to the children prior to obtaining their assent.

Children who were included in the study met the following inclusion criteria: (a) orphan between 10 and 12 years of age (and enrolled in Grades 3-5) and living permanently in the participating orphanage; (b) child not more than 2 years behind grade level; (c) clinical/borderline level of behavior concern reported by teacher or housemother; (d) presenting problem and current functioning deemed appropriate for group intervention; (e) currently not receiving mental health services; and (f) housemother was not receiving parent education during the time of the study. Of the 101 preadolescents referred to the study, 60 met all criteria and were selected to participate.

Participants were 28% third graders ( $n = 17$ ), 37% fourth graders ( $n = 22$ ), and 35% fifth graders ( $n = 21$ ). Age distribution of the participants was as follows: 25% 10 year olds ( $n = 15$ ); 33% 11 year olds ( $n = 20$ ); and 42 % 12 year olds ( $n = 25$ ). Male students represented 50% of

the participants. The average time that participants had lived at the orphanage at the start of study was 52 months, and the mode for living at the orphanage was 54 months.

### Instruments

*Child Behavior Checklist--Parent Version (CBCL).* The Child Behavior Checklist--Parent Version (CBCL; Achenbach & Rescorla, 2001) for children aged 6 to 18 years version was administered to the participants' housemothers. Children in this study have housemothers serving as their caregivers, or foster parents, in the orphanage. The CBCL was established to measure problematic child behaviors identified by parents. The first part of the CBCL consists of 20 competence items, and the second part comprises of 118 items asking caregivers to rate each one on a 3-point scale regarding the occurrence of problem behaviors. The CBCL reports clinical behavior using the three domains of Internalizing Problems, Externalizing Problems, and Total Problems which consist of eight syndrome subscales, including Anxious/Depressed, Withdrawn, Somatic Complaints, Social Problems, Thought Problems, Attention Problems, Rule Breaking Behavior, and Aggressive Behavior.

The syndrome subscales are categorized into one of the two classifications, which are Internalizing Problems or Externalizing Problems. Internalizing Problems refer mainly to problems within the self. Externalizing Problems refer to children's outwardly expressed behaviors and the children's behaviors that conflict with adults' expectations (Achenbach & Rescorla, 2001). Syndrome scales are established through the 118 clinical behaviour items, and each subscale is computed to determine T scores and percentiles. T scores above 63 are considered to be in the clinical range and scores between 60 and 63 are considered to be in the borderline range. Clinical scores highlight the crucial need for treatment, and borderline scores point to areas of concern (Achenbach & Rescorla, 2001).

The test-retest reliability of the scaled score for the CBCL empirically based problem

scales was supported by test-retest correlations of .90. The test-retest reliability coefficients were established at .91 for internalizing behavior problems scores and .92 for Externalizing behavior problems scores. The internal consistency of the empirically based problems scales was supported by alpha coefficients of .78 to .97. Strong validity evidence for CBCL scores has been established through varied research studies (Achenbach & Rescorla, 2001).

*Teacher Report Form.* The Teacher Report Form (TRF; Achenbach & Rescorla, 2001) is a teacher report instrument used to assess children's academic performance, adaptive functioning, and behavioral and emotional functioning. The TRF form is for use with children between the ages 6 and 18 years old. The TRF requires teachers to rate each student's academic performance and behavior compared to other children in the class on a 118-problem item form. The student's behavior is rated on a 3-point scale of 0 to 2 indicating, *not true* = 0, sometimes *true* = 1, or very *true* = 2. The TRF generates adaptive scores, similar to the competence scores of the CBCL, problem scores, and *Diagnostic and Statistical Manual of Mental Disorders* (DSM) oriented scores. The TRF syndrome scales are computed and presented in the same way as the CBCL scores except that the norms are based on teacher reports of nonreferred children (Achenbach & Rescorla, 2001).

Achenbach and Rescorla (2001) reported adequate internal consistency for the TRF with an alpha of .90 on the TRF Total Adaptive scale; for the problem scores, alphas of .72 to .95; and for the DSM-oriented scores, alphas ranging from .73 to .94. The test-retest reliability for the TRF was high, and the scaled scores were stable (Achenbach & Rescorla, 2001). The content, criterion-related, and construct validities of the TFR have been strongly supported by research (Achenbach & Rescorla, 2001).

## Procedures

To determine if children qualified to participate in the study, teachers completed the TRF

and housemothers completed the CBCL for identified children with consent to participate. The teachers completed TRFs during the fourth week of school, and at that time, it was hoped they would have had opportunity to build relationships with children and to provide time to accurately rate problem behaviors. Teachers and housemothers provided demographic data on each student.

Participants were stratified by gender and randomly assigned to the experimental group (GAPT,  $n = 15$  males and  $n = 15$  females) or active control group (RM,  $n = 15$  males and  $n = 15$  females) using a random table of numbers. Stratified random assignment was used to ensure an equal number of males and females in treatment groups, because of the GAPT treatment protocol that called for same-gender preadolescents to receive the intervention in small groups composed of three children per group (Bratton & Ferebee, 1999; Flahive & Ray, 2007; Ginott, 1994; Packman & Bratton, 2003; Paone, 2006; Paone et al., 2008). Criteria for assigning experimental and control participants to the intervention groups of three followed recommendations of Bratton et al. (2009) and Ginott (1994) and included: (a) same gender, (b) not more than 1 year apart in age, and (c) not classmates. In addition, members' presenting issues were considered in an effort to maximize therapeutic effect within the intervention groups (Ginott, 1994). Thus, the GAPT group was divided into five groups of three males and five groups of three females for the purpose of receiving the intervention. The RM group was likewise divided to receive mentoring.

Participants in both the GAPT and RM conditions participated in an average of 16 sessions which occurred twice weekly for 50 minutes per session over a 10-week period. Consistent with the procedures used by Packman and Bratton (2003), the length of the sessions was accommodated to the school schedule and thus shortened from the 1.5 hour group activity therapy format suggested in the literature (Bratton & Ferebee, 1999; Schiffer, 1969; Slavson & Redl, 1944). Measures were taken to insure that teachers and housemothers, as sources of pretest and posttest data, would be blinded to the study. The following were those measures: (a) the

teachers and housemothers were not informed of children's group assignment; (b) all children left the classroom for the same length of time and in the same manner; (c) treatment facilitators for both conditions were instructed to use identical statements when retrieving children from the classroom, "I am here to get Jaymar," and (d) treatment facilitators for both conditions were cautioned not to discuss the intervention with any teachers or housemothers at any time until the study was completed.

#### Experimental Treatment: GAPT

GAPT was designed as a developmentally responsive intervention for preadolescents and was based on the group play/activity therapy research protocol used by Packman and Bratton (2003). In the present study, CCPT (Landreth, 2002) principles and procedures provided the framework for conceptualization and practice. In response to the preadolescents' unique social, emotional and cognitive developmental needs, the GAPT intervention provided an integration of unstructured and semi-structured activities. According to the GAPT protocol (Appendix J), the therapist is flexible and allows group members to use expressive materials in their own way without pressure from the therapist to move in a certain direction. Consistent with Roger's (1951) teachings, principles guiding the GAPT process included the therapeutic belief in preadolescents' capacity for positive self-growth and their ability to set their own goals and work toward their own progress and the therapeutic belief in the significance of the therapeutic relationship in facilitating clients' released potential for movement toward personal growth--a relationship in which the therapist experiences and communicates genuineness, empathy, and acceptance.

Experimental group children received the GAPT intervention for 16 sessions. Sessions were held twice weekly, occurred in a specially-equipped room at the school located within the orphanage complex, and were approximately 50 minutes in length. Consistent with Packman

and Bratton (2003), the structure for the sessions included opportunities for self-directed and group-directed activities as well as semi-structured activities offered by the counselor. Approximately 10 minutes at the end of each session was allocated for closure and sharing among group members and to facilitate transition back to the classroom. Throughout the 16 session protocol, the therapist used facilitative responses characteristic of a child-centered approach, as evidenced by adherence to the GAPT skill checklist (Appendix H). Following recommendations for setting up the space and materials for group activity therapy, the materials and toys selected were consistent with the developmental needs of preadolescents (Bratton et al., 2009; Packman & Bratton, 2003). Bratton and Ferebee (1999) provided a detailed list of suggested play/expressive materials and equipment and gave guidelines for selecting materials for developmental need and therapeutic value. As suggested by Hinds (2005), culturally sensitive toys and materials for African children were provided in the play room including African dolls, variety of African music instruments, African clothes/outfits for dress up, beads, and toys representing animals found in Africa.

*Session 1.* Consistent with Ray and Schottelkorb's (2009) recommendation for child-centered work with preadolescents, participants were introduced to the playroom and the structure of the counseling relationship (Appendix J). Objectives for the first session included allowing group members to explore the playroom and materials in their own way and time, to develop a sense of safety, and to connect with the therapist and each other.

*Session 2 through 6.* The next five sessions generally followed the format described by Packman and Bratton (2003) through offering a semi-structured activity and allowing approximately 20 minutes for completion, followed by approximately 20 minutes of self-directed or group-directed activity. Consistent with the literature's choices of expressive media offered, the media offered participants most control in Session 2 and proceeded to media that offered

them less control as the sessions progressed (Bratton et al., 2009; Landgarten, 1987). As mentioned previously, opportunities for sharing and closure are important; thus time was allocated for sharing at the end of each session. Appendix J contains the GAPT protocol, and descriptions of sample activities and general guidelines for presenting and processing activities from a child-centered perspective. A brief rationale for including both semi-structured activities and unstructured time for self-directed activity follows.

From a child-centered orientation, semi-structured activities were offered tentatively and with the intent of (a) facilitating connections and interaction between group members, (b) reducing group members' anxiety and establishing sense of safety and comfort, (c) fostering opportunities for group cooperation and collaboration, and to a lesser degree, and (d) exposing participants to variety of expressive art materials with which they might not have been familiar. The overarching aim of providing semi-structured activities was twofold: to facilitate psychological contact and to release preadolescents' inner-directed and constructive potential for growth. The intent was never to direct the individual or group process. Group members were free to participate or not participate and to change the course and process of an activity at any time.

Self-directed activity is considered the heart of a child-centered approach. Bratton et al. (2009) emphasized that opportunities for spontaneous and self-directed creative expression is the primary source of intrapersonal and interpersonal growth and lasting change within an activity group format. The GAPT protocol allowed a minimum of 20 minutes for self-directed and group-directed activity during Sessions 2 through 6 to facilitate preadolescents' self-creative expression. Packman and Bratton (2003) emphasized that a humanistically-oriented group provides preadolescents a microcosm in which to experience self and others in genuine interactions that foster self understanding. Packman and Bratton posited additional benefits of

self-directed activity as providing preadolescents with opportunities to initiate contact, gain an enhanced understanding of self in relationship to peers, enhance social skills, learn self-control, confront difficulties that naturally emerge, problem-solve, make decisions, and perhaps most important, develop internal resources that they can draw on long after the group is over.

*Sessions 7 through 16.* The GAPT protocol offered guidelines for allowing self-directed activities to emerge naturally on the premise that once group members felt a sense of safety and acceptance and were comfortable with materials that semi-structured activities would become less needed. In the present study, by Session 7, all 10 groups seemed to be functioning with a felt-sense of safety, and the participants appeared comfortable with the spontaneous use of materials and toys as demonstrated by an increase in group-initiated activities. Thus, the remaining sessions followed a self-directed and group-directed process. No additional activities were offered by the therapist.

The GAPT intervention was provided by a doctoral level counselor who had received training and supervision in three play therapy courses and four advanced clinical courses including group play/activity therapy. For the purpose of supervision and treatment fidelity, all sessions were video recorded. Approximately 10% of sessions were randomly selected for viewing by a designated supervisor who was an expert in play therapy and group activity therapy. Through the video-recorded sessions and the use of the Group Play/Activity Skill Checklist (GPASC; Bratton, 2010), the supervisor provided on-going supervision to the GAPT counselor and ensured that the counselor was following GAPT protocol.

#### Active Control: Reading Mentoring

Reading mentoring (RM) was designated as the active control group to control for time and attention, rather than a comparison treatment. Thus, RM participants were offered the GAPT intervention after study completion. Students assigned to the active control participated



in RM for the same amount of time as students in the experimental group. Children received an average of 16 sessions over 10 weeks. Consistent with GAPT, RM sessions were held twice per week for 50 minutes per session. Five children received 15 sessions due to illness or change in class schedule. A graduate-level college student trained according to the reading mentoring Protocol used by Meany-Walen (2010) provided RM to participants (Appendix L). The mentor documented all sessions using the reading mentoring track form included in the protocol. A research supervisor observed all RM sessions and provided on-going supervision to mentor to ensure adherence to the reading mentoring protocol.

#### Data Collection

Teachers and housemothers completed the TRF and CBCL, respectively, for participating children prior to the study for screening and pretest purposes and again following the treatment period. I was available during collection of data to answer any questions. To assure integrity of data collection procedures, teachers and housemothers were provided a setting free from distractions in which to complete the assessments. All house mothers completed the assessments in the designated setting. However, due to scheduling and other time constraints not all teachers chose to complete assessments during the scheduled time, but stated that they understood the need to complete the forms in a quiet setting away from students. Teachers completed the TRF assessments during the fourth week of school, and at that time it was hoped that teachers would have had opportunities to build relationships with children and time to know children well enough to accurately rate problem behaviors. Time constraints prevented waiting longer to gather pretest data in order to complete the study prior to the end of the school term. Teachers and housemothers also provided the demographic data on each student.

## Data Analysis

To answer the research questions, combined between/within-subjects analysis of variance (ANOVA; i.e., split-plot analysis; Pallant, 2007) was used in data analysis. For each dependent variable, a two (group) by two (repeated measures) split plot ANOVA was performed in PASW statistics 18 to analyze group differences, changes across time, and possible interaction effect of group membership with change across time, which was of particular interest in this study. In the analysis, treatment group served as the between-subjects variable and time (pretest to posttest) served as the within-subjects variable. I ran separate analyses for the TRF Internalizing Problems, TRF Externalizing Problems, CBCL Internalizing Problems, and CBCL Externalizing Problems scales as dependent variables. The required assumption of sphericity was assumed, because there were only two points of measurement. Methodological assumptions that accompany split-plot ANOVA were considered and evaluated (Armstrong & Henson, 2005). A more conservative *a priori* alpha level of .025 was established as the criterion for determining statistical significance to avoid Type 1 error resulting from multiple hypotheses testing (Thompson, 2002). Effect size was reported according to partial eta-squared and interpreted according to Cohen's (1988) guidelines of .01 as a small effect; .06 as moderate effect; .14 represents a large effect and used to assess the practical significance of the findings (Cohen, 2002; Sink & Stroh, 2006). A power level of .80 was established as criterion for determining adequate power (Balkin & Sheperis, 2011).

## Results

### Internalizing Problems

Table 1 presents the pretest and posttest means and standard deviations for the experimental group ( $n = 30$ ) and control group ( $n = 30$ ) on the Internalizing Problems scale of the TRF and CBCL.

Table 1

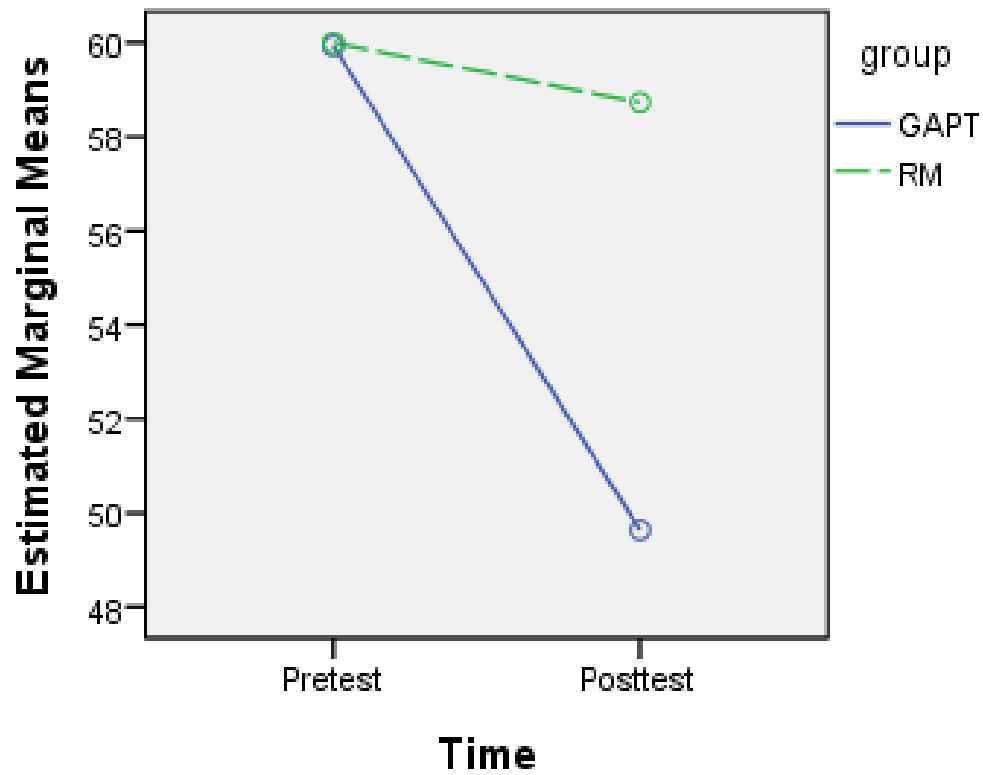
*Mean Scores of the Internalizing Problems Scales for the TRF and CBCL*

Instrument	<u>Experimental GAPT (<math>n = 30</math>)</u>		<u>Control RM (<math>n = 30</math>)</u>	
	Pretest	Posttest	Pretest	Posttest
TRF Internalizing				
Mean	59.930	49.630	60.000	58.730
<i>SD</i>	8.288	7.449	10.147	10.130
CBCL Internalizing				
Mean	62.500	52.070	62.03	62.730
<i>SD</i>	11.401	8.554	8.438	11.441

*Note.* Decreases in mean scores indicated improvements in behavior.

*TRF Internalizing Problems.* A mixed between-within subjects (split-plot) ANOVA was conducted to examine the impact of the two different interventions (GAPT, RM) on participants' scores on the TRF Internalizing Problems across two time periods (pretest and posttest). Results indicated significant interaction between treatment group and time with Wilks' Lambda = .787,  $F(1, 58) = 15.720$ ,  $p < .001$ , partial  $\eta_p^2 = .213$ . These results indicated that according to teacher report, orphaned children who participated in the experimental group (GAPT) demonstrated a statistically significant decrease in internalizing problems from pretest to posttest, when compared to students who were in the active control group (RM). Results further showed that GAPT demonstrated a large treatment effect ( $\eta_p^2 = .213$ ) on student's internalizing problems when compared to the RM group (Figure 1). Post hoc power analysis revealed an observed power of .974.

### TRF Internalizing Behavior Problems Mean Scores



*Figure 1.* Mean scores for TRF Internalizing Problems scale.

*CBCL Internalizing Problems.* Results of the split-plot ANOVA on the Internalizing Problems scale of the CBCL revealed a statistically significant interaction effect between treatment group and time with Wilks' Lambda = .756,  $F(1, 58) = 18.697$ ,  $p < .001$ , partial  $\eta_p^2 = .244$ . Results indicated that according to housemother reports, students who participated in the experimental group (GAPT) showed a statistically significant decrease in internalizing problems from pretest to posttest when compared to students who were in the active control group (RM). Using Cohen's (1998) guidelines, results showed that GAPT intervention demonstrated a large treatment effect ( $\eta_p^2 = .244$ ) on students' internalizing behaviors in comparison to the RM group (Figure 2). Post hoc power analysis revealed an observed power of .989.

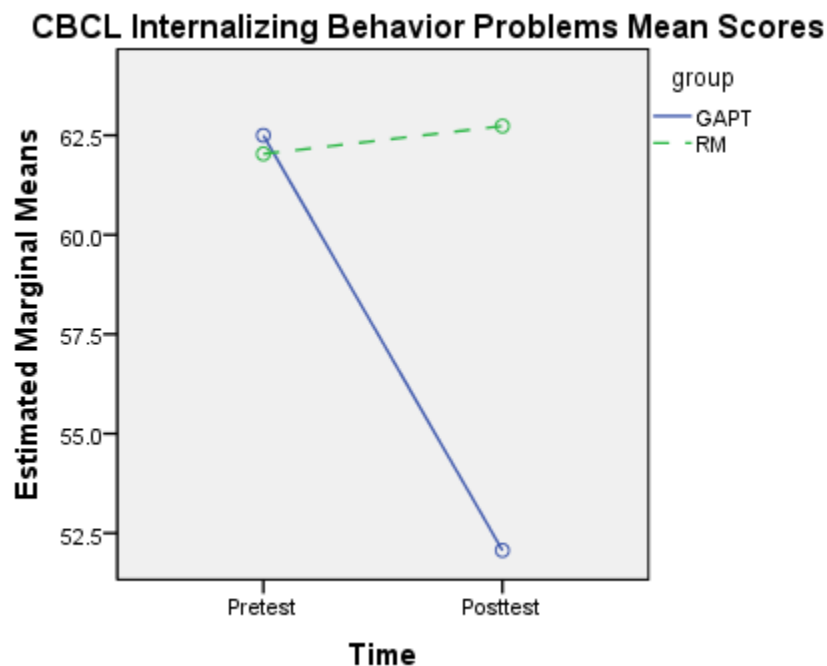


Figure 2. Mean scores for CBCL Internalizing Problems scale from pretest to posttest.

#### Externalizing Problems

Table 2 presents the results of the pretest and posttest means and standard deviations for the experimental ( $n = 30$ ) and control group ( $n = 30$ ) on the externalizing problems scale of the

TRF and CBCL.

Table 2

*Mean Scores of the Externalizing Problems Scales for the TRF and CBCL*

Scale	<u>Experimental GAPT (<math>n = 30</math>)</u>		<u>Control RM (<math>n = 30</math>)</u>	
	Pretest	Posttest	Pretest	Posttest
TRF Externalizing				
Mean	63.800	53.700	64.630	61.070
<i>SD</i>	8.616	7.548	10.046	8.630
CBCL Externalizing				
Mean	64.130	55.930	66.470	66.530
<i>SD</i>	12.470	10.954	7.167	8.072

*Note.* A decrease in mean scores indicates an improvement in behavior.

*TRF Externalizing Problems.* Results of the split-plot ANOVA on the Externalizing Problems scale of the TRF revealed a statistically significant interaction effect between treatment group and time with Wilks' Lambda = .879,  $F(1, 58) = 8.01$ ,  $p < .006$ , partial  $\eta_p^2 = .121$ . Results revealed that students who participated in the experimental group (GAPT) showed a statistically significant decrease in externalizing behaviors compared to students in the active control group (RM). Also, teachers indicated that GAPT had a moderate effect ( $\eta_p^2 = .121$ ) on externalizing behavior problems of children who participated in GAPT treatment as compared to children who participated in RM (Figure 3). Post hoc power analysis revealed an observed power of .795.

### TRF Externalizing Behavior Problems Mean Scores

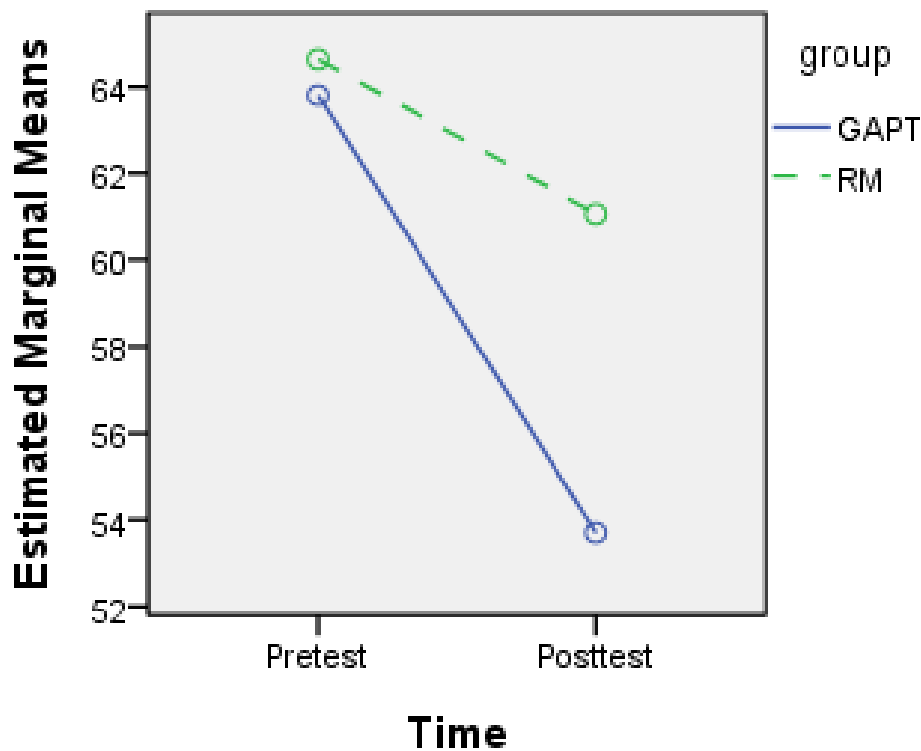
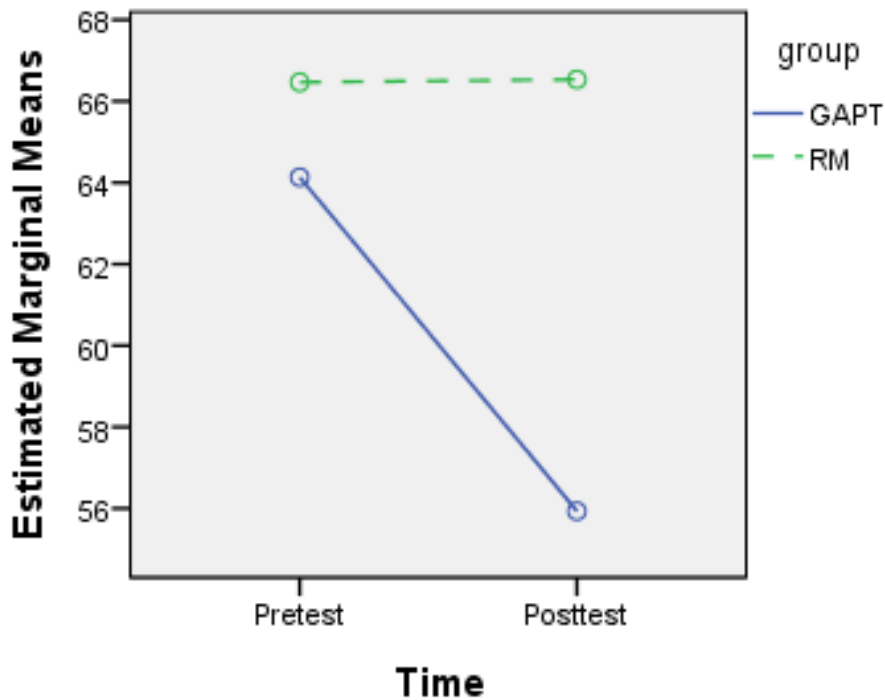


Figure 3. Means of the TRF Externalizing Problems scale for GAPT and RM at pretest and posttest.

*CBCL Externalizing Problems.* A visual inspection of means suggested a possible difference in the groups at pretest. Results from a one-way between groups ANOVA to compare pretest means revealed no statistically significant difference,  $F(1, 58) = .790, p = .379$ . Thus, I proceeded with the split-plot ANOVA as planned. Results of the split-plot ANOVA on the Externalizing Problems scale of the CBCL revealed a statistically significant interaction effect between group and time with Wilks' Lambda = .783,  $F(1, 58) = 16.118, p = <.001$ , partial  $\eta_p^2 = .217$ . Results demonstrated that children who participated in GAPT showed a statistically significant decrease in externalizing behaviors compared to students' in the active control group (RM) as reported by house mothers. In addition, housemothers indicated that the GAPT treatment had a large effect ( $\eta_p^2 = .217$ ) on the externalizing behavior problems of children who participated in the experimental GAPT group as compared to children who received RM (Figure 4). Post hoc power analysis revealed an observed power of .977.



### CBCL Externalizing Behavior Problems Mean Scores



*Figure 4.* Means of CBCL Externalizing Problems scale for GAPT and RM at pretest and posttest.

#### Clinical Significance

Clinical significance refers to practical value of treatment on client's functioning in real life (Kazdin, 2003). To ascertain if GAPT treatment modality positively impacted children, the number and percentage of participants who moved from clinical or borderline levels of behavioral problems to normal functioning were used as an indicator of the clinical significance of group activity play therapy intervention on the lives of participants (Kazdin, 2003). Using clinical/borderline cut off scores identified by the TRF and CBCL, individual participants who scored at clinical level at pretest on the Internalizing Problem Behavior scale or Externalizing Problem Behavior scale were tracked for progress to establish movement toward nonclinical scores at posttest. According to Achenbach and Rescorla (2001), normal range is considered to

be  $T$  scores below 60, borderline clinical range is fixed at  $T$  scores of 60 to 63 (approximately the 84th through 90th percentiles), and the clinical range at  $T \geq 64$  for Internalizing, Externalizing, and Total problems on the TRF and CBCL.

*Internalizing Problem Behavior Outcomes.* Participants'  $T$ -scores on the Internalizing Problem Behaviors scale on the TRF and CBCL were examined to establish the clinical significance of GAPT on children's behavior. According to teacher ratings for Internalizing Problem Behaviors on the TRF at pretest, 33 students ( $GAPT = 16$ ;  $RM = 17$ ) were identified at borderline or clinical range at pretest. Of the 16 children (clinical = 9, borderline = 7) in the treatment group who presented in the borderline and clinical range, 12 moved to normal functioning levels after treatment, 2 moved from clinical to borderline, 1 remained at borderline level, and 1 child stayed in clinical level. Thus, of the 16 children in the GAPT group demonstrating clinical functioning levels of internalizing behavior problems as reported by teacher prior to treatment, 12 out of 16 (75%) identified at normative functioning levels at posttest.

A total of 40 students ( $GAPT = 19$ ;  $RM = 21$ ) were identified by housemothers on the Internalizing Problem Behaviors scale of the CBCL at pretest as demonstrating clinical or borderline clinical levels of concern. At posttest, of the 19 children (clinical = 17, borderline = 2) who received GAPT treatment, 14 moved to normal functioning level, 2 moved from clinical to borderline, 1 remained at borderline level, and 2 stayed in the clinical level with an average of a 10-point decrease in their scores. Hence, of the 19 participants in the GAPT group who demonstrated clinical functioning levels of internalizing behavior problems as reported by housemothers prior to treatment, 14 out of 19 (74%) identified at normative functioning levels at posttest.

*Externalizing Problem Behavior Outcomes.* At pretest, a total of 42 students (GAPT = 21, RM = 42) were rated by teachers as showing clinical/borderline levels of functioning on the Externalizing Problems scale of the TRF. Of the 21 students who presented in the clinical range, after GAPT treatment, 13 moved to normative functioning, 3 moved to borderline, 2 remained at the borderline range, and 3 remained at the clinical level. Thus, of the 21 children in the GAPT group who presented in the clinical range prior to treatment, 13 (70%) moved to the normal range of functioning after their participation in GAPT.

An examination of data indicated that 48 students (GAPT = 23, RM = 25) scored at clinical/borderline levels on the Externalizing Problems scale of CBCL as rated by house mothers. At posttest, of the 23 children in the GAPT group who presented in the clinical range, 13 moved to normative functioning, 2 moved to borderline, and 8 remained at clinical level with an average of a 5-point decrease in their clinical scores. Hence, of the 23 children in the GAPT group who presented in the clinical or borderline range prior to treatment, 13 (57%) moved to normative functioning after their participation in GAPT.

### Discussion

Based on the results of this study, GAPT demonstrated positive treatment effects with orphaned Ugandan preadolescents exhibiting behavioral problems. Data analyses revealed that teachers and housemothers reported statistically significant improvement on internalizing and externalizing behavioral problems for preadolescents who participated in GAPT over children who received reading mentoring. Overall, the results from the present study were consistent with findings from Bratton et al.'s (2005) meta-analysis which showed that play therapy demonstrated a large treatment effect on children's internalizing behavior problems and on children's externalizing behavior problems and that humanistic child interventions demonstrated a large effect size.

## Effects on Internalizing Problem Behaviors

Teachers and house mothers reported a significant decrease in internalizing behavior problems among preadolescents who received GAPT compared to those who received RM. Findings further showed that the GAPT group demonstrated a large treatment effect. Findings were consistent with earlier outcome studies which showed that similar group play-based interventions were effective treatments for preadolescents with internalizing behavior problems (Flahive & Ray, 2007; Packman & Bratton, 2003). The current findings were strengthened by the fact that both house mothers and teachers reported a statistically significant therapeutic impact for GAPT on preadolescents' internalizing problems. Similarly, Packman and Bratton (2003) found consistently statistically significant results between parents and teachers, whereas Flahive and Ray (2007) differed in that teachers reported statistically significant between group differences in the internalizing behaviors of fourth and fifth graders while parents reported changes that were not statistically significant. Outcome results for the present study were also similar to findings from controlled studies following CCPT protocol in which play therapy demonstrated positive outcome with an ethnic minority population of children exhibiting internalizing behavior problems (Garza & Bratton, 2005) and children with a trauma history (Tyndall-Lind, Landreth, & Giordano, 2001).

Consistent with child centered principles, the GAPT counselor established a group climate characterized by acceptance, empathic understanding, and genuineness. Expression of these attitudes within a supportive group climate may have allowed preadolescents to experience these attitudes as activators of change (Ray, 2011). In addition, the experimental group preadolescents were offered varied materials chosen for developmental responsiveness and opportunity for creative self-expression (Bratton & Ferebee, 1999; Ginott, 1994; Kottman et al., 1987). In traditional Ugandan culture free expression of negative feelings and emotions is

discouraged including internalized feelings such as sadness, grief, and depression that result from traumatic or devastating experiences. Thus, provision of varied expressive media during the GAPT intervention along with therapeutic conditions associated with CCPT seemed to provide participants with a safe, permissive, and developmentally responsive means to express and work through previously internalized feelings. Specifically, the inclusion of traditional African musical instruments seemed to facilitate expression of difficult emotions through music. The use of music, rhythm and dance is a customary and important means of expressing emotions in African culture. Other African materials that were used extensively by the children to express themselves in their therapeutic journey included beads and collage materials, especially fabrics.

Findings demonstrated particular significance for the population studied in view of research that has shown that internalizing problems such as depression, anxiety, and sadness are the most often reported disorders in orphaned children in Uganda (Atwine et al., 2005; Cluver & Gardner, 2007; Musisi et al., 2007). The present study appears to be the first of its kind and offers promise as a solution to preventing the unnecessary suffering of preadolescent orphans.

#### Effects on Externalizing Problem Behaviors

Both teachers and housemothers reported statistically significant improvements in the experimental group's externalizing problems as compared to the active control group. In examining the practical significance of results, housemothers' reports showed a stronger effect size ( $\eta_p^2 = .217$ ) for the experimental treatment when compared to the active control than did the teachers' reports ( $\eta_p^2 = .121$ ). However, in examining outcomes for individual children, clinical significance findings indicated that teachers saw improvements in the day-to-day functioning of more children (70%) than did housemothers (57%). Nonetheless, the majority of orphaned children receiving GAPT moved from the clinical level of externalizing behavioral concerns to

normal levels of functioning following treatment. Findings were consistent with previous controlled outcome studies which showed that similar group play-based interventions had moderate to large treatment effects for preadolescents exhibiting externalized behavior difficulties (Flahive & Ray, 2007; Packman & Bratton, 2003). Interestingly, both Packman and Bratton (2003) and Flahive and Ray (2007) reported differences between parent and teacher perceptions of externalized behaviors according to their reports at posttest.

Outcome results for the present study are also similar to findings from controlled studies following CCPT protocol in which play therapy demonstrated positive outcomes on externalized problems of children (Flahive & Ray, 2007; Garza & Bratton, 2005; Kot, Landreth, & Giordano, 1998; Ray et al., 2007, 2009; Tyndall-Lind et al., 2001). Both Ray et al. (2009) and Tyndall-Lind et al. (2001) attributed the decline in aggressive behavior to an increased experience of empathy within the CCPT context and the provision of materials which allowed children to express aggressive feelings and behavior. Similarly, in the present study, materials were selected to facilitate expression of a range of feelings which might have helped group members to develop their capacity to express themselves in socially appropriate ways.

Additionally, the findings were consistent with group counseling literature which suggested the importance of a group format for preadolescents exhibiting aggression and difficulties in relationships (Akos et al., 2007). Not only were the findings regarding GAPT's effectiveness on externalized problems of displaced children promising, the present study appears to be the first of its kind to respond to the call by Ugandan researchers to identify mental health services for orphaned children who tend to display high levels of aggression, conduct problems, and relationship difficulties (Atwine et al., 2005; Doku, 2007).

## Limitations of the Study

The sample size was small and recruited from a single geographic area, limiting the generalization of the results to other children living in other contexts. A larger sample selected from multiple sites would strengthen generalizability of outcomes. Replication would add to the reliability of the current findings.

Research procedures were structured to minimize the possibility of teachers or housemothers being aware of participant's treatment groups. However, it was difficult to completely control for teachers and housemothers' recognition of children's group assignments. For example, researchers could direct treatment facilitators not to discuss the study with teachers but could not control for what participants might say to their teachers or housemothers. In addition, several children in the experimental condition took their expressive arts creations with them at the end of their group sessions. The study population had a history of extreme deprivation which may have influenced what appeared to be a strong, but unanticipated, need for some preadolescents in the experimental group to take their creations with them. Future research designs with this population should consider a comparison group treatment that used art materials. The possibility of teachers or house mothers discovering children's group assignments may have affected their judgements and perceptions of the participants, although it is important to note that teachers and housemothers viewed reading mentoring as a valuable intervention for these children.

Finally, although the literature supported the positive impact of mentoring on children's behaviour (Cavell, Elledge, Malcolm, Faith, & Huges, 2009), study rigor would have been increased by the use of a comparison treatment with an evidence base to support its use with children with behavioral problems. Replication of this research with a larger sample in a multi-site setting and compared to a well-established child counseling intervention, particularly one

that involved some type of art materials, would answer the majority of the study's limitations and is needed to provide a strong evidence base for GAPT with this population.

#### Implications for Future Practice and Research

Although the outcome of this study showed positive support for the effects of GAPT on the behavioral problems of orphaned youth in Uganda, further research in this area is needed in order to offer this intervention as an evidence-based practice for similar populations of troubled preadolescents. Proponents of evidence based treatments have advocated for the identification of specific populations and disorders in order to draw conclusions about treatment effects (Chambles & Hollon, 1998). Even though this study was focused on a very specific population of children, orphaned Ugandan preadolescents exhibiting clinical externalizing and internalizing behavior concerns, future studies could explore more specific diagnosis or symptom categories.

This research study presented promising results regarding application of a child-centered approach to GAPT in a real world setting and advanced support for the effectiveness of this intervention in reducing behavioral problems with preadolescents. However, the study did not include an examination of the process of change, which suggests a possible direction for future research on child-centered GAPT. The use of a controlled, pre-post research design with randomization of participants contributed to the strength of findings on GAPT's treatment effects. Time constraints did not allow for administration of follow up assessments to establish sustainability of treatment benefits, thus incorporating methods for follow up would strengthen future GAPT outcome research.

Drawing on research findings regarding the strong treatment effects for training parents and teachers in CCPT (Bratton, Landreth, & Lin, 2010), researchers should consider an investigation of a similar model for training important caregivers in GAPT. Such a model would seem particularly valuable for orphaned children. A noteworthy observation in this research



project was caregivers' reports of feeling more bonded to children who received GAPT, which could have been due to the children's demonstrating greater empathy toward housemothers. The caregiver-child relationship and attachment behavior were not measured as variables in this study; however, informal observations of possible effects point to another research area to explore for benefit of orphaned children.

A noteworthy observation made through conducting this research was that preadolescents tended to select different media as sessions progressed. Interestingly, their selections were consistent with recommendations provided by Bratton et al. (2009) and Landgarten (1987) on movement from media with most control to least control. Given that observation, counselors working with preadolescents should consider providing varied, expressive media to meet this age group's developmental and therapeutic needs.

Based on the study outcomes, orphaned preadolescents benefitted from experiencing acceptance and empathic understanding inherent in a child-centered counseling relationship. This finding offered practical implications for child counselors in Uganda. Communication of acceptance, along with materials that fostered symbolic expression, seemed to have encouraged exploration of issues that were most meaningful for the preadolescents in this study including religious and spiritual beliefs. In traditional Ugandan culture just like in other African societies, religion and spirituality are embedded in the human existence (Ahia, 2006) and viewed as an essential part of their support and coping process. Thus, counselors who work with this population are encouraged to provide an environment that communicates acceptance of Ugandan values and promotes free expression.

Another notable observation was participants' expression of negative feelings such as aggression and anger. The expression of negative feelings is typically not encouraged in Ugandan societies. Again, the provision of the therapeutic conditions of CCPT, including

acceptance of all feelings and acceptable outlets for expressing them, seemed to encourage participants to express their negative feelings in safe and acceptable ways.

Although empathy was not a variable measured in this study, I noticed that participants expressed increased empathy toward each other in group as sessions progressed. As therapist experienced and communicated acceptance and empathic understanding of children during GAPT intervention, preadolescents seem to experience feeling understood and cared about and thus able to extend empathy to other group members. A related and unexpected happening was the housemothers' reports of preadolescents showing increased empathy toward them. Further, I observed what appeared to be a relationship between group members' demonstrations of empathy with each other and their increased exploration of personal difficulties as they processed or shared their expressive arts creations. While these observations are not substantiated by data, they do lend credence to the use of a child-centered approach and bear further investigation.

### Conclusion

The outcome of this research project revealed that 16 sessions of GAPT demonstrated a beneficial therapeutic effect on orphaned preadolescents exhibiting significant behavioral concerns. Reports from both housemothers and teachers indicated that they noticed a marked improvement in the internalizing and externalizing behavior problems of children receiving group activity/play therapy when compared to the group who received reading mentoring. The majority of individual participants receiving GAPT moved from clinical levels of behavioral concern to normal functioning indicating the clinical utility of the intervention on the day-to-day functioning of troubled orphans. Findings further suggested that GAPT is responsive to the developmental and cultural needs of Ugandan preadolescents residing in a large children's village. Results of this study are promising, particularly in light of the critical need to identify

effective interventions for displaced children living in Ugandan orphanages. Moreover, this study appears to be the first of its kind to be carried out in Uganda. In fact, a thorough review of literature revealed no well-designed controlled outcome studies examining any mental health intervention for orphaned children or preadolescents. A major strength of the study was due to it being conducted in the real world setting of the school, adding to its relevance for this population and its potential for replication.

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APPENDIX A  
EXTENDED INTRODUCTION

Recent reports (e.g., *Children on the Brink*; UNAIDS, 2004; UNICEF, 2006) have indicated that Africa has the greatest population of orphaned children in the world, estimated at 48 million. Both UNAIDS (2004) and UNICEF (2006) cautioned that despite the increasing number of orphans, there was negligible response to the orphaned children's mental health needs. Urgent concerns about the socio-economic needs of orphaned children in Africa in the last decade overshadowed the psychological impact of orphanhood (Atwine et al., 2005).

Uganda has been particularly plagued by armed conflict, HIV/AIDS and other diseases that have led to a proliferation of internally displaced children. Displaced orphans are children who have been forced, as a result of war, death of family members, or natural disaster, to leave their original settlement areas and homes. As estimated 2.3 million children, which constitutes 14 % of Uganda children, are orphans (UNICEF, 2006). The significance of this statistic is highlighted by the fact that 50% of Uganda's population is made up of children under 15 years of age (Uganda Bureau of Statistics, 2006). The rapid increase in number of parentless children has resulted in a corresponding rise in the number of children living in orphanages (Ministry of Gender, Labour, and Social Development, 2004; Uganda Bureau of Statistics, 2006; Wakhweya et al., 2002). However, orphanages have been unable to provide for the attachment, social integration, and acculturation needs of the orphaned children in their care (Wakhweya et al., 2002).

A paucity of studies conducted with displaced orphan children were found in the literature. The few studies available were mainly focused on identifying mental health problems and symptoms expressed by displaced orphaned children and offered limited attention to interventions (Atwine et al., 2005; Betancourt et al., 2009; Derluyn et al., 2004; Gupta, 2000; Morgos et al., 2007; Musisi et al., 2007; Pfefferbaum et al., 2008; Yule, 2000; Wolff & Fesseha, 1999, 2005). Researchers identified a host of emotional and behavioral symptoms exhibited by

displaced orphans including anxiety, developmental delays, sleep disturbances, behavioral problems, social isolation, depression, sadness, hopelessness, suicidal ideation, decreased interest in activities, and learning difficulties (Atwine et al., 2005; Musisi et al., 2007; Harms et al., 2010; UNICEF; 2006; Wakhweya et al., 2002). Children living in orphanages face additional stressors as a result of being isolated from their families and communities and face further challenges associated with being forced to adjust to life with new caregivers (Wakhweya et al., 2002). Wakhweya et al. emphasized the magnitude of the problem.

The dire need for psychological services in the on-going efforts to help Ugandan orphans has been widely recognized, but remains largely overlooked due to the greater focus on services related to socioeconomic need (Atwine et al., 2005; Musisi et al., 2007; Harms et al., 2010; UNICEF; 2006; Wakhweya et al., 2002). Wakhweya et al. (2002) found that only 9% of the institutions they surveyed provided care for orphans that included some form of counseling services. On a positive note, Wakhweya et al. found that 87% of orphans were attending school, with the greatest proportion of orphans in primary Grades 1 through 5. Thus, schools have the potential to play an active role in providing developmentally responsive interventions to meet the growing mental health needs of orphans in Uganda.

Child-centered play therapy (CCPT) is a developmentally sensitive intervention that has been successfully applied in schools in the United States to address children's early mental health concerns (Bratton, 2010). Numerous controlled outcome studies, the majority of which were school-based, have demonstrated CCPT's effectiveness as a developmentally and culturally responsive intervention for treating varied social, emotional, behavioral, and learning difficulties experienced by children (Bratton & Ray, 2000; Bratton et al., 2005; Ray & Bratton, 2010). However, limited research has been conducted on the effects of play therapy with preadolescent children. Of the few well-designed, preliminary studies conducted with preadolescents, a group

play/activity-based approach has been shown effective as a developmentally responsive intervention to meet the mental health needs of this population (Flahive & Ray, 2007; Packman & Bratton, 2003; Shen, 2003, 2007; Shen & Armstrong, 2008).

#### Statement of the Problem

Without treatment, behavior problems exhibited by orphans have been predicted to lead to more serious behavior problems across their lifespan and a resulting negative impact on Uganda's social and economic development. A key priority policy for Uganda, as stated by Ministry of Gender, Labour, and Social Development (2004), is that mental health services must be provided to orphans. Given the magnitude of the rapidly increasing orphan problem in Uganda and the absence of interventions for problem behaviors exhibited by preadolescents, group activity play therapy (GAPT) offers promise as an intervention to meet the mental health needs of orphans. The few well-designed, controlled studies investigating treatment modalities with preadolescents identified in the literature were conducted in the United States (Flahive & Ray, 2007; Packman & Bratton, 2003; Shen & Armstrong, 2008). A review of the literature revealed no controlled outcome studies had been conducted with a population of children living in orphanages in Uganda.

#### Purpose of the Study

The overarching aim of this study was to identify an effective school-based mental health intervention that was developmentally and culturally responsive to the needs of a growing population of displaced Ugandan children living in orphanages. Specifically, the purpose of this pilot study was to explore the effectiveness of group play activity therapy (GAPT) as a treatment for preadolescent orphans in Uganda exhibiting significant behavioral problems. Two main questions were of concern in this study: (1) Will GAPT decrease internalizing problems of orphaned preadolescent students living in Uganda when compared to reading mentoring (RM)?



(2) Will GAPT decrease externalizing problems of orphaned preadolescent students living in Uganda when compared to reading mentoring (RM)?

APPENDIX B  
EXTENDED LITERATURE REVIEW

In this appendix, literature addressing the topics of displaced orphaned children, preadolescence and developmental needs of preadolescents, group activity play therapy, and group play and activity therapy research on internalizing and externalizing behaviors is presented. The chapter ends with a conclusion about the literature.

### Displaced Orphaned Children

Displaced orphans are children who have been forced, as a result of war, death of family members, or natural disaster, to leave their original settlement areas and homes and to live in orphanages. The number of displaced orphaned children has continued to grow with a lack of mental health professionals available to work with this population (Machel, 1996; UNGASS, 2010; UNICEF, 2003, 2006). This section provides a synthesis of relevant literature and research related to displaced orphan children. In a United Nations sponsored study on the impact of armed conflict on children, Machel (1996) noted that displaced orphaned children faced ongoing risks of interminable exposure to violence and persecution. Machel found that the breakdown of traditional support systems contributed to the emergence of orphanages. Additionally, Machel and Wakhweya et al. (2002) found that orphanages lack the resources necessary to meet the children's mental health, socio-emotional, and intellectual needs.

### Emotional and Behavioral Problems of Displaced Orphaned Children

The literature presented a few studies about psychological experiences of orphaned children in Africa. Focus has been shifting in the past few years from mainly an emphasis on the socioeconomic impact of AIDS and armed conflict on orphaned children to psychological impact which has been overshadowed by the socioeconomic concerns (Atwine et al., 2005). Also, studies identifying experiences of orphaned children have mainly focused on children orphaned by AIDs and armed conflict in Africa.

In 2007, Cluver and Gardner conducted a review of 23 studies examining mental health of children orphaned by AIDS. Cluver and Gardner reviewed research conducted in 24 studies worldwide, with 19 in Africa, on the mental health of children orphaned by AIDS. Cluver and Gardner found that significant internalizing problems in orphaned children were reported in 16 out of 19 studies which measured them, and significant externalizing problems were found in 5 out of 10 studies which examined them. Findings from the review revealed that orphaned children experienced high levels of psychological distress. A further finding of the review was that there was dearth of studies reporting interventions for orphaned children beyond the investigation of psychological distress. Cluver and Gardner recognized the importance of exploring interventions to improve children's outcomes. Examination of studies which have investigated psychological problems of orphaned children provides insight into designing interventions that may improve child based research and outcomes for orphaned children. Although Cluver and Gardner presented a review of 19 studies conducted in Africa, they cautioned about assuming the generalizability of findings due to the diversity of the social, cultural, and economic situations in Africa. In view of Cluver and Gardner's caution a few studies conducted in Uganda and other African countries are reviewed.

Musisi et al. (2007) investigated the emotional and behavioral problems of 210 orphans and 210 non-orphans in Uganda. Participants were primary school going children from third through seventh grades. Musisi et al. noted that majority of orphans were aged 10 to 13 years, and constituted 72% of the orphan population in the study. By highlighting the high percentage of orphaned children aged 10 to 13 years, findings suggested that preadolescents might need to be prioritized in provision of interventions. Musisi et al. specifically measured children's emotional and behavioral problems, social functioning, and school achievement and found that more orphans compared to non-orphans expressed emotional and behavioral problems including

depression, anxiety, suicidal ideation, and use of alcohol. Similarly, qualitatively, teachers, children, and care givers described orphans as compared to non-orphans as sad, withdrawn, showing reduced confidence, and lacking in self-esteem. Regarding social functioning, Musisi et al. found a statistically significant difference between orphans and non-orphans with orphans rated as worse in social functioning. Researchers noted that children's academic performance was related to emotional and behavioral problems. Children with significant psychological problems were rated as low achievers/low academically. The authors concluded that orphans' problems which were primarily psychological were impacting children's social and academic growth with no counseling available in the school and recommended provision of counseling services since there were no counselors in the schools. Developmentally appropriate counseling interventions facilitate working through psychological difficulties for children, indicating need for counseling in settings with orphans.

In a related earlier study, Atwine et al. (2005) examined the mental health problems exhibited by primary school children aged 11 to 15 years old and orphaned by AIDS in a rural district in Uganda and explored areas for potential intervention. Participants included 123 children orphaned as a result of AIDS and 110 children who were non-orphans. Atwine et al. found that orphans scored significantly higher on anxiety, depression, and anger than non-orphaned children. Also, Atwine et al. noted that orphans scored significantly higher scores on items on the Beck Youth Depression Inventory that are considered possible indicators of potential existence of a depressive disorder included feelings of hopelessness and suicidal ideation. The authors concluded that although material support was being provided to orphans, incorporation of interventions responsive to their psychological well-being needed to be included as one of the top priorities to attain the sustainable recovery of orphaned children. Again, just like in Musisi et al.'s (2007) study, Atwine et al. provided valuable information on experiences

of orphaned preadolescents which provides a framework for research into interventions for this population.

Doku (2009) investigated the psychological wellbeing of orphans, non-orphans, and children living with parents infected with HIV/AIDS. Using the Strengths and Difficulties Questionnaire, Doku measured hyperactivity, emotional, conduct, and peer problems in 200 children. Doku found that orphaned children scored significantly higher on conduct problems, relationship difficulties, and emotional problems. Doku concluded that there was indication that orphan hood was associated with increased internalizing problems in children. Again, like Atwine et al. (2007), Doku recognized that orphaned children's mental health problems needed to be addressed in addition to identification of psychological needs for this population. However, Doku did not provide any suggestions of potential interventions.

Arnab and Serumaga-Zake (2006) investigated the plight of children orphaned by AIDS in Botswana. They found that the percentage of orphans was highest for children aged 10 to 14 years old and cautioned that this age group was at higher risk of contracting HIV compared to other age groups. In addition, Arnab and Serumaga (2006) noted that children were most likely to become orphaned during the ages of 10 to 14 years. Also, Arnab and Serumaga strongly recommended that interventions needed to be provided for orphaned children. Given the high vulnerability of children aged 10 to 14 years, Arnab and Serumaga (2006) recommended that interventions targeted for this age group needed to be prioritized. Clearly, delineation of experiences of orphaned preadolescents by researchers (Arnab & Serumaga, 2006; Atwine et al., 2005; Doku, 2009; Musisi et al., 2007) suggested that a logical progression might be intervention research targeting this population.

Stein et al. (1999) investigated displaced children's mental health problems in wartime Bosnia and used a sample of 304 children aged 5 to 12 years old, with 54 % ( $n = 157$ ) girls and

46% ( $n = 147$ ) boys. Using a cartoon self-report instrument with the children, Stein et al. concluded that displaced and orphaned children residing in refuge centers in Bosnia expressed significant posttraumatic stress, anxiety, depression, sadness, emotional numbing, hyper arousal, and intrusive thoughts. Stein et al. found that the trend of children's trauma-related symptoms differed by age in boys and girls and suggested that the optimal timing of interventions may be different for boys than for girls.

In a recent qualitative study of mental health problems among orphaned children displaced by war in Uganda, Betancourt et al. (2009) used a rapid assessment approach to interview caretakers and children aged 10 to 17 years. Betancourt et al. interviewed 31 children, aged 10 to 17 years, and 15 adults, mostly care givers, regarding the major observed mental health problems. Betancourt et al. reported that the mental health problems noted in the children included anxiety, depression, conduct problems, diminished interest in activities, fatigue, feelings of worthlessness, difficulties in concentration, suicidal ideations, and aggressive behavior. They found the rapid ethnographic assessment allowed the participants to identify mental health concerns from their local perspectives. Similar to other studies, Betancourt et al. focused on experiences of orphaned and displaced preadolescents and young adolescents.

In a study of psychological reactions of displaced and orphaned Kuwait children, Al-Elssa (1995) observed children showing symptoms of tension, anti-social behavior, behavior problems, difficulties with concentration, distractibility, shouting, destructivity, depression, aggressive or regressive behavior, over dependency, unhappiness, withdrawal, difficulty sleeping, nightmares, and suspicious attitude. Al-Elssa had a randomly selected sample of Kuwait children broken into two groups: experimental and control. The experimental group was composed of 106 children displaced from Kuwait who were aged 7 to 14 years and residing in two places. The experimental group mean age was 10.1 years, and 48% were boys and 52%

girls. The control group sample included 102 Kuwait children with a mean age of 10.4 years, and 55% were boys and 45% girls. Al-Elssa studied the symptoms of psychological distress expressed by the children according to age and gender; however, Al-Elssa focused on the identification of the symptoms of psychological distress and did not provide suggestions for treatment for the presenting problems of the displaced children. Al-Elssa showed for 68 of the children who were aged 7 to 10 years, bedwetting, indifference, and nagging behaviors were reported more frequently.

Derluyn et al. (2004) explored symptoms of traumatic stress expressed by displaced and orphaned child soldiers in Uganda. Derluyn et al. interviewed 301 former child soldiers, all above 12 years old, and randomly selected 71 of the children to complete the Impact of Event Scale Revised (IES-R) instrument. The authors found that children had high rates of posttraumatic symptoms and focused on identification of clinical indicators of psychological distress with no suggested intervention.

Paardekooper (1999) conducted an exploratory study into the experiences of displaced and orphaned Sudanese children. Paardekooper used six questionnaires as instruments to identify the experiences of 345 displaced and orphaned children aged 7 to 12 years. Paardekooper reported that the displaced children experienced significant posttraumatic stress, behavioral problems, and depressive symptoms.

In a related study in Southern Sudan, Morgos et al. (2007) investigated the psychological effects of war experiences on 331 displaced and orphaned children aged 6 to 17 years old in Southern Darfur. Participants were administered three instruments that had been translated into the local language. For the translations, the contextual meaning of the items had been reviewed prior to the instruments' administrations. Morgos et al. reported that mental health problems expressed by the children identified in the study-included depression, traumatic grief, PTSD



symptoms, intrusion, and avoidance. From the data, authors found significant gender differences in how trauma reactions were observed. Girls reported more severe levels of traumatic reactions than boys. However, authors focused on the identification of symptoms of psychological distress and suggested no interventions. In writing about experiences and needs of displaced orphaned children in Bosnia, Yule (2000) surveyed nearly 3,000 school children of 9 to 14 years old affected by war and observed children uprooted from their homes showed unresolved grief reactions and displayed high risks for mental health problems.

#### Interventions with Displaced Orphaned Children

Wolff, Tesfai, Egasso, and Aradom (1995) conducted a comparison study of the social-emotional state and cognitive development between displaced Eritrean orphan children living in orphanages and refugee children living in families. Each group in this study had 74 children aged 4 to 7 years. Both groups of children had been exposed to war trauma. While Wolff et al. reported that the orphans performed better than the comparison group on cognitive tests, they attributed this cognitive testing difference to child-centered peer education services, which the orphans received in the orphanage. In addition, researchers found that the orphans showed more behavioral and emotional distress symptoms compared to the refugee children living with their parents. The prevalence of behavioral and emotional distress symptoms among displaced orphan children in Eritrea was consistent with similar findings in other studies that included depression and anxiety (Wolff & Fesseha, 1999) and adjustment difficulties and emotional distress (Wolff & Fesseha, 2005). Although the children in the local orphanage demonstrated expected levels of cognitive development, the need for an intervention to address their emotional and behavioral problems was still present.

Gupta (2000) explored psychosocial assessment of 315 displaced and orphaned children aged 8 to 17 years exposed to war related violence in Sierra Leone. Gupta expressed, in the

pretest findings, that children reported sleep disturbances, concentration problems, and anxiety about their future well-being. The posttest findings after the 4-week structured Rapid-Education Response (Rapid-Ed) Trauma Healing and Expression intervention indicated the children experienced significant reductions in the prevalence of intrusive recollections sleep disturbances, concentration problems, and anxiety about the future. The Rapid-Ed Trauma Healing and Expression intervention did not provide documentation of implementation, process, or activities used. Gupta did not report on the effect size; hence, ascertaining the practical effectiveness or clinical significance of the intervention is difficult at best.

Gupta and Zimmer (2008) conducted a study to assess the psychosocial status of displaced and orphaned Sierra Leone children enrolled in the Rapid-ED intervention. In the study, 315 displaced and orphaned children aged 8 to 17 years old were randomly selected to participate in the Rapid-Ed intervention, which combined basic education and trauma healing activities. During the intervention, eight 60 minute structured trauma-healing activities were implemented twice a week during each week of the 4-week intervention. At posttest interviews, Gupta and Zimmer found significant reductions in intrusion and arousal symptoms along with a slight increase in avoidance reactions. A significant reduction in concentration problems, sleep disturbances, and intrusive images after participating in the trauma healing and recreation activities was also observed. The study had no control group and ascertaining effectiveness is therefore difficult. The authors concluded the intervention was more effective in reducing the levels of intrusive images, and this finding could be used to explain the reported increase in avoidance reactions.

Bolton et al. (2007) conducted a study to investigate whether group interpersonal psychotherapy (GIP) and an activity-based intervention (Creative Play [CP]) were effective in relieving mental health and psychosocial problems that resulted from war and displacement

among adolescents. Using randomized, controlled trials, researchers used the interventions to treat depression symptoms with 314 displaced and orphaned adolescents aged 14 to 17 years old in northern Uganda. Bolton et al. assigned 105 adolescents to the GIP intervention group, 105 adolescents to the CP group, and 104 to the wait-list control group. Participants in both the GIP and CP interventions attended 16 weekly group meetings. The GIP intervention involved identification of interpersonal problems and assisting participants to build skills to manage those problems. CP was an activity based intervention in which participants were engaged in creative activities and discussions applied to life experiences. Findings revealed that girls undergoing the GIP intervention showed a significant reduction in depression symptoms compared to girls in the other groups. However, boys did not experience a reduction in depression symptoms. The authors reported that the CP intervention had no effect on depression severity. Also, there were no statistically significant improvements in anxiety symptoms, conduct problems, and functioning for either intervention group. Additionally, Bolton et al. acknowledged GIP was more suited for mature participants, which highlighted the need for utilization of age appropriate treatments.

In summary, literature reviewed on displaced orphaned children was focused on identification of mental health problems experienced by this population. The absence of literature addressing interventions for displaced orphaned children was notable. Drawing from field experiences in areas with displaced orphaned children affected by armed conflict, Betancourt (2008) identified absence of treatments for this population as the most crucial mental health gap. As indicated in most of the reviewed studies, age appropriateness of the studied interventions was not considered or discussed.

#### Preadolescence and the Developmental Needs of Preadolescents

Uncertainty in the literature regarding a precise or definite age range for preadolescents

was observed. However, most authors described the preadolescent phase of growth as including the ages 9 to 12 years old (Bratton et al., 2009; Bratton & Ferebee, 1999; Packman & Bratton, 2003; Packman & Solt, 2004). The preadolescence period is marked by significant developmental changes that can make the period one of uncertainty and turmoil for preadolescent children.

According to Piaget's (1977) theory of cognitive development, children in the preadolescence stage are developmentally in transition while moving from the concrete operational stage to the formal operational stage of thinking (Wadsworth, 1979). As a result, preadolescent children are in an on-going process of developing abstract thinking and might have difficulty expressing their thoughts and feelings verbally. Landreth (2002) proposed that children's natural medium for communication was play, and developmentally, preadolescents lack the cognitive ability to effectively limit communication to verbal expressions of their experiences.

Ray (2011) applied Piaget's cognitive development to play therapy. Ray explained that children at the concrete operational stage are developing abilities to think about symbols and meaning. Hence, children at this point still need concrete materials to facilitate their learning experiences. The author affirmed that provision of concrete materials to children in the context of play therapy fostered preadolescents process of creating meaning of the world responded to the developmental need of children at the concrete operations stage. Last, Ray noted that relating with peers was a developmental milestone for children in concrete operations. In view of preadolescents' developmental needs, interventions that provide concrete materials within a group context might contribute to positive outcomes.

As proposed by Erikson (1980), preadolescents enter into the stage of industry versus inferiority. According to Erikson, in industry versus inferiority, preadolescents have a need to

become competent and productive in mastering new skills, desire to learn and make things, and need to learn the social rules in society. Erikson argued that toward the end of the preadolescent period, the psychological task of identity versus role confusion gains importance with preteens who concern themselves with self-definition as individuals in relation to peers. As the preadolescents interact with their peers, they are influenced by their peers' opinions, and their developing sense of self is impacted.

Furthermore, Erikson (1980) proposed that the social-emotional growth of preadolescents depends on developing industry over inferiority and is facilitated by preadolescents developing appropriate social skills for interpersonal relationships. The group therapy format may facilitate preadolescents' psychosocial development, and as group members, they could develop peer interactions, try out new roles in the safety of the group, and develop both industry and identity. Regarding the developmental needs of preadolescents and given the vital importance of peer acceptance to preadolescents, the group format provides opportunities for participants to change behavior and develop appropriate interpersonal skills (Bratton & Ferebee, 1999).

In consideration of preadolescents' valuing and being greatly influenced by peers, Gerrity and DeLucia-Waack (2007) and Kulic et al. (2001) supported the use of activity and play during group work with this population. As a result of preadolescents' unique needs, researchers and counselors working with this age group have recommended using appropriate counseling interventions based on the group's age and cognitive and emotional development (Akos & Martin, 2003; Flahive & Ray, 2007; Gerrity & Delucia-Waack, 2007; Kulic et al., 2001; Salloum, Garside, Irwin, Anderson, & Francois, 2009). Akos et al. (2007) proposed group process as valuable to preadolescents. Akos et al. argued for group cohesion as a means for preadolescents to experience feeling accepted and valued and realizing that other members of the group share similar feelings and experiences. Through experience sharing, preadolescents

develop social skills, which impact their interpersonal relationships (Akos et al., 2007). Akos et al. proposed a sense of belonging resulted from group cohesion and facilitated preadolescents' healthy adjustment. Akos et al. further promoted the group format as enabling participants to socialize, to learn through interpersonal relationships, and to emulate behaviors. In support of group therapy for preadolescents, Hargrave and Hargrave (1983) concluded that group process facilitated social skill development and interpersonal interaction within this population.

Play therapy has been acknowledged as a workable and developmentally appropriate treatment for a variety of presenting issues in children (Bratton et al., 2005). However, preadolescent children might view play therapy as childish (Ginott, 1994). In their historical work, Slavson and Redl (1944) recognized the need to provide troubled preadolescents with a therapeutic setting and activities tailored to their developmental needs. Slavson and Redl proposed age-appropriate play materials and expressive arts in a group format as effective modalities for facilitating preadolescents' processes of working through the feelings and thoughts they had difficulty with verbally expressing. Provision of age appropriate play materials and activities within a group format has been recommended as consistent with the developmental needs of preadolescents (Bratton & Freebee, 1999).

Additionally, the inclusion of creative and expressive media within the play therapy group format offers preadolescents with developmentally responsive means to express themselves due to making and sharing creations (Shen & Armstrong, 2008). Creative activities provide preadolescents with opportunities to adjust perception regarding self, others, and the world as they work out new roles and resolutions within the safety of the group (Bratton et al., 2010; Bratton & Freebee, 1999). Bratton and Freebee (1999) proposed that using expressive arts enhanced preadolescents' creative self-development and provided them with inner resources from which they could draw in dealing with future problems.

Hence, activity therapy bridges the gap between concrete and abstract thinking and is considered most suitable for preadolescent children (Ginott, 1994). The utilization of expressive media during group work with this population has been recommended by researchers (Flahive & Ray, 2007; Packman & Bratton, 2003; Paone et al., 2008; Shen, 2007) and presents a developmentally responsive modality to meet the unique and varied maturational needs of this population. The use of expressive activities during group work has been found to be cross-culturally effective (Flahive & Ray, 2007; Shen, 2003; Shen & Armstrong, 2008), supporting the usefulness of this modality with preadolescents from varied cultures.

### Group Activity Play Therapy

Play therapy is an empirically validated intervention, responsive to the developmental needs of children, and has been observed to be effective with the varied social, emotional, behavioral, and learning difficulties presented by children (Bratton & Ray, 2000; Bratton et., 2005). Given the developmental needs of preadolescents, they might view play therapy as childish (Ginott, 1994). Group activity therapy as a modality is used in consideration of preadolescents' developmental levels, is developmentally sensitive to their needs, and facilitates their ability to work through issues (Bratton & Freebee, 1999; Ginott, 1994; Kottman, Strother, & Deniger, 1987; Packman & Lebeauf, 2010; Schiffer, 1952; Slavson & Redl, 1944). Activity therapy provides preadolescents with both verbal and non-verbal options for developing relationships and working through and resolving conflicts (Kottman et al., 1987). Chad et al. (1999) argued for activity therapy, which allows preadolescents to express their feelings using age appropriate media. Chad et al. affirmed that combining activities within the group modality of intervention facilitates the treatment of the emotional and behavioral problems expressed by children.

MacLennan (1977, 1983) argued that using activity group therapy with preadolescents would meet their developmental needs as an experiential modality. MacLennan (1983) proposed activity group therapy to be appropriate for enhancing preadolescents' self-esteem, decreasing difficulties related to authority and sibling conflicts, acknowledging achievements and failures, working through pressing individual demands within the group, developing self-identity, dealing with social fears, and fulfilling the need for a sense of belonging. Several researchers affirmed that providing preadolescents with age-appropriate play materials and activities offers them a suitable and safe means of expressing their feelings and experiences (Bratton & Ferebee, 1999; Chad et al., 1999; Ginott, 1975; Landreth, 2002; Salloum et al., 2009).

According to Landreth (2002), children naturally communicate through play and activity. Group activity play therapy facilitates or allows children to express feelings in a safe consistent environment (Ross & Jones, 1982). In support of group activity play therapy, Packman and Lebeauf (2010) affirmed that it offers preadolescents avenues to learn and develop their social and coping skills in a safe and developmentally sensitive atmosphere. Preadolescents can work through difficult behaviors via the group activity therapy modality under the consideration of their cognitive development and social emotional needs (Packman & Lebeauf, 2010). Group play therapy provides children with the medium of play and helps them learn about themselves and feel valued (Sweeney & Homeywer, 1999). Howarth and Riester (1997) studied the psychological functioning of 31 children and adolescents, aged 6 to 16 years, and reported that children and adolescents had improved after 14 sessions of activity group therapy.

In writing about the theoretical framework for group play therapy, Ginott (1994) noted that group play therapy facilitates children's efforts to reduce tension as they work with others in the group, and group play therapy encourages children to participate, to create, to initiate, and to have spontaneity. Ginott (1994) affirmed that participating in the group process enables children



to begin trusting the counselor more easily. In addition, Ginott (1994) argued that group play therapy enhances children's awareness of their problems and facilitates their learning and experimenting with new social skills within a safe environment. In support of group play therapy, Sweeney (1997) summarized the basic benefits of using the group format in play therapy as follows: (a) promoting spontaneity in and enhancing the level of involvement in the group process, (b) providing participants with the opportunity to work through their intrapsychic and interpersonal concerns at the same time, (c) vicarious learning and catharsis occurring among the children, (d) helping participants engage in self-growth and self-exploration through peer feedback, (e) providing children with opportunities to anchor therapy to reality, (f) gaining insight into the children's daily life experiences from the group interactions, (g) lessening the children's inclinations to repetition or to retreat into fantasy, (h) offering children opportunities to develop interpersonal skills and to try out alternative behaviors, and (i) reducing the anxiety level of children feeling anxious about interacting alone, or one-on-one, with the therapist.

#### Group Activity Play Therapy Process and Structure

Activity therapy group researchers have expressed different views concerning group structure (Bratton & Ferebee, 1999). Some researchers proposed that preadolescents would benefit from the unstructured and non-directive format (Slavson & Redl, 1944; Slavson & Schiffer, 1975). These same researchers argued that the non-directive format allowed participants to freely express themselves and to direct their own activities. Celano (1990) argued that structured and directive activities were more beneficial for preadolescents. Bratton and Ferebee (1999) and Slavson and Redl (1944) affirmed that feeling safe and accepted is vital if group members are to participate meaningfully in the group process.

In the humanistic approach to using groups with preadolescents, Bratton et al. (2009) and Bratton and Ferebee (1999) recommended the integration of unstructured and planned activities

in order to meet the developmental unique needs of this population. The proposed structure for the sessions included 15 to 20 minutes structured activity presented by the therapist, 20 to 25 minutes of unstructured free activity chosen by the children, and 15 final minutes of structured snack time and sharing (Bratton & Freebee, 1999; Packman & Bratton, 2003). Packman and Bratton (2003) emphasized that within the context of a humanistic non-directive approach, structured activities focused on the following: (a) facilitating contact, collaboration, and cooperation; (b) facilitating group participants' comfort, (c) reducing anxiety, and (d) exposing participants to variety of expressive art materials with which they might not be familiar.

Drawing from their clinical experience Bratton et al. (2009) and Bratton and Freebee (1999) affirmed that opportunities for spontaneous self-directed creative expressiveness are vital for preadolescents who are often self-conscious and reluctant to interact with others in the group. Structured activities are vital to reducing preadolescents' anxieties and to the promotion of group interaction. Packman and Bratton (2003) proposed that within the context of a humanistic non-directive approach, structured activities focused on the following: (a) facilitating contact, collaboration, and cooperation; (b) facilitating group participants' comfort; (c) reducing anxiety; and (d) exposing participants to variety of expressive art materials with which they might not be familiar. Bratton et al. (2009) and Bratton and Freebee (1999) proposed that the balance between the use of structured and unstructured activities should be determined by the clinician's judgment of the unique needs of the group's participants and the stage of development represented by the group members.

#### Recommended Setting and Selection of Materials for Group Activity Play Therapy

Several authors recommended selecting only age-appropriate settings and materials to establish inviting environments, stimulation for self-expression, and interaction for group activity (Bratton et al., 2009; Bratton & Freebee, 1999; Chad et al., 1998; MacLennan, 1977, 1983). In

order to meet preadolescents' need for applying excess energy, the provision of space for activity therapy has been suggested (Bratton et al., 2009; Bratton & Ferebee, 1999; Packman, 2003).

Additionally, Ginott (1969) proposed that most preadolescents seen in counseling might be either acting out or over inhibited and recommended that therapy environments provide activities and materials responsive to the development of controls in the children in this population who are overactive while providing for the development of spontaneity in those who are over inhibited.

Bratton and Ferebee (1999) presented a detailed description of their suggested components of a well-designed activity room for preadolescents. Bratton and Ferebee emphasized the need for selecting age-appropriate equipment and materials to facilitate the children's expression in varied creative activities. In writing about toys and materials for activity rooms, Bratton and Ferebee proposed that the materials selected should be focused on the following purposes: (a) encouraging peer interaction; (b) enhancing creative expression; (c) encouraging the exploration of feelings, thoughts, and experiences; (d) facilitating the expression of real life concerns; (e) enhancing children's growth of problem solving strategies (Bratton et al., 2009; Bratton & Ferebee, 1999). Detailed descriptions of expressive materials for activity rooms have been presented in literature (Bratton et al., 2009; Bratton & Ferebee, 1999, Ginott, 1961; Ray & Schottelkorb, 2009). Also, recommended was the use of culturally sensitive materials (Bratton et al., 2009; Bratton & Ferebee, 1999; Salloum et al., 2009). Additionally, Chad et al. (1998) emphasized that the developmental level of the group must be considered in the selection of materials.

#### Recommended Selection of Participants for Group Activity Play Therapy

Ginott (1975) and MacLennan (1983) proposed the purposeful selection of group members as critical in forming potential therapeutic preadolescents' groups. In selecting children for groups, MacLennan (1983) recommended considering the personalities and coping

skills of the participants. Heterogeneous groups composed of participants whose personality characteristics, presenting problems, and coping styles complement each other have been recommended as potentially therapeutic (Bratton et al., 2009; Bratton & Ferebee, 1999; Ginott, 1975; MacLennan, 1983; Packman & Bratton, 2003). In forming groups for preadolescent children, same gender and not more than one year apart in developmental age has been strongly recommended (Bratton et al., 2009; Kulic et al., 2001; Salloum et al., 2009; Sullivan, 1953).

According to Ginott (1975), a major consideration when selecting group participants is their level of interest in the group, their capacity to form peer relationships, and their desire to be accepted by the group. Ginott cautioned that the selection of appropriate group members was critical for therapeutic benefit because of the potential for harm being enhanced in a group modality. Hence, the importance of considering who could be appropriate for a group implies that preadolescents experiencing high levels of anxiety and significant difficulty in connecting with others would benefit from individual therapy prior to joining group treatment (Bratton & Freebee, 1999; Chad et al., 1998). Likewise, Bratton and Freebee (1999) affirmed that preadolescents who have experienced previous traumatic events, such as sexual abuse, would benefit from individual treatment before participating in the group experience. In order to minimize the possibility of exposing group members to inappropriate behavior and information, Bratton et al. (2009) recommended assessing potential group members' background history and presenting issues and administering standardized measurements, such as the Child Behavior Checklist (CBCL) and the Behavioral Assessment System for Children (BASC), to screen for severity of behavioral concern and to identify coping style. Literature revealed that three to six group members were recommended for humanistic non-directive group activity models (Bratton & Freebee, 1999, Flahive & Ray, 2007; Packman & Bratton, 2003).

## Child-Centered Approach to Group Activity Play Therapy

The child-centered approach is built on the foundation of individual and group child centered play therapy. An over view of child-centered counseling philosophy as the base for the theoretical and conceptual framework for child centered approach to group activity play therapy is included in this section.

### Child-Centered Play Therapy

Child-centered play therapy (Axline, 1947; Landreth, 2002; Ray & Schottelkorb, 2009) is founded on person-centered theory developed by Rogers (1951). Rogers believed that individuals and groups have the innate capacity to set their own goals and work toward their own progress in counseling (Raskin et al., 2011). Rogers believed that individuals and groups had the innate capacity to set their own goals and work toward their own progress in counseling and for positive self-growth (Raskin et al., 2011). Rogers (1951) affirmed that the potential of any individual to move toward personal growth could be released in a relationship in which the therapist was experiencing and communicating genuineness, caring, and profound nonjudgmental understanding. In agreement with Rogers (1951), person-centered counselors working with children believe that provision of a counseling relationship in which the aforementioned attitudes are communicated to the child help the child attain positive change (Bratton et al., 2009; Landreth, 2002; Ray & Schottelkorb, 2009).

Axline (1947) extended the application of person-centered perspective in counseling children. Axline used play in her application of person-centred theory to children. Play is a developmentally responsive approach which allows children to use their natural way of communicating to deal with obstacles to self-realization which they may not overcome by words alone. Axline held a belief in children's capacity to move toward self-healing and resolution of their own problems in application of non-directive play therapy while working with this

population. The nondirective nature of CCPT is portrayed in therapist's belief in a child's innate tendency to move toward a constructive direction (Ray, 2011; Wilkins, 2010).

From Roger's (1942) detailed description for therapeutic process, Ray and Schottelkorb (2009) described the process of change for children within CCPT context. The two authors explained that a child centered counselor creates a climate in which the child can work to resolve their own problems. In this environment, an accepting and understanding counselor facilitates the child's free expression of both negative and positive feelings. Ray and Schottelkorb stated that this process allowed the child to gain increased understanding and acceptance of self followed by insight into positive constructive movement and personal growth.

Ray (2011) clearly articulated further processes involved in children's therapeutic progression within child/person-centered philosophy. Ray explained that child-centered therapy operated on the premise that within an accepting climate provided by the therapist, the child experiences no threat to the self-structure; hence, the child may be able to examine experiences perceived as inconsistent with self-structure and then work toward revising and including those experiences. Again, within this environment as the child feels positively regarded, he or she becomes able to behaviorally express feelings and thoughts of incongruence between the ideal self or environment through play and symbolic expression. In this self-exploration process, the child integrates new awareness of self to develop full functioning. Ray emphasized that this therapeutic change occurs when the therapist communicates and experiences acceptance and empathic understanding of child and expresses genuineness (Ray, 2011). Provision of empathic understanding and acceptance allowed the child to experience these dynamics as activators of change, thus facilitating change (Ray, 2011).

Also, Ray (2011) affirmed that child-centered therapy was built on the premise that getting rid of threats to self-structure allowed a child to explore experiences that were consistent

or inconsistent with self in order to have them assimilated and gradually integrated within a revised self. In agreement with Rogers (1951), Ray noted that problem behaviors suggest a child is struggling with incongruence between self and perceived values or the environment. Ray concluded that an effective CCPT therapist provided a non-threatening environment which facilitated a child's active and inherent processes for improvement.

#### Child-Centered Approach to Group Activity Play Therapy

Activity play therapy has been recognized as the developmentally appropriate treatment modality for preadolescents (Ginott, 1994). As stated by Ray and Schottelkorb (2009) skills used in child-centered individual and child centered group play are applicable in work with preadolescents. A responsive theoretical treatment modality for preadolescents would need to consider their developmental needs. In Piaget's theory, preadolescents operate between concrete operations and formal operations. At the concrete operational stage, children's thinking and problem solving are easier for them to accomplish when applied to real, concrete events or symbols as opposed to abstract contexts (Broderick & Blewitt, 2010). Using concrete operations, children at this stage make cognitive changes as they think about images and associated meaning of those images; hence, they learn through doing (Ray, 2011). Ray (2011) described how provision of concrete materials during play therapy allowed children to make meaning of their world. While preadolescents might communicate at a concrete level they may struggle with communicating their thoughts, feelings, and concerns verbally. Ginott (1969) cautioned that toys used in traditional play therapy would be considered childish by preadolescents and would not effectively facilitate communication by this population. Using expressive materials helps preadolescents to combine new cognitive abilities and play expression.

Literature on child-centered therapeutic use of expressive activities with preadolescents in response to their developmental needs is very limited. A few attempts found in the literature have provided non-directive humanistic theoretical approach to working with preadolescents (Flahive and Ray, 2007; Packman & Bratton, 2003). For preadolescents and older children, Ray and Schottelkorb (2009) suggested using person-centered talk and expressive arts approaches would be more developmentally appropriate.

Ray and Schottelkorb (2009) proposed a structure to be utilized when using child-centered expressive arts. Within a child-centered context, they proposed expressive arts be utilized through the presentation of materials to preadolescents and allow them to explore using media during counseling. Ray and Schottelkorb suggested presenting counseling structure as “a place where you can talk or use any of the materials in my office” (p. 23). As they explained, following this presentation, preadolescents could decide either to use the expressive arts or verbal expression to communicate. Ray and Schottelkorb affirmed that presenting this structure was beneficial for resistant and anxious preadolescents and explained that in the case of the preadolescent deciding to use expressive arts materials, the counselor would use child-centered skills to facilitate the counseling process as the client worked on his/her creation. The two authors provided examples of the expressive arts materials to be used and recommended that within child-centered perspective, the materials be exposed allowing the preadolescents to be free to work on projects during sessions if they wanted. Ray and Schottelkorb concluded that this openness provided the preadolescents with a nonthreatening climate to explore difficult issues in their lives. On the issue of using expressive arts, Meador (1975) suggested that within a person-centered context, the therapist decides on what experiences, such as art, dance, creative writing, and other non-verbal experiences, would work for the group.



In consideration of preadolescents' changing cognitive abilities involving use of concrete objects and concrete experiences for resolving issues, Wilson and Ryan (2005) recommended that using symbolic expression would meet their developmental needs and proposed that structured activities could be used in the context of non-directive play therapy with preadolescents. In using structured activities in the context of non-directive play therapy, Wilson and Ryan cautioned that activities needed to be used in response to what children were conveying and experiencing during play therapy sessions as opposed to being utilized as planned techniques in a directive way. Also, they posited that therapist in this context needed to provide a therapeutic relationship or climate in which children would be able to change the course and process of play during structured exercises like they do in other activities. They concluded that while using structured activities, non-directive play therapists still needed to be flexible, empathic, and responsive to children's emotional communication. In addition, Wilson and Ryan recommended that in a non-directive approach, preadolescents be allowed to spontaneously use concrete symbolic representation in their own way without pressure from the therapist to move in a certain direction.

While working with preadolescents, the climate for group is established by therapist's creating a relationship based on empathic understanding, acceptance, warmth, and genuineness. In addition some self-disclosure and establishing trust by being real has been recommended when working with preadolescents using a non-directive approach (Ray, Tsai, & Blanco, 2008). Also, acceptance of the preadolescents and trust in their ability to move toward growth, allows for working with children within their cultural and ethnic backgrounds. Just like in CCPT, during child-centered group activity therapy, the preadolescent's unique experiences are accepted as part of his/her reality including cultural specific aspects (Bratton et al., 2009; Ray & Schottelkorb, 2009).

Wilson and Ryan (2005) acknowledged that children are capable of creating their own means of expression which they find most appropriate for their personality, competencies, and emotional life. Wilson and Ryan affirmed that using structured exercises with preadolescents arises in response to their emotional communication and serves as a potential way of assisting children to use symbols to convey their feelings, thoughts, and experiences. Also, as stated by Davis (2002), using prompts and guidelines as part of the expressive arts experience with preadolescents facilitated self-awareness and psychological contact with self and other group members. Broderick and Blewitt (2010) noted that preadolescents found difficulty in thinking logically about abstract information and look out for something concrete in an effort to make sense of their experiences.

Packman (2002) proposed that semi-structured activities within a non-directive approach be presented as needed in order to facilitate the starting process of self-exploration and group interaction. Packman emphasized that semi-structured activities facilitate the start of group cooperation and collaboration and help reduce anxiety for preadolescents who might be withdrawn. Ginott (1969) proposed that helping preadolescents initially when they are not familiar with the materials facilitates making contact with even the resistant children. In facilitating activity groups, Packman (2002) utilized humanistic principles based on person-centered philosophy such as the belief in preadolescents' capacity for positive self-direction and in the therapeutic relationship between therapists and group members being vital for process.

Davis (2002) presented group person-centered expressive arts guidelines with the goal of supporting the process of clients' making psychological contact with themselves and each other. These guidelines facilitate the process of helping clients become open to experience and attuned to personal emotional and physiological reactions during the process. The guidelines also emphasize that clients need to be in charge of the process and that therapists trust the clients to

know what they need in this experience. Consistent with this rationale for use of guidelines, during the GAPT process, therapists may present varied materials to preadolescents to create a supportive environment, to foster making psychological contact, and to enhance the therapeutic process (Davis, 2002).

Also, Davis (2002) wrote about guidelines for the process of responding to expressive arts creations in a group context using person-centred approach. In group person-centred expressive arts, a client's work is not interpreted or analyzed. Person-centred therapists believe that each individual has capacity for self-understanding and insight, and a vital therapeutic process allows each person to establish personal meaning in one's creation (Davis, 2002). In the non-directive group climate, clients are invited to share what the process is like and their own meaning of the process and their creation (Davis, 2002). Rogers (1961) wrote about the desire to share one's creation as part of the experience involved in creativity. Davis (2002) asserted that sharing inner dynamic experiences depicted in creations assisted individuals' communication and development of increased self-awareness. Using expressive arts and giving freedom to share the process facilitates making psychological contact with self and others (Davis, 2002).

#### Child-Centered Play Therapy Research on Behavioral Problems

Through meta-analysis, Bratton et al. (2005) showed that play therapy was beneficial for children with behavioral problems. Meta-analytic findings of 24 studies on effects of play therapy outcomes targeting internalizing problem behaviors showed that play therapy had a large treatment effect on children's internalizing behavior problems ( $ES = 0.81$ ). Additional, 17 studies were focused on externalizing problem behaviors ( $ES = 0.78$ ), and internalizing and externalizing problem behaviors ( $ES = 0.93$ ) were combined in 16 studies. Additional analysis revealed that humanistic treatments demonstrated large effect sizes and effects for humanistic treatments were more positive than for non-humanistic treatments. In describing humanistic play therapy,

Bratton and Ray (2002) noted that it included varied theoretical orientations, including person-centered, existential, and Gestalt. In the present literature review, studies which used a child-centered play therapy (CCPT) and person-centered theoretical orientation will be highlighted. Review of the literature indicated a paucity of studies of the humanistic approach in exploring the issue of behavioral problems specifically with preadolescents; hence, this review highlights studies that included this population as the research participants.

Beyond the meta-analysis, the literature presented some recent play therapy studies using a humanistic approach to treat behavioral problems. Garza and Bratton (2005) investigated effects of CCPT on elementary and Hispanic children experiencing behavioral problems compared to curriculum based small group counseling. Participants of the study included 30 children aged 5 to 11 years. Using parent reports, Garza and Bratton found that Hispanic elementary children who received 15 CCPT sessions demonstrated statistically significant decreases in externalizing behavior problems as compared to a curriculum-based small group intervention. Garza and Bratton revealed that according to parent reports, the CCPT intervention had a large treatment effect ( $d = .76$ ) on children's externalizing problems behaviors and a moderate effect on internalizing problems over the comparison group. The positive outcome of this CCPT approach with children's behavioral problems suggested the potential for using the approach with other children.

Schumann (2005) conducted another study which demonstrated the positive impact of CCPT on externalizing behavioral problems. Participants included 37 children identified as aggressive from kindergarten through fourth grade who were aged 5 to 12 years old. Schumann investigated the effectiveness of CCPT for children referred for aggression compared to an evidence-based guidance curriculum delivered in small group format. The participants in the experimental group which included 20 children received 12 to 15 sessions of CCPT and were

compared with 17 children in the control group which participated in an evidence based violence prevention guidance program. Schumann found that both groups showed statistically significant decrease in the aggressive behaviors of children, and statistically significant decrease in externalizing and internalizing behaviors of aggressive children. Schumann concluded that CCPT was as effective in decreasing aggressive behaviors in children as a recognized evidence based guidance program for prevention of violence. Tyndall-Lind et al. (2001) found that 4 to 10 year-old children in domestic violence shelters showed a significant decrease in total behavior problems, externalizing and internalizing behavior problems, aggression, anxiety, and depression after 12 child-centered sibling group play therapy sessions.

Dogra and Veeraraghavan (1994) supported the positive outcome of using a nondirective play therapy approach in an earlier study which investigated the impact of play therapy on 20 children, aged 8 to 12 years, who had been referred for aggressive behavior. The experimental group received nondirective play therapy twice a week plus parental counseling for 8 weeks. In comparison with a control group, children in the experimental group demonstrated significant positive change on varied measures of adjustment. Dogra and Veeraraghavan also noted that children in the experimental group showed a reduction in aggression, disobedience, temper tantrums, and strong dislike for school.

Kot et al. (1998) explored issues of internalizing behavior problems, externalizing behavior problems and total behavior problems in the context of child-centered play therapy (CCPT) with children aged 4 to 11 years. They compared 11 children participating in 12 CCPT sessions to 11 children in a control group not getting intervention. They reported that children participating in CCPT showed significant decreases in externalizing and total behavior problems. Kot et al. noted that children participating in CCPT expressed less aggression and less delinquent behaviors than children in the control group. The positive results of this study indicated that the

humanistic theory base or philosophy of CCPT, supported by the value by an empathic relationship while working with children expressing behavioral problems such as aggression (Trotter, Eshelman, & Landreth, 2003), offers promise for attempts with other children. In addition, children in the Kot et al. study were aged 4 to 11, suggesting that a humanistic approach might be responsive with preadolescents as well.

In a related study, Muro, Ray, Schottelkorb, Smith, and Blanco (2006) used CCPT with children exhibiting behavior problems. Using teachers' reports on the Teacher Report Form, Muro et al. found that children who participated in 32 sessions of CCPT demonstrated statistically significant improvement on the Total Child Behavioral Problems Scale, as rated by teachers. Children's behavior improved as measured by teachers. Participants included 23 children from pre-kindergarten through fifth grades who were aged 4 to 11 years, furthering the postulate that a humanistic approach might be responsive with preadolescents.

More recently, Ray, Blanco, Sullivan, & Holliman (2009) specifically explored using CCPT with children referred for problematic aggressive behaviors. Participants included children from prekindergarten through fifth grades and aged 4 to 11 with 19 in the CCPT group and 22 in the control group. Using parent reports on the aggressive behavior subscale of the Child Behavior Checklist, Ray et al. found a moderate decrease for aggressive children who participated in CCPT compared with control group children. Again, this study's results offered promise for using the CCPT intervention with children exhibiting externalizing behavioral problems. Ray et al. concluded that an empathic relationship during therapy seemed to facilitate aggressive children's ability to reduce aggressive problem behaviors.

Apart from individual child-centered studies exploring issues of behavioral problems using humanistic theory base, a few studies focused on group activity play therapy. Flahive and Ray (2005) specifically explored issue of internalizing, externalizing, and total behavior

problems in the context of group sandtray, a model of play therapy. Flahive and Ray (2007) found that after 10 sessions of a child-centered approach to group sandtray with fourth and fifth grade preadolescents, teacher reports indicated that participants had significantly reduced their internalizing and externalizing problems behaviors. Also, parents reported significant reduction in externalizing problem behaviors.

In a randomized controlled study, Packman (2003) used humanistic principles in school-based activity groups with preadolescents in fourth and fifth grades. Packman specifically explored the effect on internalizing and externalizing behaviors with 12 participants in group activity therapy compared to 12 participants in the control group. Packman noted that the humanistic theoretical base included conveying a belief in preadolescent capacity for self-understanding and self-direction which allowed the preadolescents to modify their behavior in order to become part of the group. Packman found that after 12 weekly group activity play sessions, teacher and parents reported that participants demonstrated a statistically significant reduction in total problem and internalizing problem behaviors compared to the nonintervention control group.

### Group Activity Play Therapy Research

A review of the group activity research literature revealed few research studies had been conducted regarding group activity therapy with preadolescents. Roos and Jones (1982) examined activity group therapy with 15 girls who were aged 9 to 10 years and experiencing loss. The participants in this study lived in a multi-ethnic community, and the girls had experienced varied family losses due to death, divorce, immigration, and other interruptions. Roos and Jones used a self-designed narrative form, which was completed by the group leaders to evaluate the efficacy of the group. Self-reporting was a weakness in this study, because subjective responses, whose accuracy was difficult to ascertain, were used as the data and details

about how the girls' progress was measured were not provided. The authors reported that the group helped the girls by enhancing their coping with loss and acculturation issues and development of positive peer relationships. Also, Roos and Jones attributed the progress observed to the safety, consistency, and nurturing provided in the group process and affirmed that the findings from this study, first, supported the effectiveness of activity group therapy when working with children experiencing losses, and second, demonstrated its value as an effective modality for multi-ethnic groups.

Utilizing a randomized controlled design, Packman and Bratton (2003) examined the effects of using group activity play therapy with 29 preadolescents attending school in the United States who were diagnosed with learning difficulties and exhibiting behavior problems. The preadolescents were randomly assigned to the control and treatment groups. In the treatment protocol diverse structured and unstructured expressive activities were used within a humanistic activity group format. The group format included time for self or group-directed activities, and a semi structured activity was presented, as needed, with time for a snack. Also, group members were free to participate or not to take part in any activity presented by therapist or group members. Packman and Bratton found that preadolescents who received 12 weekly group activity play therapy sessions demonstrated statistically significant reductions, from pretest to posttest, in total problem and internalizing problem behaviors compared to the preadolescents in the no treatment control group. Packman and Bratton revealed that group activity play therapy showed a large effect size for total and internalizing problem behaviors and a moderate effect on externalizing behavior problems. Further analysis of the anxiety and depression subscales showed large treatment effect sizes for the group activity play therapy group.

Paone et al. (2008) also used a pretest-posttest treatment-comparison group design and followed the group activity play therapy protocol used by Packman and Bratton (2003). Paone et



al. examined the effects of using group activity play therapy versus talk therapy interventions on the moral reasoning of 61 at-risk ninth graders. The participants who attended 10 sessions of group activity play therapy showed statistically significant difference in changes in moral reasoning overtime compared to participants of the talk therapy group.

In another play therapy model of group intervention with preadolescents using a pretest-posttest control group design, Flahive and Ray (2007) examined the effectiveness of 10-week group sandtray therapy with 56 preadolescents who were students attending school in United States and exhibiting behavioral difficulties. The group format included an unstructured time for group members to make their sandtray scenes and a more structured time for processing what they had created. Flahive and Ray (2007) stated that teacher reports showed statistically significant differences in total, externalizing, and internalizing behaviors in favour of group sandtray participants over the control group participants over time, while participants' parents reported results indicating statistically significant change for externalizing behaviors. Flahive and Ray concluded the intervention was effective in preventing participants from experiencing increased behavioral difficulties.

Recently, Shen and Armstrong (2008) conducted a study, with 37 seventh grade girls aged 11 to 13 years. They randomly assigned the participants to control and experimental groups to investigate the effectiveness of group sandtray therapy in enhancing the participants' self-esteem and followed procedures used by Flahive and Ray (2007). Shen and Armstrong reported a statistically significant improvement in self-esteem for the treatment group compared to the control group over time. The findings of the study supported the effectiveness of group sandtray therapy for improving self-esteem with young adolescent girls.

Shen (2007) compared the effects of using development-based Gestalt group expressive play activities compared to a cognitive-verbal intervention on 73 seventh and eighth grade

Chinese adolescents in a Taiwanese school. The author reported a statistically significant improvement in both treatments groups and overall behavioral and emotional strengths as reported by teachers, and the Gestalt play group treatment contributed to the greatest change in enhancing target behaviors. Additionally, the author noted that parents reported no significant changes and offered mixed findings. Finally, Shen concluded that Gestalt-play and cognitive-verbal methods were both applicable in the Chinese cultural context.

The literature offered a scarcity of research on the use of group activity play therapy. The few experimental studies identified, which were well designed and controlled studies and all conducted in the past 5 years, were carried out in school settings in the United States and with small samples (Bratton & Packman, 2003; Flahive & Ray, 2007; Paoene et al., 2008; Shen & Armstrong, 2008). Findings could not be generalized to populations outside the United States. However, strengths of the well-designed, randomized group studies provided insight into development of vigorous research interventions which might lead to positive outcomes for orphaned preadolescents.

### Conclusion

A great need to provide a developmentally appropriate and effective treatment for preadolescent Uganda orphans exhibiting behavior problems exists. While play therapy is recognized as an effective and well-researched treatment for children, little research exists on the effectiveness of group activity play therapy. The few research studies available for review have demonstrated group activity play therapy to be an effective treatment for children's emotional and behavioral difficulties. The research studies have been mainly conducted in the United States. No known research has been conducted to investigate the effectiveness of group activity therapy with displaced preadolescent orphans in Uganda.

Results from well-designed group activity therapy studies implied its effectiveness as a treatment option for preadolescents. The findings suggested the potential for positive outcomes to be produced by designing a research intervention with preadolescents within another cultural context. Thus, exploring working with Uganda's preadolescent orphans in the context of group activity therapy might be a beneficial process.

APPENDIX C  
EXTENDED METHODS AND PROCEDURES

## Introduction

In this appendix, I focus on the methods and procedures used to measure the effectiveness of group activity play therapy (GAPT) as a clinical intervention on the internalizing and externalizing behaviors of preadolescent orphans. Using a randomized control group design with two treatment conditions (experimental /active control) and two points of measurement (pretest/posttest), I examined the effectiveness of GAPT compared with an active control treatment, reading mentoring (RM). Participants were third, fourth, and fifth grade students between the ages of 10 and 12 years who were identified by teachers and housemothers as exhibiting internalizing and externalizing behavior problems. Participants who met the specified criteria were randomly assigned to either the experimental group or the active control group. Both treatment groups received 16 sessions of intervention in groupings of three children. The interventions occurred twice a week and lasted 50 minutes each. Included in this chapter are the research questions, definition of terms, instrumentation, participant selection, procedures, data collection, and data analysis.

## Research Questions

The purpose of this study was to investigate the effects of GAPT on orphaned preadolescents identified with behaviour problems, when compared to an active control group treatment (RM). The current study was based on the following research questions:

1. Will group activity play therapy decrease internalizing behaviors of orphaned preadolescent students living in Uganda?
2. Will group activity play therapy decrease externalizing behaviors of orphaned preadolescent students living in Uganda?

## Definition of Terms

For the purposes of this study the following terms are operationally defined in the following paragraphs.

*Displaced preadolescent orphans* was defined as children aged 9 to 11 years who have been forced, as a result of war, death of family members, or natural disaster, to leave their original settlement areas and homes and to live in orphanages.

*Externalizing behaviors* referred to the outward expression of internal problems. These behaviors include aggression, hyperactivity, and conduct problems. Behaviors include conflict with other people, especially representative of child behavior that does not meet adult expectations, such as rule breaking and aggression (Achenbach & Rescorla, 2001). For purpose of this study, externalizing behaviors is operationally, the externalizing behavior score on the Teacher Report Form (TRF; Achenbach & Rescorla, 2001) and the Child Behavior Checklist (CBCL; Achenbach & Rescorla, 2001).

*Group activity play therapy (GAPT)* was defined as a therapeutic modality in which a trained play therapist provides developmentally appropriate play materials and activities to facilitate the development of a safe environment in which preadolescent children can utilize expressive arts media to work through difficult experiences (Bratton et al., 2009).

*Reading mentoring (RM)* was defined as a relationship between an adult trained in RM and a child assigned to the active control group. The main task within this relationship is to spend time together and read children's books.

*Internalizing behaviors* referred to difficulties that involve inner distress or difficulties within the self-such as anxiety, depression, withdrawal, and somatic symptoms. In this study, internalizing behaviors problems is operationally the internalizing behavior score on the TRF and CBCL (Achenbach & Rescorla, 2001).

*Orphan* was used as a term consistent with the national orphans and other vulnerable children policy of Uganda (Ministry of Gender, Labour, and Social Development, 2004).

Orphan is defined as a child below the age of 18 years who has lost one or both parents.

*Orphanage*, for purpose of this study, was defined as a group living arrangement for children in which the remunerated adults will not be regarded as traditional caregivers within the wider society but provide care. The term refers to children's villages where clusters of houses are built for orphaned children in Uganda.

*Preadolescence* referred to the transitional development period between childhood and the beginning of puberty and considered as the period between the ages of 9 and 12 years (Bratton & Ferebee, 1999). For the purpose of this study, preadolescents were operationally defined as children aged 9 to 12 years.

### Instruments

Two instruments were used to measure the variables of this study, the Teacher Report Form (TRF) and the Child Behavior Checklist-Parent Version (CBCL).

#### Teacher Report Form

The TRF (Achenbach & Rescorla, 2001) is a teacher report instrument used to assess children's academic performance, adaptive functioning, and behavioral and emotional functioning. The TRF form is for use with children between the ages 6 and 18 years. It is a self-administered instrument and takes about 20 minutes to complete. The instrument requires teachers to rate each student's academic performance and behavior compared to other children in the class on a 118-problem item form. The student's behavior is rated on a three-point scale of 0 to 2 indicating: *not true* = 0, *sometimes true* = 1, or *very true* = 2.

The TRF generates adaptive scores, problem scores, and DSM-oriented scores (Achenbach & Rescorla, 2001). The normative sample of TRF was based upon teachers' reports

of 4,437 non-referred children aged 6 to 18 years residing in 40 United States and the District of Columbia (Achenbach & Rescorla, 2001). The TRF provides two broad scores for internalizing behavior and externalizing behavior (Achenbach & Rescorla, 2001). Three specific scores fall within the internalizing behavior domain as follows: (1) Anxious, (2) Withdrawn-Depressed, and (3) Somatic Complaints (Achenbach & Rescorla, 2001). The two subscales of the externalizing domain are Rule Breaking Behavior and Aggressive Behavior (Achenbach & Rescorla, 2001).

Achenbach and Rescorla (2001) reported adequate internal consistency for the TRF with an alpha of .90 on the TRF Total Adaptive scale; for the problem scores, alphas of .72 to .95; and for the DSM-oriented scores, alphas ranging from .73 to .94. The test-retest reliability for the TRF was high, and scaled scores were stable (Achenbach & Rescorla, 2001). The content, criterion-related and construct validity of the TFR has been strongly supported by research (Achenbach & Rescorla, 2001).

#### Child Behavior Checklist--Parent Version

The CBCL (Achenbach & Rescorla, 2001) was administered to the participants' housemothers. Children in the study had housemothers serving as their caregivers, or foster parents, in orphanages. The CBCL for ages 6 to 18 years version was used to measure housemother's reports of children's school and social competencies, behavioral functioning, and problems.

The CBCL is composed of 120 items. For each item, the parent, or in this study housemother, chooses the best response from among three possible answers that describe varied problem behaviors exhibited by children. Respondents indicate whether or not a child shows the item's particular behavior via the following options: 0 for not true, 1 for sometimes true, and 2 for very true. The CBCL requires approximately 20 minutes to complete and can be scored by hand or computer. The CBCL includes several open-ended questions to allow respondents to



report any observed behavior through the instrument's 120 items. The CBCL consists of three scales measuring Internalizing Problems, Externalizing Problems, and Total Problems. The CBCL ages 6 to 18 years version consists of eight syndrome subscales as follow: (a) anxious /depressed, (b) withdrawn, (c) somatic complaints, (d) social problems, (e) thought problems, (f) attention problems, (g) rule breaking behavior, and (h) aggressive behavior.

The syndrome subscales are categorized into one of the two classifications: Internalizing Problems, Externalizing Problems. Internalizing Problems refers mainly to problems within the self and is measured through the following Internalizing Problems syndrome subscales: (a) Anxious / Depressed, (b) Withdrawn, and (c) Somatic Complaints (Achenbach & Rescorla, 2001). Externalizing Problems refer to children's outwardly expressed behavior and the children's behavior conflicting with adults' expectations. The two Externalizing Problems syndrome subscales for the 6 to 18 year old version are Rule Breaking Behavior and Aggressive Behavior. The Social Problems, Thought Problems, and Attention Problems subscales also included in the Total Problems scale.

The CBCL results provide scores for each syndrome subscale in addition to providing scores for the domains of Internalizing Problems, Externalizing Problems, and Total Problems. The 6 to 18 year old version of the CBCL provides scores for children's competency in the three areas of Activities, Social, and School. A decrease in syndrome scores indicates improvement in the targeted behavior (Achenbach & Rescorla, 2001). An increase in the competency scores indicates improvement in the targeted areas (Achenbach & Rescorla, 2001).

The normative population for the CBCL was based on a diverse sample, including children referred for clinical and special education services and children attending various school and childcare settings. The children of the normative sample were residents of the United States, Canada, Australia, and Jamaica. The test-retest reliability of the CBCL is strong ( $r = .85$ ). The

test-retest reliability coefficients for the syndrome subscales of the CBCL are the following: (a) Anxious/Depressed,  $r = .68$ ; (b) Withdrawn,  $r = .80$ ; (c) Somatic Complaints,  $r = .84$ ; (d) Attention Problems,  $r = .78$ ; (e) Rule Breaking Behavior,  $r = .85$ ; (f) Aggressive Behavior,  $r = .87$ ; (g) Internalizing Problems,  $r = .90$ ; (h) Externalizing,  $r = .87$ ; (g) Total Problems,  $r = .85$  (Achenbach & Rescorla, 2001). The content validity of the problems scales is strong, as supported by research, and all but two items discriminate between referred and non-referred children. Finally, the criterion-related validity of the problem scales has been supported by the instrument score's capability to differentiate between referred and non-referred children (Achenbach & Rescorla, 2001).

#### Participant Selection and Recruitment

Participants were students from one elementary school located in an orphanage in the central region of Uganda. The school enrollment was 624 students with students in prekindergarten to seventh grade who were considered to be among the country's highest risk children (Wakhweya et al., 2002). The orphanage serves children displaced as a result of losing their parents primarily as a consequence of armed conflict, HIV/AIDS, and other tragedies. Due to varied factors associated to experiences of orphaned children, such as being economically disadvantaged, they start school late, experience developmental delays, and often have a history of trauma. The children live in small group homes situated in a village within the orphanage complex where they attend school. One housemother lives in each home and serves as the primary caregiver (or foster parent) to eight children.

Upon receiving research approval from the Ugandan National Council for Science and Technology (UNCST), the participating orphanage, and IRB, a 3-step process for identifying participants was established. First, teachers and house mothers were asked to identify children who were experiencing behavioral difficulties such as disruptive behavior in class, rule breaking,

difficulty getting along with others, aggression, withdrawal, and showing signs of anxiety or sadness. Next, house mothers gave their approval for the identified children's participation, and last, the orphanage's education team leader, as the designee of guardianship, gave official consent for children to participate in the study. The purpose of the study was explained to children prior to obtaining their assent.

Children who were included in the study met the following inclusion criteria: (a) an orphan between 10 to 12 years of age (and enrolled in Grades 3 through 5) living permanently in the participating orphanage; (b) child could not be more than 2 years behind grade level; (c) clinical/borderline level of behavior concern reported by teacher or housemother; (d) child currently was not receiving mental health services; and (e) housemother was not receiving parent education programs during the time of the study. Of the 101 preadolescents referred to the study, 60 met all criteria and were selected to participate. The exclusion and inclusion criteria were utilized in order to help accurately test for the effects of the group activity play therapy intervention (Festinger & DeMatteo, 2008). Consistent with criteria for empirically validated treatments, the characteristics of the participants were specified (Crits-Christoph, 1998).

Participants were 28% third graders ( $n = 17$ ), 37% fourth graders ( $n = 22$ ), and 35% fifth graders ( $n = 21$ ). Age distribution of the participants was as follows: 25% 10 year olds ( $n = 15$ ); 33% 11 year olds ( $n = 20$ ); and 42 % 12 year olds ( $n = 25$ ). Male students represented 50% of the participants. The average time that participants had lived at the orphanage at the start of study was 52 months, and the mode for time living at the orphanage was 54 months. Table C.1 summarizes demographic information of participants.

Table C.1

*Demographic Information for Participants in the Experimental GAPT Group (n = 30) and Active Control RM Group (n = 30)*

Demographic Variable		Experimental Group	Control Group
Gender	Male	15	15
	Female	15	15
Grade	3	10	7
	4	11	11
	5	9	12
Age	10 years old	8	7
	11 years old	12	8
	12 years old	10	15
Duration at Orphanage	4-15 months	4	5
	16-30 months	2	1
	31-45 months	2	4
	46-60 months	10	11
	61-75 months	5	3
	76-90 months	6	6
	91-105 months	0	0
	106-120 months	1	0

### Procedures and Treatment

To determine if children qualified to participate in the study, teachers completed the TRF and housemothers completed the CBCL for identified children with consent to participate. The teachers completed TRFs during the fourth week of school, and at that time it was hoped they would have had opportunity to build relationships with children and to provide time to accurately

rate problem behaviors. Teachers and housemothers completed demographic data on each student.

Participants were stratified by gender and randomly assigned to the experimental group (GAPT:  $n = 15$  males and  $n = 15$  females) or active control group (RM:  $n = 15$  males and  $n = 15$  females) using a random table of numbers. Stratified random assignment was used to ensure an equal number of males and females in treatment groups, because the GAPT treatment protocol called for same-gender preadolescents to receive the intervention in small groups of three (Bratton & Ferebee, 1999; Ginott, 1994; Flahive & Ray, 2007; Packman & Bratton, 2003; Paone, 2006; Paone et al., 2008). Criteria for assigning experimental and control participants to the intervention groups of three followed recommendations of Bratton et al. (2009) and Ginott (1994) and included: (a) same gender, (b) not more than 1 year apart in age, and (c) not classmates. In addition, members' presenting issues were considered in an effort to maximize therapeutic effect within the intervention groups (Ginott, 1994). Thus, the GAPT group was divided into 5 groups of 3 males and 5 groups of 3 females for the purpose of receiving the intervention. The RM group was likewise divided to receive RM.

Participants in both the GAPT and RM condition participated in an average of 16 sessions, twice weekly for 50 minutes per session, over a 10-week period. Prior play therapy research demonstrated that beneficial medium and large effect sizes were attained in 16 sessions or fewer (Bratton et al., 2005; Flahive & Ray, 2007; Packman & Bratton, 2003; Ray, Schottelkorb, & Tsai, 2007). Consistent with the procedures used by Packman and Bratton (2003), length of session was accommodated to the school schedule and thus shortened from the 1.5 hour group activity therapy format suggested in the literature (Bratton & Ferebee, 1999; Schiffer, 1969; Slavson & Redl, 1944). Measures were taken to insure that teachers and housemothers, as sources of pretest and posttest data, would be blinded to the study: (a) they

were not informed of children's group assignment; (b) all children left the classroom for the same length of time and in the same manner; (c) treatment facilitators for both conditions were instructed to use identical statements when retrieving children from the classroom, "I am here to get Jaymar;" and (d) treatment facilitators for both conditions were cautioned not to discuss the intervention with teachers or housemothers at any time until the study was completed.

### Description of Treatment

#### GAPT Intervention

GAPT was designed as a developmentally responsive intervention for preadolescents and closely followed the group play/activity therapy research protocol used by Packman and Bratton (2003). In the present study, CCPT (Landreth, 2002) principles and procedures provided the framework for conceptualization and practice. In response to preadolescent's unique social, emotional, and cognitive developmental needs, the GAPT intervention provided an integration of unstructured and semi-structured activities (Bratton & Ferebee, 1999; Bratton et al., 2009; Davis, 2002; Packman & Bratton, 2003; Wilson & Ryan, 2005). According to the GAPT protocol, the therapist is flexible and allows group members to use expressive materials in their own way without pressure from the therapist to move in a certain direction (Appendix J). Consistent with Roger's (1951) teachings, principles guiding the GAPT process included belief in preadolescents' capacity for positive self-growth and their ability to set their own goals and work toward their own progress and belief in the significance of the therapeutic relationship in facilitating clients' released potential for movement toward personal growth--a relationship in which the therapist experiences and communicates genuineness, empathy, and acceptance.

The GAPT treatment protocol consisted of 16 sessions. Sessions were held twice weekly in a specially-equipped room at the school located within the orphanage complex and were approximately 50 minutes in length. Consistent with Packman and Bratton (2003), the structure

for the sessions included opportunities for self-directed and group-directed activities as well as semi-structured activities offered by the counselor. Throughout the 16 session protocol, the therapist used facilitative responses characteristic of a child-centered approach, as evidenced by adherence to the GAPT skill checklist (Appendix H). Approximately 10 minutes at the end of each session was allocated for closure and sharing among group members, and to facilitate transition back to the classroom. GAPT sessions were conducted in a specially-equipped room set up in the school. Following recommendations for setting up the space and materials for group activity therapy, materials and toys were selected that were consistent with the developmental needs of preadolescents (Bratton et al., 2009; Packman & Bratton, 2003). Bratton and Ferebee (1999) provided a detailed list of suggested play/expressive materials and equipment and gave guidelines for selecting materials for developmental need and therapeutic value. As suggested by Hinds (2005), culturally appropriate toys/materials for African children were provided in the play room including African dolls, variety of African music instruments, African clothes/outfits for dress up, beads and toys of animals found in Africa.

*Session 1.* Consistent with Ray and Schottelkorb's (2009) recommendation for child-centered work with preadolescents, participants were introduced to the playroom and the structure of the counseling relationship. Therapist introduced session by saying,

This is our special play room. In here you can talk or play with the toys (pointing to toy shelves) or use the materials (pointing to expressive materials) in a lot of the ways you would like. I will not share with your teacher or house mother what you share or do here unless if I think you or others are not safe. It is okay for you if you chose to share what you individually share in here but it is not okay for you to share what other members of the group share during our time together.

Objectives for the first session were to allow group members to explore the playroom and materials in their own way and in their own time, to begin to develop a sense of safety, and to connect with the therapist and each other.

*Sessions 2 through 6.* The next five sessions generally followed the format described by Packman and Bratton (2003) of offering a semi-structured activity and allowing approximately 20 minutes for completion, followed by approximately 20 minutes of self-directed or group-directed play. Consistent with the literature choices of expressive media offered proceeded from media which offered participants most control in Session 2 to media that offered less control as sessions progressed (Bratton et al., 2009; Landgarten, 1987). As mentioned previously, opportunity for sharing and closure is important; thus time was allocated for sharing and closure at the end of each session. Appendix J contains the GAPT protocol and provides descriptions of sample activities and general guidelines for presenting and processing activities from a child-centered perspective. A brief rationale for including both semi-structured activities and unstructured time for self-directed activity follows.

From a child-centered orientation, semi-structured activities were offered tentatively and with the intent of facilitating connections and interaction between group members, reducing group members' anxiety and establishing sense of safety and comfort, fostering opportunities for group cooperation and collaboration, and to a lesser degree, and exposing participants to variety of expressive art materials with which they might not be familiar. The overarching aim of providing semi-structured activities was twofold. The semi-structured activities served as a means for facilitating psychological contact and releasing preadolescents' inner-directed and constructive potential for growth. The intent was never to direct the individual or group process. Group members were free to participate or not participate and to change the course and process of an activity at any time.



Self-directed activity is considered the heart of a child-centered approach. Bratton et al. (2009) emphasized that opportunities for spontaneous and self-directed creative expression is the primary source of intra- and inter-personal growth and lasting change within an activity group format. The GAPT protocol suggests allowing a minimum of 20 minutes for self-directed and group-directed activity during Sessions 2 through 6 to expressly facilitate self-creative expression. Packman and Bratton (2003) emphasized that a humanistically-oriented group provides preadolescents a microcosm in which to experience self and others in genuine interactions that foster understanding of self and others. Packman and Bratton posited the additional benefits of self-directed activity as providing preadolescents with opportunities to initiate contact, gain an enhanced understanding of self in relationship to peer interactions, confront difficulties that naturally emerge, problem-solve, make decisions, learn self-control, and perhaps most important, develop internal resources that they can draw on long after the group has ended.

*Sessions 7 through 16.* The GAPT protocol offers guidelines for allowing self-directed activities to emerge naturally. The expectation is that after six to seven sessions in which semi-structured activities are offered primarily as a means of facilitating psychological contact the need for semi-structured activities would be less. In the present study, by Session 7 all of the 10 groups had established a sense of safety, and the participants seemed comfortable with the spontaneous use of materials and toys. Thus the remaining sessions followed a self-directed and group-directed process.

The GAPT intervention was provided by a doctoral level counselor who had received training and supervision in three play therapy courses and four advanced clinical courses including group play/activity therapy. For the purpose of supervision and treatment fidelity, all sessions were video-recorded. Approximately 10% of the sessions were randomly selected for

viewing by a designated supervisor who was an expert in play therapy and group activity therapy. Through the video-recorded sessions and the use of the Group Play/Activity Skill Checklist (GPASC; Bratton, 2010), the supervisor provided on-going supervision to the GAPT counselor and ensured that the counselor was following the GAPT protocol. Additionally, I recorded notes of the treatment sessions after each session using group activity therapy session summary (Appendix I).

#### Active Control Group: Reading Mentoring

RM was designated as the active control group to control for time and attention, rather than a comparison treatment. Thus, RM participants were offered the GAPT intervention after study completion. Students chosen for the active control participated in RM for the same amount of time as students in the experimental group. Children received an average of 16 sessions over 10 weeks. Consistent with GAPT, RM sessions were held twice per week for 50 minutes per session. Five children received 15 sessions due to illness or change in class schedule. A graduate-level college student, trained according to the reading mentoring Protocol used by Meany-Walen (2010), provided RM to participants (Appendix L). The mentor documented all sessions using the RM track form included in the protocol (Appendix L). A research supervisor observed all RM sessions and provided on-going supervision to mentor to ensure adherence to the reading mentoring protocol.

#### Data Collection

Teachers and housemothers completed the TRF and CBCL, respectfully, for participating children prior to the study for screening and pretest purposes and again following the treatment period. I was available during the collection of data to answer any questions. To assure the integrity of data collection procedures, teachers and housemothers were provided a setting free from distractions in which to complete assessments. All house mothers completed assessments

in the designated setting; however, due to scheduling and other time constraints, not all teachers chose to complete assessments during the scheduled times. Teachers completed TRFs during the fourth week of school, and at that time it was hoped they would have had opportunity to build relationships with children and to provide time to accurately rate problem behaviors. Time constraints prevented waiting longer in order to complete the study prior to the end of the school term. Teachers and housemothers also provided the demographic data for each student.

### Data Analysis

To answer the research questions, combined between/within-subjects analysis of variance (ANOVA; i.e., split-plot analysis; Pallant, 2007) was used in data analysis. For each dependent variable, a two (group) by two (repeated measures) split plot ANOVA was performed in PASW to analyze group differences, changes across time, and possible interaction effect of group membership with change across time, which was of particular interest in this study. In the analysis, treatment group served as the between-subjects variable and time (pretest to posttest) served as the within-subjects variable. I ran separate analyses for the TRF Internalizing Problems, TRF Externalizing Problems, CBCL Internalizing Problems, and Externalizing Problems scales as dependent variables. The required assumption of sphericity was assumed, since there were only two points of measurement. Methodological assumptions that accompany split-plot ANOVA were considered and evaluated (Armstrong & Henson, 2005).

An *a priori* alpha level of .025 was used as the criterion for determining statistical significance (Thompson, 2002). A more conservative *a priori* alpha level of .025 was established as the criterion for determining statistical significance to avoid Type I error resulting from multiple hypothesis testing (Armstrong & Henson, 2005). Thompson (2002) noted that statistical significance conveys how particular outcomes may occur under certain circumstances but does not offer information on the importance of result. Effect size refers to the strength of

the difference between groups (Kazdin, 2003; Pallant, 2007). Effect size was reported according to partial eta-squared ( $\eta^2$ ), interpreted according to Cohen's (1988) guidelines of .01 as a small effect; .06 as a moderate effect; .14 as a large effect, and used to determine the practical significance of the results (Cohen, 2002; Sink & Stroh, 2006). As proposed by Vacha-Haase and Thompson (2004), all effect sizes were reported following either significant or non-significant statistical testing results in order to determine the practical significance of the results. A power level of .80 was established as criterion for determining adequate power (Balkin & Shepris, 2011).

Clinical significance focuses on evaluation of treatment effects impact on client's functioning (Kazdin, 2003). The number and percentage of participants who moved from clinical or borderline levels of behavioral problems to normal functioning were used as an indicator of the clinical significance of the group play activity therapy intervention on the lives of participants (Kazdin, 2003).

APPENDIX D  
EXTENDED RESULTS

## Introduction

In this appendix, I discuss the results of this study. Results of data analyses are presented in the order of the research questions.

For each dependent variable, the Teacher Report Form's (TRF) Internalizing Problems and Externalizing Problems and the Child Behavior Checklist's (CBCL) Internalizing Problems and Externalizing Problems, a two (group) by two (repeated measures) split plot ANOVA was performed in PASW to analyze group differences, changes across times, and the possible interaction effect of group membership with change across time, which was the primary focus of this study. This repeated measures approach was used to measure change between groups over time. The two levels of time were pretest and posttest for each dependent variable. Significant differences between the means across time were tested at the .025 alpha levels. Prior to conducting the analysis, dependent variables were inspected to screen data for normality and homogeneity of variance. The TRF and CBCL were administered prior to treatment and at the end of intervention. A reduction in scores on the TRF and CBCL scales indicated improvement in the targeted behavior. Wilks' Lambda was used to interpret results. Partial eta squared ( $\eta_p^2$ ) effect sizes were calculated to assess the magnitude of difference between the two groups over time due to treatment. In the interpretation of effect sizes, the guidelines utilized included .01 as a small effect; .06 as a moderate effect; .14 as a large effect (Sink & Stroh, 2006).

## Research Question Analyses

Research Question 1 asked: Will GAPT decrease internalizing problems of orphaned preadolescent students living in Uganda when compared to reading mentoring (RM)? Table D.1 presents the pretest and posttest means and standard deviations for the experimental ( $n = 30$ ) and control group ( $n = 30$ ) on the Internalizing Problems scales of the TRF and CBCL.

Table D.1

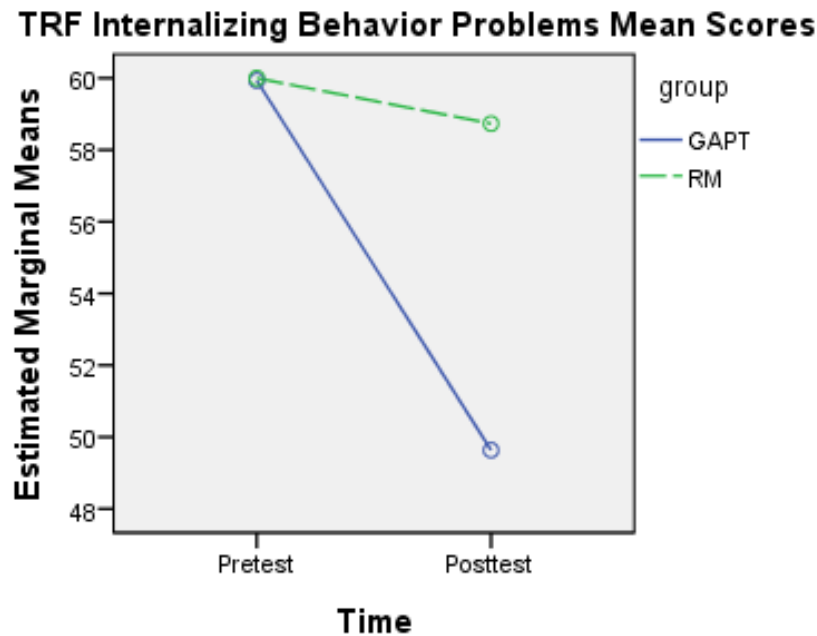
*Mean Scores on the Internalizing Problems Scales for the TRF and CBCL*

Instrument	<u>Experimental (n = 30)</u>		<u>Control (n = 30)</u>	
	Pretest	Posttest	Pretest	Posttest
TRF Internalizing				
Mean	59.93	49.63	60.00	58.73
SD	8.288	7.449	10.147	10.130
CBCL Internalizing				
Mean	62.50	52.07	62.03	62.73
SD	11.401	8.554	8.438	11.441

*Note.* Decreases in mean scores indicated improvements in behavior.

### TRF Internalizing Problems

A mixed between-within subjects ANOVA (split-plot ANOVA) was conducted to examine the impact of two different interventions (GAPT, RM) on participants' scores on the TRF Internalizing Problems, across two time periods (pretest and posttest). There was significant interaction between treatment group and time with Wilks' Lambda = .787,  $F(1, 58) = 15.720$ ,  $p < 0.001$ , partial  $\eta^2 = .213$ . These results indicated that according to teacher reports, students who participated in the experimental group (GAPT) demonstrated a statistically significant decrease in internalizing problems from pretest to posttest, when compared to students who were in the active control group (RM). GAPT demonstrated a large treatment effect ( $\eta_p^2 = .213$ ) on student's internalizing problems when compared to the RM group (Figure D.1). Post hoc power analysis revealed an observed power of .974.

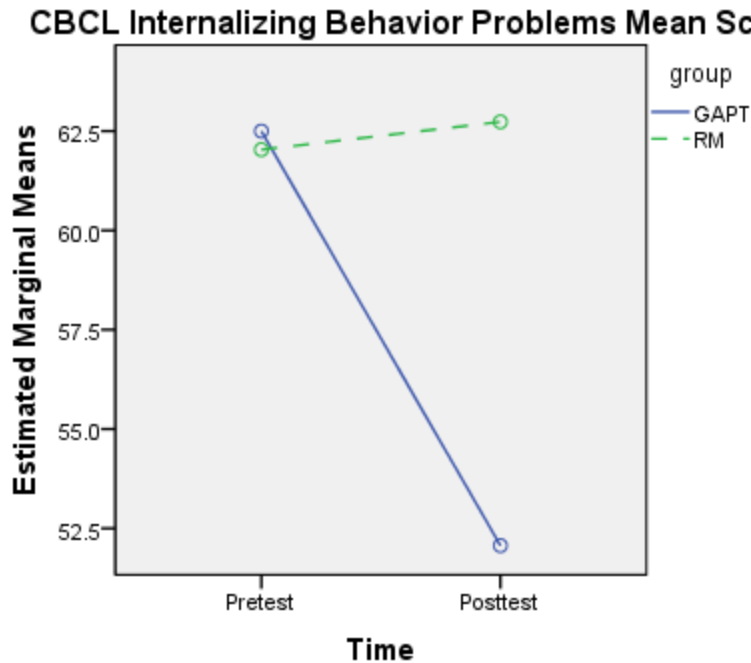


*Figure D.1.* Mean scores for TRF Internalizing Behavior Problems from pretest to posttest.

#### CBCL Internalizing Problems

Results of the split-plot ANOVA on the Internalizing Problems scale of the CBCL revealed a statistically significant interaction effect between treatment group and time with Wilks' Lambda = .756,  $F(1, 58) = 18.697$ ,  $p < .001$ , partial  $\eta^2 = .244$ . According to housemother reports, students who participated in the experimental group (GAPT) showed a statistically significant decrease in internalizing problems from pretest to posttest, when compared to students who were in the active control group (RM). Using Cohen's (1998) guidelines, the GAPT intervention group demonstrated a large treatment effect ( $\eta_p^2 = .244$ ) on students' Internalizing Behavior in comparison to the students in the RM group (Figure D.2). Post hoc power analysis revealed an observed power of .989.





*Figure D.2.* Mean scores for CBCL Internalizing Behavior Problems from pretest to posttest.

Research Question 2 asked: Will GAPT decrease externalizing problems of orphaned preadolescent students living in Uganda when compared to reading mentoring (RM)? Table D.2 presents the results of the pretest and posttest means and standard deviations for the experimental group ( $n = 30$ ) and control group ( $n = 30$ ) on the externalizing problems scale of the TRF and CBCL.

Table D.2

*Mean Scores on the Externalizing Problem Scales on the Teacher Report Form and Child Behavior Checklist*

Scale	<u>Experimental GAPT (<math>n = 30</math>)</u>		<u>Control RM (<math>n = 30</math>)</u>	
	Pretest	Posttest	Pretest	Posttest
TRF Externalizing				
Mean	63.800	53.700	64.630	61.070
SD	8.616	7.548	10.046	8.630
CBCL Externalizing				
Mean	64.130	55.930	66.470	66.530
SD	12.470	10.954	7.167	8.072

*Note.* A decrease in mean scores indicates an improvement in behavior.

#### TRF Externalizing Problems

Results of the split-plot ANOVA on the Externalizing Problems scale of the TRF revealed a statistically significant interaction effect between treatment group and time with Wilks' Lambda=. 879,  $F(1, 58) = 8.01$ ,  $p < .006$ , partial  $\eta^2 = .121$ . Results revealed that students who participated in the experimental group showed a statistically significant decrease in externalizing behaviors compared to students' in the active control group (RM). Also, teachers indicated that GAPT had a moderate effect ( $\eta_p^2 = .121$ ) on the externalizing behavior problems of children who participated in the GAPT treatment as compared to children who participated in RM (Figure D.3). Post hoc power analysis revealed an observed power of .795.

Figure D.3 presents mean scores on TRF Externalizing Problems from pretest to posttest for the GAPT and RM groups as rated by teachers.

### TRF Externalizing Behavior Problems Mean Scores

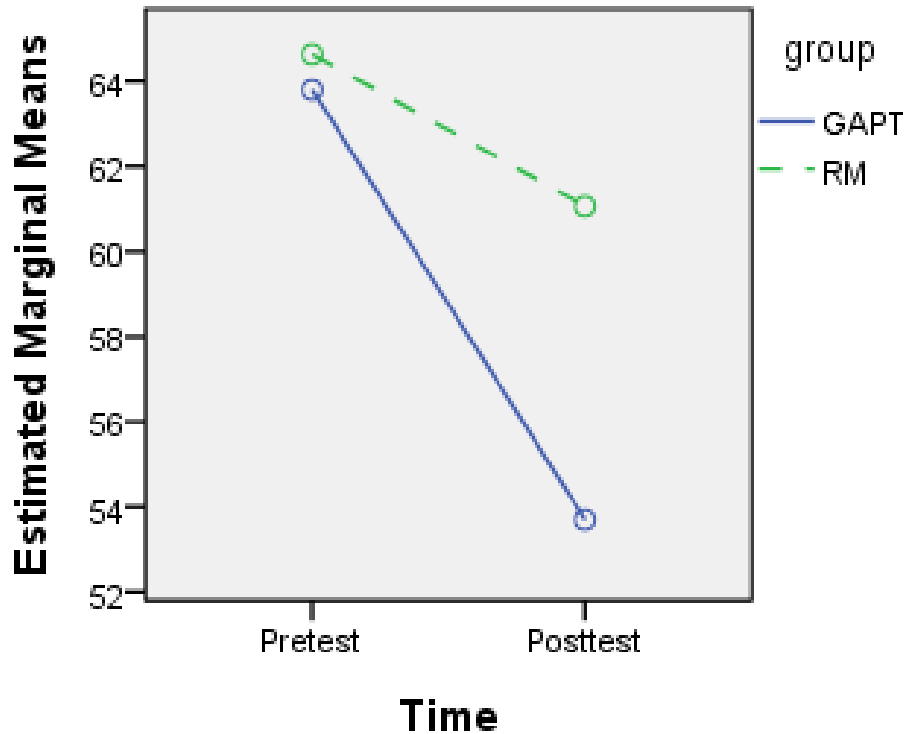


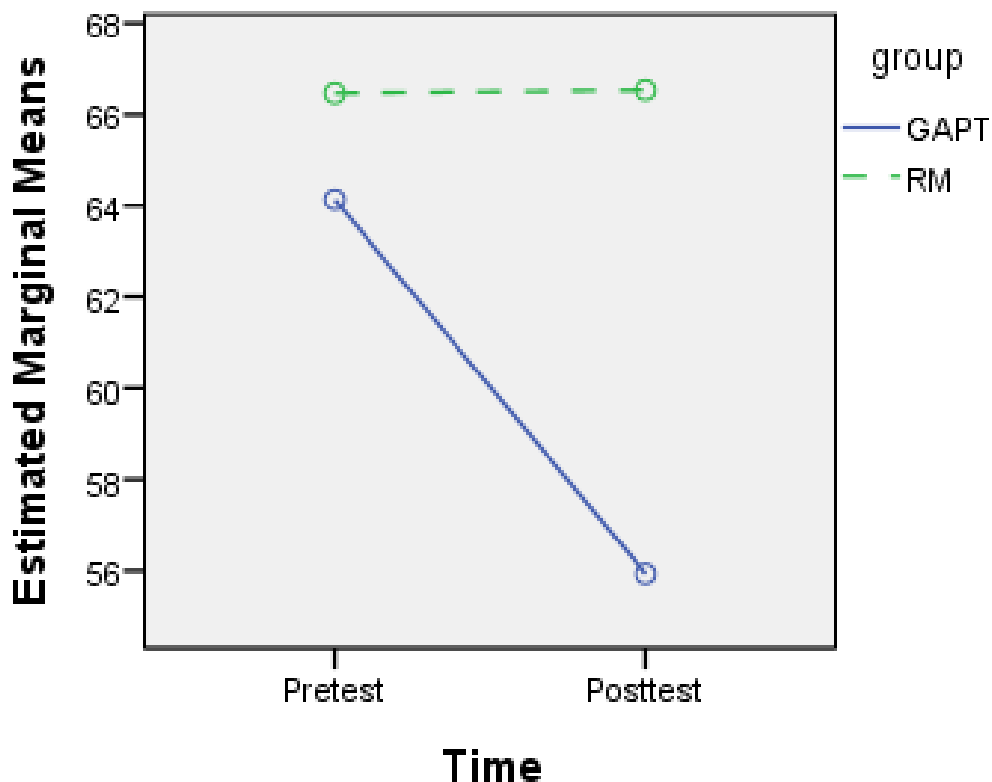
Figure D.3. Means of Externalizing Problem Behaviors scores for GAPT and RM at pretest and posttest as measured on the TRF.

#### CBCL Externalizing Problems

A visual inspection of means suggested a possible difference in the groups at pretest (Figure D.4). Results from a one-way between groups ANOVA to compare pretest means revealed no statistically significant difference,  $F(1, 58) = .790, p = .379$ ; thus, I proceeded with split-plot ANOVA as planned. Results of the split-plot ANOVA on the Externalizing Problems scale of the CBCL revealed a statistically significant interaction effect between group treatment and time, Wilks' Lambda = .783,  $F(1, 58) = 16.118, p < .001$ , partial  $\eta_p^2 = .217$ . Results demonstrated that children who participated in GAPT showed a statistically significant decrease in externalizing behaviors compared to students' in the active control RM group as reported by

housemothers. In addition, the housemothers indicated that the GAPT treatment had a large effect ( $\eta_p^2 = .217$ ) on the externalizing behavior problems of children who participated in the experimental group as compared to the children who received RM. Post hoc power analysis revealed an observed power of .977.

### CBCL Externalizing Behavior Problems Mean Scores



*Figure D.4.* Means of Externalizing Problems scores for GAPT and RM at pretest and posttest as measured on the CBCL.

### Clinical Significance

Clinical significance refers to practical value of treatment on client's functioning in real life (Kazdin, 2003). To ascertain if the GAPT treatment modality positively impacted children, the number and percentage of participants who moved from clinical or borderline levels of

behavioral problems to normal functioning were used as an indicator of the clinical significance of group activity play therapy intervention on the lives of participants (Kazdin, 2003). Using clinical/borderline cut off scores identified by the TRF and CBCL, individual participants who scored at clinical level at pretest on the Internalizing Problems scale or Externalizing Problems scale were tracked for progress to establish movement toward nonclinical scores at posttest. According to Achenbach and Rescorla (2001), normal range is considered to be T scores below 60, borderline clinical range is fixed at *T* scores of 60 to 63 (approximately the 84th through 90th percentiles), and the clinical range at  $T \geq 64$  for Internalizing, Externalizing, and Total Problems on the TRF and CBCL.

#### Internalizing Problem Behavior Outcomes

Participant's T-scores on the Internalizing Problem scales on the TRF and CBCL were examined to establish the clinical significance of GAPT on children's behavior. According to teacher ratings for Internalizing Problems on the TRF at pretest, 33 students (GAPT = 16; RM = 17) were identified at borderline or clinical range at pretest. Of the 16 children (clinical = 9, borderline = 7) in the treatment group who presented in the borderline/clinical range, 12 moved to normal functioning levels after treatment, 2 moved from clinical to borderline, 1 remained at borderline level, and 1 child stayed in clinical level. Thus, of the 16 children in the GAPT group demonstrating clinical functioning levels of internalizing behavior problems as reported by teachers prior to treatment, 12 out of 16 (75%) were identified as achieving normative functioning levels at posttest.

A total of 40 students (GAPT = 19; RM = 21) were identified by housemothers on the Internalizing Problems scale of the CBCL at pretest as demonstrating clinical or borderline clinical levels of concern. At posttest, of the 19 children (clinical = 17, borderline = 2) who received GAPT treatment, 14 moved to normal functioning level, 2 moved from clinical to

borderline, 1 remained at borderline level, and 2 stayed in the clinical level with an average of a 10 point decrease in score. Hence, of the 19 participants in the GAPT group who demonstrated clinical functioning levels of internalizing behavior problems as reported by housemothers prior to treatment, 14 out of 19 (74%) were identified as achieving normative functioning levels at posttest.

#### Externalizing Problem Behavior Outcomes

At pretest, a total of 42 students (GAPT = 21, RM = 42) were rated by teachers as showing clinical/borderline levels of functioning on the Externalizing Problems scale of the TRF. Of the 21 students who presented in the clinical range, after GAPT treatment, 13 moved to normative functioning, 3 moved to borderline, 2 remained at the borderline range, and three remained at the clinical level. Thus, of the 21 children in the GAPT group who presented in the clinical range prior to treatment, 13(70%) moved to normative functioning after their participation in GAPT.

An examination of data indicated that 48 students (GAPT= 23, RM= 25) scored at clinical/borderline levels on the Externalizing Problem Behaviors scale of CBCL as rated by house mothers. Of the 23 children in the GAPT group who presented in the clinical range at pretest, by posttest, 13 moved to normative functioning, 2 moved to borderline, and 8 remained in clinical level with an average of a 5-point decrease in clinical score. Hence, of the 23 children in the GAPT group who presented in the clinical or borderline range prior to treatment, 13 (57%) moved to normative functioning after participation in GAPT.

APPENDIX E  
EXTENDED DISCUSSION

## Introduction

In this study, group activity play therapy (GAPT) demonstrated positive treatment effects with orphaned Ugandan preadolescents exhibiting behavioral problems. Data analyses revealed that teachers and housemothers reported statistically significant improvements regarding the internalizing and externalizing behavioral problems for preadolescents who participated in GAPT over children who received reading mentoring (RM). Overall, results from the present study were consistent with findings from Bratton et al.'s (2005) meta-analysis in which play therapy demonstrated a large treatment effect on children's internalizing and externalizing behavior problems and humanistic child interventions demonstrated a large effect size.

### Effects on Internalizing Problem Behaviors

Teachers and housemothers reported a significant decrease in internalizing behavior problems among preadolescents who received GAPT compared to those who received RM. Findings further showed that GAPT demonstrated a large treatment effect. The findings were consistent with earlier outcome studies (Flahive & Ray, 2007; Packman & Bratton, 2003) which showed that similar group play-based interventions were effective treatments for preadolescents with internalizing behavior problems. In addition, these results were similar to findings from CCPT studies where CCPT demonstrated positive outcome with an ethnic minority population of children exhibiting internalizing behavior problems (Garza & Bratton, 2005) and children with a trauma history (Tyndall-Lind et al., 2001). Study findings were strengthened by the fact that both housemothers and teachers reported statistically significant therapeutic impact for GAPT on preadolescents' internalizing problems. Similarly, Packman and Bratton (2003) found consistent statistically significant results between parents and teachers; whereas Flahive and Ray's (2007) findings differed in that teachers reported statistically significant between group differences in



the internalizing behaviors of fourth and fifth graders, while parents' reports were not statistically significant.

Consistent with child centered principles, the GAPT counselor established a group climate characterized by acceptance, empathic understanding, and genuineness. Expression of these attitudes within a supportive group climate may have allowed preadolescents to experience these attitudes as activators of change (Ray, 2011). In addition, the experimental group preadolescents were offered varied materials chosen for developmental responsiveness and opportunity for creative self-expression (Bratton & Ferebee, 1999; Ginott, 1994; Kottman et al., 1987). In traditional Ugandan culture free expression of negative feelings and emotions is discouraged including internalized feelings such as sadness, grief, and depression that result from traumatic or devastating experiences. Thus, provision of varied expressive media during the GAPT intervention along with therapeutic conditions associated with CCPT seemed to provide participants with a safe, permissive, and developmentally responsive means to express and work through previously internalized feelings. Specifically, the inclusion of traditional African musical instruments seemed to facilitate expression of difficult emotions through music. The use of music, rhythm and dance is a customary and important means of expressing emotions in African culture. Other African materials that were used extensively by the children to express themselves in their therapeutic journey included beads and collage materials, especially fabrics.

Findings demonstrated particular significance for the population studied in view of research that has shown that internalizing problems such as depression, anxiety, and sadness are the most often reported disorders in orphaned children in Uganda (Atwine et al., 2005; Cluver & Gardner, 2007; Musisi et al., 2007). The present study appears to be the first of its kind and offers promise as a solution to preventing the unnecessary suffering of preadolescent orphans.

## Effects on Externalizing Problem Behaviors

Both teachers and housemothers reported a statistically significant improvement in the experimental GAPT group's externalizing problems compared to the active control RM group. In examining the practical significance of the results, housemother reports showed a stronger effect ( $\eta_p^2 = .217 = \text{large effect size}$ ) for the experimental treatment when compared to the active control than did teacher report ( $\eta_p^2 = .121 = \text{moderate effect size}$ ). However, the clinical significance of the findings occurred as teachers saw improvement in the day-to-day functioning of more children (70%) than did housemothers (57%). Nonetheless, it is noteworthy that the majority of orphaned children receiving GAPT moved from clinical externalizing behavioral concern to normal levels of functioning following treatment. Findings were consistent with previous controlled outcome studies which showed that similar group play-based interventions had moderate to large treatment effects for preadolescents exhibiting externalized behavior difficulties (Flahive & Ray, 2007; Packman & Bratton, 2003). Interestingly, both the Packman and Bratton (2003) and Flahive and Ray (2003) studies reported differences between parent and teacher perceptions of externalizing behaviors according to their reports at posttest.

Outcome results for the present study were similar to findings from controlled studies following CCPT protocol in which play therapy demonstrated positive outcomes on the externalizing problems of children (Flahive & Ray, 2007; Garza & Bratton, 2005; Kot et al., 1998; Ray et al., 2007; Ray et al., 2009; Tyndall-Lind et al., 2001). Both Ray et al. (2009) and Tyndall-Lind et al. (2001) attributed the decline in aggressive behavior to an increased experience of empathy within the CCPT context and provision of materials which allowed for expression of aggressive feelings and behavior. Similarly, in the present study, materials were

selected to facilitate expression of a range of feelings which might have helped group members develop their capacity to express themselves in socially appropriate ways.

Additionally, findings supported group counseling literature which suggested the importance of a group format for preadolescents exhibiting aggression and difficulties in relationships (Akos et al., 2007). The present findings regarding GAPT's effectiveness on externalized problems of displaced children appear to represent the first study to respond to the call by Ugandan researchers to identify mental health services for orphaned children who tend to display high levels of aggression, conduct problems, and relationship difficulties (Atwine et al., 2005; Doku, 2007).

#### Limitations of Study

The sample size was small, and the participants were recruited from a single geographic area, limiting the generalization of the results to other children living in other contexts. A larger sample selected from multiple sites would strengthen generalizability of outcomes. Replication would add to the reliability of the current findings.

Research procedures were structured to minimize the possibility of teachers or housemothers being aware of participant's treatment groups. However, it was difficult to completely control for teachers and housemothers' recognition of children's group assignments. For example, researchers could direct treatment facilitators not to discuss the study with teachers but could not control for what participants might say to their teachers or housemothers. In addition, several GAPT members took their expressive arts creations with them at the end of each group session. The study population had a history of extreme deprivation which may have influenced what appeared to be a strong, but unanticipated, need for some preadolescents in the experimental group to take their creations with them. Future research designs with this population should consider a comparison group treatment that used art materials. The possibility

of teachers or house mothers discovering children's group assignments may have affected their judgements of and perceptions about the participants, although it is important to note that teachers and housemothers saw RM as a valuable intervention for these children.

Finally, although the literature supported the positive impact of mentoring on children's behaviour (Cavell et al., 2009), study rigor would have been increased by the use of a comparison treatment with evidence to support its use with children with behavioral problems. Replication of this research with a larger sample in a multi-site setting and compared to a well-established child counseling intervention, particularly one that involves some type of art materials could answer the majority of this study's limitations and is needed to provide a strong evidence base for GAPT with this population.

#### Implications for Future Practice and Research

Although this study showed positive support for effects of GAPT on the behavioral problems of orphaned youth in Uganda, further research in this area is needed in order to offer this intervention as an evidence-based practice for similar populations of troubled preadolescents. Proponents of evidence based treatments have advocated for the identification of specific populations and disorders in order to draw conclusions about treatment effects (Chambles & Hollon, 1998). Even though this study focused on a very specific population of children, orphaned Ugandan preadolescents who were exhibiting clinical externalizing and internalizing behavior concerns, future studies could explore more specific diagnosis or symptom categories.

This research study presented promising results regarding the application of a child-centered approach to GAPT in a real world setting and advanced support for the effectiveness of this intervention in reducing behavioral problems with preadolescents. However, the process of

change was not examined in this study, which suggests a possible direction for future research on child-centered GAPT.

The use of a controlled, pre-post research design with randomization of participants contributed to the strength of findings on GAPT's treatment effects. Time constraints did not allow for administration of follow up assessments to establish sustainability of treatment benefits, thus incorporating these methods could strengthen future GAPT outcome research. Drawing on research findings regarding the strong treatment effects for training parents and teachers in CCPT (Bratton, Landreth, & Lin, 2010), researchers should consider an investigation of a similar model for training important caregivers in GAPT. Such a model would seem particularly valuable for orphaned children. A noteworthy observation in this research project was caregivers' reports of feeling more bonded to children who received GAPT. Caregiver-child relationship and attachment behavior were not measured as variables in this study; however, informal observations of possible effects points to another research area to explore for benefitting orphaned children.

A noteworthy observation made through conducting this research was that preadolescents tended to select different media as sessions progressed. Their selections matched recommendations provided by Bratton et al. (2009) and Landgarten (1987) on movement from media with most control to least control. Given that observation, counselors working with preadolescents might consider providing varied expressive media to meet their developmental and therapeutic needs.

Based on study outcomes, orphaned preadolescents seemed to benefit from experiencing acceptance and empathic understanding inherent in a child-centered counseling relationship. This finding may offer practical implications for child counselors in Uganda. Communication of acceptance, along with materials that fostered symbolic expression, seemed to have

encouraged exploration of issues that were most meaningful for the preadolescents in this study including religious and spiritual beliefs. In traditional Ugandan culture just like in other African societies, religion and spirituality are embedded in the human existence (Ahia, 2006) and viewed as an essential part of their support and coping process. Thus, counselors who work with this population are encouraged to provide an environment that communicates acceptance of Ugandan values and promotes free expression.

Another notable observation was participants' expression of negative feelings such as aggression and anger. The expression of negative feelings is typically not encouraged in Ugandan societies. Again, the provision of the therapeutic conditions of CCPT, including acceptance of all feelings and acceptable outlets for expressing them, seemed to encourage participants to express their negative feelings in safe and acceptable ways.

Although empathy was not a variable measured in this study, I noticed that participants expressed increased empathy toward each other during group sessions as sessions progressed. As the therapist experienced and communicated acceptance and empathic understanding of children during GAPT intervention, preadolescents seemed to experience feeling understood and cared about and thus were able to extend empathy to other group members. A related and unexpected happening was housemothers' reports of preadolescents showing increased empathy towards them. Further, I observed what appeared to be a relationship between group members' demonstrated empathy with each other and their increased exploration of personal difficulties as they processed or shared their expressive arts creations. While these observations were not substantiated by data, they do lend credence to the use of a child-centered approach and bear further investigation.

## Conclusion

The outcome of this research project revealed that GAPT demonstrated a beneficial therapeutic effect on orphaned preadolescents exhibiting significant behavioral concerns. Reports from both housemothers and teachers indicated that they noticed a marked improvement in the internalizing and externalizing problems of children receiving GAPT when compared to the group who received RM. The majority of individual participants receiving GAPT moved from clinical levels of behavioral concern to normal functioning, indicating the clinical utility of the intervention on the day-to-day functioning of troubled orphans. Findings further suggested that GAPT was responsive to the developmental and cultural needs of Ugandan preadolescents residing in a large orphanage.

Results of this study are promising, particularly in light of the critical need to identify effective interventions for displaced children living in Ugandan orphanages. A major strength of the study was derived from it being conducted in the real world setting of the school, adding to its relevance for this population and its potential for replication. Moreover, this study appears to be the first of its kind to be carried out in Uganda. In fact, a thorough review of literature revealed no well-designed controlled outcome studies examining any mental health intervention for orphaned children or preadolescents. Replication of this research with a larger sample in a multi-site setting, and compared to a well-established intervention, is needed to provide a strong evidence base for GAPT with this population.

APPENDIX F

INFORMED CONSENT FORMS



Informed Consent Recommendation  
University of North Texas Institutional Review Board  
Housemothers Recommendation for Counseling

Before agreeing to recommend \_\_\_\_\_ (child's name) to participate in this research study, it is important that you read and understand the following explanation of the purpose, benefits and risks of the study and how it will be conducted.

**Title of Study:** Group Activity Play Therapy: Effects on Behavioral Problems of Preadolescent Orphans of Uganda.

**Principal Investigator:** Dr. Sue Bratton, LPC-S, RPT-S, professor at the University of North Texas (UNT) Department of \_Counseling and Director of the Center for Play Therapy. Co-investigator is Ms. Deborah Ojiambo, M.A., assistant lecturer at Kyambogo University.

**Purpose of the Study:** You are being asked to recommend the child named above to participate in a research study which involves determining if counseling is effective in helping orphaned children who have behavioral difficulties such as poor social skills, attentions problems, and withdrawn.

**Study Procedures:** Child will be asked to participate in group activity play therapy or in a small group of reading mentoring. In group activity play therapy, children use toys and art materials to express themselves. Children will participate in 1 hour sessions, 2 times per week over a course of 8 weeks. All sessions will take place during regular school hours at a time determined by the teacher.

**Benefits and Risks to the Participants or Others:** We expect the project to benefit children by allowing them the opportunity to learn self-control and socially acceptable behaviors and reduce behavioral and emotional difficulties. As with any counseling intervention, children may become more aware of emotional difficulties

**Procedures for Maintaining Confidentiality of Research Records:** Children will be assigned a number to be used in place of their name. Names will be removed from all collected material during the study. Child's name will not be included in any reports from the study.

**Questions about the Study:** If you have any questions about the study, you may contact Deborah Ojiambo.

**Review for the Protection of Participants:** This research study has been reviewed and approved by the UNT Institutional Review Board (IRB), the Uganda National Council for Science and Technology, and the orphanage's administration.

**Research Participants' Rights:** Your signature below indicates that you have read or have had read to you all of the above and you recommend child's participation in study and that you confirm all of the following:

- Dr. Sue Bratton or Deborah Ojiambo has explained the study to you and answered all of your questions. You have been told the possible benefits and the potential risks and/or discomforts of the study.
- You understand that you do not have to recommend child to take part in this study. The study personnel may choose to stop child's participation at any time.
- You understand why the study is being conducted and how it will be performed.
- You have been told you will receive a copy of this form.

\_\_\_\_\_  
Printed Child's Name/ Grade Level

\_\_\_\_\_  
Printed Name of House Mother

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Housemother

**For the Principal Investigator or Designee:** I certify that I have reviewed the contents of this form with the housemother signing above. I have explained the possible benefits and the potential risks and/or discomforts of the study. It is my opinion housemother understood the explanation.

\_\_\_\_\_  
Signature of Principal Investigator or Designee

\_\_\_\_\_  
Date

University of North Texas Institutional Review Board

Informed Consent Form

Before agreeing to provide consent for \_\_\_\_\_ (child's name) to participate in this research study, it is important that you read and understand the following explanation of the purpose, benefits and risks of the study and how it will be conducted.

**Title of Study:** Group Activity Play Therapy: Effects on Behavior Problems of Preadolescent orphans of Uganda

**Principal Investigator:** Dr. Sue Bratton, LPC-S, RPT-S, professor at the University of North Texas (UNT) Department of Counseling and Director of the Center for Play Therapy. Co-investigator is Ms. Deborah Ojiambo, M.A., assistant lecturer at Kyambogo University.

**Purpose of the Study:** The purpose of this study is to investigate the effects of a school-based intervention designed to help orphaned children who have behavioral difficulties such as aggression, inappropriate social skills, attention problems, hyperactivity, conduct problems, and rule breaking to reduce their behavior problems.

**Study Procedures:** Children who have consent will be asked to participate in 16 group activity play therapy sessions or reading mentoring sessions. Children who give their assent will then be assigned to either the group activity play or reading mentoring. Children will participate in 1 hour sessions, 2 times per week over a course of 8 weeks. All sessions will take place during regular school hours at a time determined by the teacher. Sessions will be video-recorded for supervision purposes and to ensure that the counseling procedure for the proposed study is followed.

**Foreseeable Risks:** The potential risks involved in this study are minimal. As with any counseling intervention, children may become more aware of emotional difficulties. In such a case, the treatment provider, Deborah Ojiambo, will be available during school hours to help the child work through any emotional difficulty.

**Benefits to the Subjects or Others:** We expect the project to benefit children by allowing them the opportunity to learn self-control and socially acceptable behaviors and reduce behavioral and emotional difficulties.

**Procedures for Maintaining Confidentiality of Research Records:** Children will be assigned a random code to be used in place of their name. Names will be removed from all collected material including assessments, videos, and notes to ensure participant anonymity and confidentiality. All data and confidential information, including notes, records and videos will be kept in a secure filing cabinet located at the research site. Only the principal and co-investigators will have access to data and participant information. DVDs will be locked in a secure filing cabinet while in Uganda and after transportation to UNT will be stored in the office area of the Principal Investigator at the Center of play Therapy. Collected information will be kept for a period of three years following the conclusion of this study. At that time, all records will be properly destroyed. The confidentiality of each child's individual information will be maintained

in any publications or presentations regarding this study. Research data will be transmitted to UNT through a password protected untranet site through the University of North Texas.

**Questions about the Study:** If you have any questions about the study, you may contact Dr. Sue Bratton at 0001 940 565 3864 or [sue.bratton@unt.edu](mailto:sue.bratton@unt.edu) or Deborah Ojiambo [deborah.ojiambo@unt.edu](mailto:deborah.ojiambo@unt.edu)

**Review for the Protection of Participants:** This research study has been reviewed and approved by the UNT Institutional Review Board (IRB), the Uganda National Council for Science and Technology, and the orphanage administration. The UNT IRB can be contacted at 0001 (940) 565-3940 with any questions regarding the rights of research subjects.

**Research Participants' Rights:** Your signature below indicates that you have read or have had read to you all of the above and that you confirm that you have the right to give consent for the child named below. Further your signature confirms all of the following:

- Dr. Sue Bratton or Deborah Ojiambo has explained the study to you and answered all of your questions. You have been told the possible benefits and the potential risks and/or discomforts of the study.
- You understand that you do not have to allow the child to take part in this study, and your refusal to allow the child to participate or your decision to withdraw him/her from the study will involve no penalty or loss of rights or benefits. The study personnel may choose to stop the child's participation at any time to protect the child's welfare.
- You understand why the study is being conducted and how it will be performed.
- You understand your rights as the designate of the orphanage administration responsible for this child, and you voluntarily consent to the child's participation in this study.
- You have been told you will receive a copy of this form.

\_\_\_\_\_  
Printed Child's Name /Grade Level

\_\_\_\_\_  
Printed Name of Organization Designate

\_\_\_\_\_  
Signature of Organization Designate

\_\_\_\_\_  
Date

**For the Principal Investigator or Designee:** I certify that I have reviewed the contents of this form with the designate of orphanage signing above. I have explained the possible benefits and the potential risks and/or discomforts of the study. It is my opinion that the designate understood the explanation.

---

Signature of Principal Investigator or Designee

---

Date

APPENDIX G  
CHILD ASSENT FORM

## CHILD ASSENT FORM

You are being asked to be part of a research activity to help me learn how to help children.

If you would like to be part of this activity you will go to a play room or reading corner at school. You will be playing or reading two times a week for eight weeks. You will play or read with two other children for one hour. These play times will be videotaped. Your teacher and housemother will be filling out forms about your feelings and behaviors.

If you would like to be part of this activity, please write your name by the X.

If you change your mind, you can stop coming any time.

\_\_\_\_\_  
Printed Name of Child

\_\_\_\_\_  
Signature of Child

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Principal or Co-Investigator

\_\_\_\_\_  
Date

APPENDIX H

GROUP ACTIVITY PLAY THERAPY CHECKLIST



## GROUP ACTIVITY PLAY THERAPY SKILL CHECKLIST

Therapist: \_\_\_\_\_

Supervisor: \_\_\_\_\_ Children/Ages: \_\_\_\_\_

ACTIVITY/ PLAY THERAPY SKILLS	RANGE	COMMENTS
	Needs Work – Average - Excellent	
1. Reflected non verbal content	1.....2.....3.....4.....5 _____	
2. Reflected verbal content	1.....2.....3.....4.....5 _____	
3. Reflected feelings/intent/wishes	1.....2.....3.....4.....5 _____	
4. Facilitated and/or acknowledged therapist/child relationship	1.....2.....3.....4.....5 _____	
5. Facilitated decision making & responsibility	1.....2.....3.....4.....5 _____	
6. Facilitated spontaneity and creativity	1.....2.....3.....4.....5 _____	
7. Facilitated self-esteem and confidence	1.....2.....3.....4.....5 _____	
8. Conveyed understanding/ identified themes/larger meaning of child's play and or words	1.....2.....3.....4.....5 _____	
9. Limit setting	1.....2.....3.....4.....5 _____	

### GROUP ACTIVITY PLAY THERAPY SKILLS

10. Appropriate focus on individual needs of each child (includes use of child's name – 1 <sup>st</sup> person)	1.....2.....3.....4.....5 _____	
11. Appropriate focus on the relationship needs between 2 or more children		
a. Facilitated interaction between children	1.....2.....3.....4.....5 _____	
b. Facilitated connection between children	1.....2.....3.....4.....5 _____	
c. Facilitated cooperation/ problem solving between children	1.....2.....3.....4.....5 _____	

**THERAPIST NON-VERBAL LANGUAGE**

12. Comfortable/open/interested 1.....2.....3.....4.....5 \_\_\_\_\_
13. Fully present/genuine use of self 1.....2.....3.....4.....5 \_\_\_\_\_
14. Immediate/Spontaneous 1.....2.....3.....4.....5 \_\_\_\_\_
15. Facial expression and voice tone  
matches child/children's affect 1.....2.....3.....4.....5 \_\_\_\_\_
16. Voice tone congruent  
with response 1.....2.....3.....4.....5 \_\_\_\_\_
17. Tolerant of noise/messiness 1.....2.....3.....4.....5 \_\_\_\_\_

Note responses not consistent with skills listed:

APPENDIX I

GROUP ACTIVITY PLAY THERAPY SESSION SUMMARY

CFRC ____
CHDC ____

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

Date/Session # \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Code # \_\_\_\_\_

**GROUP ACTIVITY THERAPY SESSION SUMMARY (for rooms 9 & 10)**

Page 1 of 2

Signature on bottom of each page required

Counselor \_\_\_\_\_  
 Theory \_\_\_\_\_ Diagnosis \_\_\_\_\_  
 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
SAD: disappointed, hopeless, pessimistic, discouraged, lonely	HESITANT: timid, confused, nervous,
ANGRY: impatient, annoyed, frustrated, mad, mean, jealous	CURIOUS: 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 "1<sup>st</sup>", indicate discontinued play as "DP", Indicate play disruption as "PD", and indicate any therapist initiated activity as "TH".

- A. \_\_\_\_ B. \_\_\_\_ C. \_\_\_\_ D. \_\_\_\_ tool box/tools
- A. \_\_\_\_ B. \_\_\_\_ C. \_\_\_\_ D. \_\_\_\_ 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. \_\_\_\_ bob bag/bean bag
- A. \_\_\_\_ B. \_\_\_\_ C. \_\_\_\_ D. \_\_\_\_ dress up/jewelry/hats/masks/wand
- A. \_\_\_\_ B. \_\_\_\_ C. \_\_\_\_ D. \_\_\_\_ crafts table/clay/markers/paints/sand/art/ beads/etc
- A. \_\_\_\_ B. \_\_\_\_ C. \_\_\_\_ D. \_\_\_\_ doll family/bottle/ pacifier
- A. \_\_\_\_ B. \_\_\_\_ C. \_\_\_\_ D. \_\_\_\_ telephone/camera/flashlight
- A. \_\_\_\_ B. \_\_\_\_ C. \_\_\_\_ D. \_\_\_\_ medical kit/bandages
- A. \_\_\_\_ B. \_\_\_\_ C. \_\_\_\_ D. \_\_\_\_ musical instruments
- A. \_\_\_\_ B. \_\_\_\_ C. \_\_\_\_ D. \_\_\_\_ Assorted balls etc.
- A. \_\_\_\_ B. \_\_\_\_ C. \_\_\_\_ D. \_\_\_\_ constructive blocks
- 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/rope
- A. \_\_\_\_ B. \_\_\_\_ C. \_\_\_\_ D. \_\_\_\_ blocks/
- A. \_\_\_\_ B. \_\_\_\_ C. \_\_\_\_ D. \_\_\_\_ sandtray/miniatures

**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:

SOCIALLY 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 above appropriate level.

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/CONTROL:

HELPLESS/INADEQUATE:

AGGRESSION/REVENGE:

SAFETY/SECURITY:

MASTERY: constructive/competency/integration/resolution

NURTURING: self-care/reparative/healing

DEATH/LOSS/GRIEVING:

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

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

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

IP = Individual Play\_\_\_\_\_ PP= Parallel Play\_\_\_\_\_ CP = Cooperative Play\_\_\_\_\_ CF = Conflict\_\_\_\_\_ Note which child initiated conflict

**Children's Engagement (Connection):** (T = therapist; =====connected; ^^^^^^aggressive; ~~~~~ ambivalent)

Isolated:

Connected with other child:

Connected with therapist:

Dominant:

Submissive:

Leader:

Competitive:

Aggressive:

Jealous:

Accepting other child:

Refusing other child:

Other:

**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.)

APPENDIX J

GROUP ACTIVITY PLAY THERAPY PROTOCOL

## **Child- Centered Group Activity Play Therapy Protocol**

GAPT was designed as a developmentally responsive intervention for preadolescents based on child-centered play therapy (CCPT, Landreth, 2002) principles and procedures. In response to preadolescent's unique social, emotional and cognitive developmental needs, the GAPT intervention provided an integration of unstructured and semi-structured activities. Each session was intended to be approximately 50 minutes. Structure for the sessions included approximately 20 minutes of a semi structured activity offered by the therapist as a possible way to begin group, approximately 20 minutes of self-directed or group-directed activity chosen by group members, and approximately 10 minutes for closure and sharing.

### **Presentation of GAPT counseling structure**

#### **Session 1**

Participants were introduced to the playroom and the structure of the counseling relationship as: "This is our special play room. In here you can talk or play with any of the materials and toys in a lot of the ways you would like. I will not share with your teacher or house mother what you share or do here unless if I think you or others are not safe. It is okay for you if you choose to share what you individually share in here but it is not okay for you to share what other members of the group share during our time together." I showed them all the materials in the playroom to help them be comfortable getting started. The aim of the first session was to allow group members to explore the playroom and materials, develop a sense of safety, and begin to connect with the therapist and each other.

#### **Session 2-6**

Session 2 through 6 offered a semi structured activity as needed and allowed approximately 20 minutes for completion, followed by approximately 20 minutes of self- or group-directed activity and approximately 10 minutes for closure.

### **Presentation of semi-structure activity**

Semi-structured activities were offered tentatively and with the intent of a) facilitating connections and interaction between group members, b) reducing group members' anxiety and establishing sense of safety and comfort, c) fostering opportunities for group cooperation and collaboration, and to a lesser degree, d) exposing participants to variety of expressive art materials that they might not be familiar with (Packman & Bratton, 2003; Wilson & Ryan, 2005; Ray & Schottelkorb, 2009). The overarching aim of providing semi-structured activities was twofold: to facilitate psychological contact and to release preadolescents' inner-directed and constructive potential for growth. The intent was never to direct the individual or group process. Group members were free to participate or not participate and to change the course and process of an activity at any time.

Choices of different media were offered in session 2 to 6. Choices of expressive media offered proceeded from media which offered participants most control in session 2 to media that offered less control as sessions progressed (Bratton et al., 2009; Landgarten, 1987). Choices offered in the different sessions included; Session 2 (drawing materials and model magic), Session 3 and 4 (model magic and puppets), Session 5 and 6 (sandtray and collage materials).



Presentation of choices were offered as “Here is paper, markers, crayons or model magic you can use any of these materials to create anything you like or anything in your life ” . Participants were free to choose media which interested them. If group members choose one media and were hesitating to begin then guidelines were offered to help them get started. The aforementioned was presentation for session two and the same format was used for sessions 3-6. Details of guidelines offered for each activity are presented in the section for sample activities in this protocol. If participants of a group decided to use media which was not offered, therapist allowed them to proceed. For example if they were hesitating then therapist would respond by saying “You can choose to use the model magic or any other materials in the playroom.

For each of the sessions as the participants worked on their projects during the semi structured time, I observed and facilitated process using child-centred skills, and group activity play therapy skills. Consistent with Wilson and Ryan (2007) I provided a therapeutic climate/relationship in which participants were able to change the course and process of structured activities during session. In GAPT protocol therapist was flexible and allowed group members to use expressive materials in their own way without pressure from therapist to move in a certain direction (Wilson & Ryan, 2007). After creating their projects, I invited the group members to share their stories about their projects. The participants were not required to share. I informed them they could choose to share or not. Depending on needs of group, after 20 minutes, I invited them to choose to play or use any of the materials for the next 20 minutes during self or group directed play.

### **Presentation of Self-directed Activities**

In the GAPT protocol approximately 20 minutes were planned to be used for self-directed activities facilitate preadolescents’ self-creative expression. self-directed activities are the heart of a child-centred approach and provide preadolescents with opportunities to initiate contact, gain an enhanced understanding of self in relationship to peers, enhance social skills, learn self-control, confront difficulties that naturally emerge, problem-solve, make decisions, and perhaps most important, develop internal resources that they can draw on long after the group is over (Packman & Bratton, 2003). Participants are free to change course of direction during the entire session.

I presented counseling structure of the self –directed or group members directed time by saying, “you can talk, play with toys or use any of the materials in any way you choose in our remaining time”. If participants seemed like they were interested in proceeding with activity they had started with, treatment provider allowed them to move in the direction they had chosen. Again, I used child-centred skills to facilitate group session process.

### **Presentation of Counseling Structure for Closure**

Approximately 10 minutes allotted for closure provided opportunity for sharing and processing and facilitating transition back to classroom as session ended with discussion about school events. Consistent with child-centred principles, client’s work was not interpreted or analysed, hence closure time allowed preadolescents to share their own personal meaning of their creations or not to share (Davis, 2002; Wilson & Ryan, 2005). Basing on belief that individual preadolescents or the group had potential for self-direction, I did not interpret group member’s work, they each shared personal meaning of their creations.

The closure time was presented as, “We have 10 more minutes today before it is time to go back to class, you can share or choose not to share what you have created today.” This prompt was used if children had created something. There was flexibility on prompts used in situations where a child or some group members had not created anything using expressive media but opted to play with toys or just talk. Basing on belief that individual preadolescents or the group had potential for self-direction, I did not interpret group member’s work, they each shared personal meaning of their creations.

### **Sessions 7-16**

Sessions 7 to 16 followed a self- and group-directed process. No additional activities were offered by the therapist. The GAPT protocol offers guidelines for allowing self-directed activities to emerge naturally on the premise that once group members felt a sense of safety and acceptance and were comfortable with materials that semi-structured activities would become less needed.

## **Sample Activities for Group Activity Play Therapy Sessions**

### **Drawing Activity**

#### **Rationale for Drawing**

Drawing provides children with opportunity for self-expression, expression of feelings and establishment of self-identity (Oaklander, 2007).

Materials: paper, pencils, colored pencils, crayons, markers, pens.

#### **Procedure:**

“Here is paper and a collection of crayons, markers, pens and pencils. You can use any of the materials to create or draw anything in your life or anything you would like on paper in any way that interests you”.

Therapist facilitates participants’ description/sharing of their drawing. Therapist tentatively shares observations of the process/creation. Group members share their own personal meaning of their drawings without interpretation by therapist.

### **Play Dough/Model Magic Creature**

#### **Rationale for Play Dough/Model Magic Creation:**

Allows preadolescents to access feelings easily, provides for flexibility and facilitates their process of overcoming barriers to their emotions and experiences (Bratton & Ferebee, 1999; Bratton et al., 2008; Oaklander, 1988). Also, the media helps reduce anxiety as group members get to know each other (Bratton et al., 2008)

#### **Materials:**

Play dough/model magic, paper plates, craft materials such as features, construction paper, markers, assorted beads, and scissors.

#### **Procedure:**

Therapist presents group members with a portion of clay/model magic and introduces activity by saying “Here is play dough/model magic you can use the play dough/model magic to create anything you would like. You will have about 15 minutes to make your creation”.

Therapist notices process of making creations. Therapist facilitates participants’ description/sharing of their creation. Therapist tentatively shares observations of the process/creation. Therapist encourages participants to connect with the experience/creation. Therapist later facilitates process by reflecting on process of creation and experiences reflected by participants through their creation of their needs and difficulties (Bratton & Ferebee, 1999).

## Group Puppetry

### 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. Puppets also provide children with opportunity to express their thoughts and feelings symbolically and concretely.

### Materials:

1. Variety of puppets, 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.
2. A puppet theater is also needed for group puppetry. The puppet theater allows preadolescents the opportunity to be invisible while the character speaks.

### 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. You can decide if you would like to play with the puppets or play or use other materials in the playroom” .
- 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 any story of their choice using the puppets. The group is reminded that a story has a beginning, middle, and end. Therapist gives children time to plan their story and choose how they would like to share their story during the puppet show.
- d. Therapist interaction with puppets: During the fourth step, the therapist interacts briefly with each character in the story, reflecting content and feelings 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 do not want 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 (Packman & Bratton, 2003).

### Sandtray Play Therapy

#### Rationale for Sandtray play:

Sandtray helps participants to access feelings that are difficult to verbalize (Homeyer & Sweeney, 1998). The miniatures and sand tray provides preadolescents with more concrete opportunities for symbolic expression (Bratton & Ferebee, 1999). Using miniatures requires no skill or artistic ability hence preadolescents can easily create their own world while developing a sense of mastery and control (Bratton & Ferebee, 1999). Also helps preadolescents to increase self-awareness and examine relationships

#### Materials:

Small plastic sand trays. Variety of miniatures including people, animals, household items, natural items, and buildings.

#### Procedure:

1. Therapist introduces the activity by saying, “Here is a collection of miniatures/small toys (pointing to the shelves) and this is a sandtray where you can create a “story’ or a “picture” of your world or life in the sand. You may use as many or as few as you like. Take a few minutes to look at the miniatures/small toys and pick a few that interests you. Place them in the sandtray (pointing to the sandtray). Then add as many as you like to create a world, anything in your life in the sand (Homeyer & Sweeney, 2011; Flahive and Ray, 2007).
2. Therapist notices process of creating scenes. Later therapist facilitates participant’s description of their scenes or telling of stories about their scenes. Therapist invites group members to share their stories about their creations in the sand. Group members are not required to share. Participants can choose to share or not to share.

## Group Collage

### Rationale for Group Collage:

Collage engages preadolescents in the creative process easily as they look through magazines to pick out images that have personal meaning. Using collage allows participants to focus on the process rather than the product.

### Materials:

Markers, crayons, package of assorted colors of tissue paper, colored construction paper, magazines/pictures, paper plates, scissors, fabric, buttons, assorted colors of ribbons and yarn, glue sticks.

### Procedure:

Therapist presents materials and introduces the activity by saying, “Here is a collection of materials you can use any of the materials to create/make the picture you want” You will have approximately 15 minutes to make your picture. Again, like in any other activities offered if group members want use different media, therapist is flexible and allows them to take direction chosen.

Therapist notices process of creating collages. Therapist facilitates participants’ description/sharing of their collage. Group members are not required to share. Participants can choose to share or not to share.

Therapist tentatively shares observations of the process/creation. Therapist encourages participants to connect with the experience/creation.

## APPENDIX K

### LIST OF TOYS AND MATERIALS FOR EXPRESSIVE ARTS ACTIVITIES FOR GROUP ACTIVITY PLAY THERAPY

## LIST OF TOYS AND MATERIALS FOR EXPRESSIVE ARTS

Markers	Assortment of lace, ribbons, buttons
Crayons	Assorted plastic form items
Glue sticks	Assorted colors of tissue paper
Scissors	Assortment of sand tray miniatures
Paper plates	Pencils, paper clips
White drawing paper	Stapler
Play dough	Animal figures
Assorted Magazines	Medical kit
Assorted fabrics	Plastic knife
News print/ paper	Plastic cell phone
Modelling clay	Musical instruments
Assorted plastic form items	Blocks
Sand tray miniatures	Building toys
Various colours of construction paper	Dress up clothes
Puppets and puppet theatre	Dolls, cars and other real life toys
Assortment of beads, features, yarn	Cello tape/mark sin tape

APPENDIX L

READING MENTORING PROTOCOL



### **Reading Mentor Protocol**

Reading mentoring is an intervention for children who have a variety of concerns. Mentoring provides children with extra attention they may not receive in other areas of their lives. As a mentor you will spend undivided scheduled time with randomly assigned groups of elementary-aged children. Each group will have three children. The children will be 4<sup>th</sup> and 5<sup>th</sup> grade students. For each group you are assigned, you will facilitate 16, 1-hour sessions (2 times each week for 8 weeks).

#### **During the sessions**

You will be given a kit, which consists of a variety of age-appropriate children's books. You will need to go with the kit each time you have a session with a group of children. The books range in topics and are not specifically selected for each group of children. In an assigned area of the school you will spend time with the children. The children may choose to read or talk with you. The children or you can choose which book(s) to read.

- 1) Arrive at the school 20 minutes prior to your session. Dress appropriately for elementary school environment.
- 2) Report to the main office of the school when you arrive.
- 3) Set up your mentoring area so you are ready for the child to join you.
- 4) The office assistant can show you which classroom(s) the child(ren) are in.
- 5) Go to the classroom to get the children – wait for the teacher to acknowledge you and let him/her know that you are here for (child's name). DO NOT SAY, "I'm here for (child's name) reading mentoring time." It is VERY important that the teachers do not know which group the children are assigned.
- 6) Go directly to the mentoring area and have your mentoring session
- 7) Return the child(ren) to his/her classroom.
- 8) Make sure the teacher acknowledges his/her return.
- 9) After your final session, clean/straighten your area.
- 10) Track your session on the Mentor Tracking Form. Turn in your weekly sheets to reading mentoring supervisor.

(Adapted from Meany-Walen (2010))

### Reading Mentoring Tracking Form

Child's Name: \_\_\_\_\_ Teacher: \_\_\_\_\_

Class: \_\_\_\_\_ School: \_\_\_\_\_

Mentor's Name: \_\_\_\_\_

Date	Session #	Comments /book read

Please return each week to reading mentoring supervisor

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